September 16 2020 Regular Meeting

September 16 2020 Regular Meeting - September 16 2020 Re

AGENDA

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

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

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

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

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: 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 will be 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. New Business:
   A. Pioneer Home Health Board of Directors introductions (*information item*).
   B. Chief Nursing Officer transition (*information item*).
   C. 2020 NIHD Strategic Planning Development (*action item*).
   D. Approval of Interim Chief Executive Officer serving as a member of the Pioneer Home Health Board of Directors (*action item*).
   E. Administrator-on-Call Policy and Procedure approval (*action item*).
   F. Revised Safe Patient Handling Charter (*action item*).
4. Chief of Staff Report, Stacey Brown, MD:
   A. Policy and Procedure approvals (*action items*):
      1. *Admission, Documentation, Assessment, Discharge, and Transfer of Swing-Bed Patients*

2. *Adult Oxygen Protocol*
3. *Cardiopulmonary Department Cardiac Stress Tests*
4. *Chemotherapy Administration and Precautions*
5. *Discharging a Patient with a Hospital Administered Metered Dose Inhaler (MDI)*
6. *Omnicell Automated Dispensing Unit (ADU)*
7. *Potassium Intravenous Administration*
8. *Procedural Sedation*
9. *Pulmonary Function Testing*
10. *Vortran GO2VENT Use as Emergency Ventilator*
11. *Management of the Diabetic Patient (Insulin and Hyperglycemia Prococol)*

B. Annual Approvals (*action items*):

1. *Standardized Procedure – Adult Health Maintenance*
2. *Standardized Protocol – Adult Health Maintenance*

C. Medical Staff Bylaws update (*action item*).

Consent Agenda (action items)

5. Approval of minutes of the August 19 2020 regular meeting
6. Interim Chief Executive Officer and Chief Operating Officer report
7. Interim Chief Medical Officer report
8. Chief Nursing Officer report
9. Financial and Statistical reports as of August 31 2020
10. Compliance Department Quarterly report
11. Cerner Implementation update

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12. Reports from Board members (*information items*).
13. Adjournment to Closed Session to/for:

A. Conference with Legal Counsel, existing litigation (*pursuant to Paragraph (1) of subdivision (d) of Government Code Section 54956.9).* Name of case: Inyo County LAFCO and NIHD v. SMHD, Case No. 3-2015-8002247-CY-WM-GDS-Sacramento County.

B. Conference with Labor Negotiators, Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).

C. Conference with Legal Counsel, existing litigation (*pursuant to Paragraph (1) of subdivision (d) of Government Code Section 54956.9*), claim of Lisa J. Kuly.

D. Discussion of a real estate negotiation regarding price, 152 Pioneer Lane, Bishop, California, agency negotiators Kelli Davis, MBA; and Nickoline Hathaway MD and Asao Kamei MD (*pursuant to Government Code Section 54956.8*).

E. Confer with legal counsel regarding significant exposure to litigation (*Government Code Section 54956.9(d)(2)and (e*)(*2*)), 1 matter involving invoices submitted by John Tremble.

F. Public Employee Performance Evaluation (*pursuant to Government Code Section 54957(b*)) title: Interim Chief Executive Officer.

14. Return to Open Session and report of any action taken (*information item*).
15. Adjournment.

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

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Administrator-On-Call Policy	
Scope: Hospital Wide	Manual: Administration
Source: Chief Executive Officer/Administrator	Effective Date: 6/18/14

PURPOSE:
Ensure that an authorized and trained officer of NIHD is always available after regular business hours (i.e. nights, weekends and holidays) to help coordinate NIH's response during an emergency situation. During off hours, the Administrator-On-Call (AOC) is the appointed senior voice for the entire facility.

POLICY:

1. The Chief Executive Officer, who acts in this capacity during normal business hours, will rotate responsibility among the ~~leadership team of the administrative staff~~l leadership team, ~~that is, the Chief Operating Officer, Chief Nursing Officer, Chief of Fiscal Services, Chief Performance Excellence Officer, Chief Human Relations Officer~~, or other person designated by the CEO.

2. The monthly listing of the AOC shall be posted on the NIHD intranet and will be accessible to all units, department directors and the switchboard.

3. In accordance with schedules developed by administration, there shall be an AOC twenty-four (24) hours a day, seven (7) days a week. It shall be the responsibility of the scheduled AOC to notify CEO of any changes in the schedule.

~~4. The AOC shall cover for one full week beginning at 0800 each Monday and conclude at 0759 the following Monday.~~

5. AOCs shall remain available by telephone at all times during their time on duty and shall remain close enough to the hospital to respond in person within ~~30~~ 60 minutes.

6. During evenings, nights, major holidays and weekends, the on-site designated administrator for the Hospital is the Nursing Department's House Supervisor. This individual should be contacted first if emergency problems/questions or general questions of patient care and administration should arise.

7. The AOC is available to assist House Supervisors should the need arise. The AOC must be notified in the event of serious incidents such as the following:
   a. Hospital-wide or facility-wide emergency conditions.
   b. Emergency situations outside the facility which might have an impact on NIHD facilities.
   c. Emergency of unusual conditions on NIHD facilities wherein the health and welfare of patients, employees or visitors could be in question such as significant acts of violence, significant staffing problems, safety/care issues related to the physical facilities.
   d. Situations in which patient refuses to consent to life-sustaining treatment (i.e. refusal of blood products, etc…)
   e. Sentinel events

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Administrator-On-Call Policy	
Scope: Hospital Wide	Manual: Administration
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f. Situations where there is inadequate staffing or a high census, pending surge plan particularly in the ICU and ED and there are no available beds or sufficient nursing staff AND the House Supervisor is unable to resolve the situation. Decision to ~~close to~~not accept new admissions in specific units must be discussed with the AOC.
g. Public relations issues that may have an adverse effect on NIHD and related media requests.

8. In most cases, the AOC will act as the Incident Commander and may provide support and assistance in coordination and communication. The AOC should assess the reasonableness of the response and relieve the House Supervisor or other person acting as initial Incident Commander, when needed.

9. All actions by the AOC shall be communicated to the CEO on the next regular business day or immediately at the AOC's discretion. The Risk Manager and other appropriate parties will be notified of any sentinel event or other such critical incidents.

REFERENCES:

1. Joint Commission Resources. *Guide to Emergency Management Planning in Health Care*. Oakbrook Terrace, IL: Joint Commission Resources, 2002. Print.

CROSS REFERENCE P&P:
1. Nursing Administrative Coverage

Committee Approval	**Date**
Senior Management	**5/12/2014**
Board of Directors	**6/18/2014**
Board of Directors Last Review	

Developed: 5/11/2014
Reviewed:
Revised:
Responsibility for review and maintenance: CEO

Northern Inyo Hospital
Nursing Services
Safe Patient Handling Subcommittee (SPH)

Lead by: Employee Health Specialist
Reports to: Chief Nursing Officer (CNO)
Information flowed to Safety Committee

Membership: Employee Health Specialist, CNO, COO, HR Benefit/LOA Specialist, Staff members form DI, RHC/NIA Clinic, ED, ICU, Perinatal, Peri-Operative, Rehab, Cardiopulmonary, Medical/Surgical, One Clinical Staff Educator (CSE), District Education Coordinator, Environment of Care Safety Specialist, and Nurse Managers as alternates when needed.

Convenes: Quarterly and/or Ad Hoc
Purpose:

1. Inspire clinical teamwork and collaboration with SPH activities to reduce patient and HCW injuries.
2. To evaluate and recommend a plan of action of Federal and Cal- OSHA changes and/or requirements of the SPH regulations.
3. Develop and oversee plans and P&P's that support SPH:
    a. Annual review Safe Patient Handling P&P
    b. Annual review Minimal Lift P&P
4. Review and discuss any SPH Unusual Occurrence Reports (UOR) and events to prevent future occurrence.
5. Annual review of SPH equipment list

Developed: 6/2020 MM
Revised:
Reviewed:

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: Stacey Brown, MD, Chief of Medical Staff
DATE: September 1, 2020
RE: Medical Executive Committee Report

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

A. Policies and Procedures (*action items*)
    1. *Admission, Documentation, Assessment, Discharge, and Transfer of Swing-Bed Patients*
    2. *Adult Oxygen Protocol*
    3. *Cardiopulmonary Department Cardiac Stress Tests*
    4. *Chemotherapy Administration and Precautions*
    5. *Discharging a Patient with a Hospital Administered Metered Dose Inhaler (MDI)*
    6. *Omnicell Automated Dispensing Unit (ADU)*
    7. *Potassium Intravenous Administration*
    8. *Procedural Sedation*
    9. *Pulmonary Function Testing*
    10. *Vortran GO2VENT Use as Emergency Ventilator*
    11. *Management of the Diabetic Patient (Insulin and Hyperglycemia Protocol)*

B. Annual Approvals (*action item*)
    1. Standardized Procedure – Adult Health Maintenance
    2. Standardized Protocol – Adult Health Maintenance

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: ~~Admission, Documentation, Assessment, Discharge, and Transfer of Swing Bed Patients*~~	
Scope: Acute/subacute Services	Manual: ~~Admission, Discharge, Transfer Documentation (ADT)~~
Source: ~~MANAGER MED SURG ICU~~	Effective Date: 1/1/15

Field Code Changed

Field Code Changed

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PURPOSE:
To identify the admission, documentation, assessment, discharge and transfer process for Swing Bed Residents.

POLICY:

1. NIH has adopted the Medicare concept to allow Critical Access Hospitals (CAH) to interchangeably use acute care beds with sub-acute care beds called swing bed.
2. Swing bed reimbursement status has changed to skilled nursing services and reimbursement.
3. NIH is licensed for 15 swing beds.
4. Medicare reimbursement requires a 3-day qualifying stay in a hospital bed prior to admission to a swing bed. The swing bed stay must fall within the same spell of illness as the qualifying stay. Reimbursement for non-Medicare patients requires preauthorization before admission to swing status.
5. The acute care patient that meets admission criteria to sub-acute care (swing bed status) is to be discharged from acute care and admitted to swing bed.
6. Admission priority to swing bed will be given to NIHD acute care patients.
   a. External transfers of Inyo County residents will be considered for admissions based on current swing patient census.
   b. Case Management will approve external transfers in collaboration with the house supervisor and Hospitalist.

PROCEDURE:

1. Case Management will work with the patient's physician and with the house supervisor (HS) to determine whether a Medicare patient is eligible for swing bed status. If there is a difference of opinion, the Utilization Review Committee Chairman (or the Chief of Staff) and the CNO will be consulted.

~~**POLICY:**~~

~~1. NIH has adopted the Medicare concept to allow Critical Access Hospitals (CAH) to interchangeably use acute care beds with sub-acute care beds called swing bed.~~
~~1. Swing bed reimbursement status has changed to skilled nursing services and reimbursement (SNF).~~
~~2. NIH is licensed for 15 swing beds.~~
~~3. Medicare reimbursement requires a 3-day qualifying stay in a hospital bed prior to admission to a swing bed. The swing bed stay must fall within the same spell of illness as the qualifying stay.~~
~~4. The acute care patient that meets admission criteria to sub-acute care (swing bed status) is to be discharged from acute care and admitted to swing bed.~~
~~5. Admission priority to swing bed will be NIH acute care patients.~~
   ~~a. External transfers of Inyo County residents will be considered for admissions based on current swing patient census.~~
   ~~b. The Case Management DON will approve external transfers in collaboration with Hospitalist.~~

~~**PROCEDURE:**~~

~~1. Case Management will work with the patient's physician and with the House Supervisor (HS) to determine whether a Medicare patient is eligible for swing bed status. If there is a difference of opinion, the Utilization Review Committee Chairman (or the Chief of Staff) and the CEO will be consulted.~~
   a. Patients who benefit from the swing bed program are individuals recovering from surgery or illness who require skilled care. The goal of skilled nursing care is to help improve a patient's condition or to maintain their current condition and prevent it from getting worse.

NORTHERN INYO HOSPITAL
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Source: ~~MANAGER MED SURG ICU~~	Effective Date: 1/1/15

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b. To be admitted to a swing bed, Medicare patients must have a 3-day qualifying stay, have Medicare Part A, and a physician order for swing bed admission.
c. A Medicare patient is allowed up to 100 days per benefit period for swing bed, as long as criteria are being met. The patient must be able to work towards a goal and must be making progress towards achievement of the goal.
d. The patient does not have to physically move to a different bed from the acute setting rather the "swing" process is more of an accounting function that indicates a different level of care and Medicare payment.

2. When a Medicare patient has been approved for swing bed admission, the physician will enter a CPOE or write discharge orders from acute care and an admission order to swing bed status, a discharge summary, update history and physical, and write new orders for patient care.
3. The acute care paper chart will be sent to Medical Records for processing and coding, and a new swing bed chart will be initiated (new ~~event~~ visit ID # will be generated). The acute care electronic chart will be ~~stored in HPF.~~available in the electronic health record (EHR).
~~4. The admitting office shall be notified by nursing that the patient is to be discharged from acute care and admitted to"swing bed status with transitional care status."~~
~~5. Admitting will create and distribute a new face sheet, assign a new account number and will complete a swing bed admission packet with the patient or the patient's legal representative.~~
~~6.~~4. ~~Admitting will issue a new face sheet,~~Patient will be given "NIH Patient Rights" form, "Swing Bed Discharge Notification" form, and the "NIHD Swing Bed Patient and Family Member or Significant Other Invitation" letter inviting them to the daily interdisciplinary meeting. ~~, and obtain signatures on ABN's if indicated.~~
   ~~a.~~ The case load RN will review Resident's Rights with the patient/family.
   ~~7. The department clerk will disassemble the acute care chart and will copy the following, which will be included in the swing bed chart:~~
   ~~a. History and Physical from HPF so the MD can update for the swing bed Admission~~
   ~~b. Copy the order for transfer to swing bed status that prints on the OCR or written order.~~
   ~~c. Discharge Summary from acute care record. This needs to be dictated and can be found in HPF.~~
   ~~d. To be found in patient profile: pertinent lab, radiology and other notes.~~
   ~~e. New swing bed admission orders either written or CPOE.~~
   ~~f.~~a. ~~Advance Directives follow the patient as a permanent record.~~
~~8.~~5. The Department Clerk will notify~~notifies~~ the Activities Coordinator of the patient's admission to swing bed status.

Assessment:

1. Physicians will visit swing bed Residents at least every 7 days. The physician will write a progress note at the time of each visit.
2. In addition to the Initial Nursing Assessment, ~~and the Patient Profile,~~ the RN will conduct an initial and periodic comprehensive, accurate assessment of each resident's functional capacity within 12 hours of admission.
   a. The periodic assessment will be repeated within 14 days after a significant change in the resident's physical or mental condition and not less often than once every 12 months.
3. ~~The NIH Electronic Record and Care Plan tab will be utilized for swing bed residents.~~ The interdisciplinary team meets every day at 11 to discuss the swing bed resident's care goals and recommends appropriate interventions/referrals.

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a. Families and/or significant others are included in the care planning and family conferences are held as needed.

Documentation:

1. The NIHD Electronic Record will be utilized for documentation of care for swing bed residents. ~~Nursing will utilize the NIH electronic record; clinical care station for documentation~~T~~, and t~~he Daily Focus Assessment will be completed every twelve hours ~~following the Swing Bed Assessment/Reassessment schedule (Refer to the attached Swing Bed Assessment/Reassessment Swing Patient Population Guidelines).~~
2. Medications will be administered and documented according to the current NIHD policy.
3. Advance Directives for swing bed patients will be maintained according to the NIHD hospital policy.

Discharge/Transfer:

1. Swing bed residents at NIHD are transferred or discharged based on patient progress toward goals.
   a. Patient/conservator notices of transfer/discharge is documented on the Swing Bed Transfer/Notification form (see attached).
   b. Patient or their guardians have the right to request transfer or discharge at any time, but NIH only initiates transfers or discharge when appropriate regulatory criteria are met.
2. When a swing bed resident is discharged/transferred, the physician completes a discharge summary and documents the reasons for the discharge/transfer in the progress notes.
3. The post-discharge plan of care is developed with the participation of the resident and his or her family.
4. The NIHD non-emergent transfer form will be used for transfers. ~~The NIH discharge instruction form will be used when a patient is discharged.~~
5. The swing bed chart will be sent to Medical Records for processing and coding. ~~The electronic swing bed record is stored in HPF.~~
   a. The swing bed chart will remain separate from the acute care medical record.
6. If a patient is being transferred to a SNF, a "Notice of Medicare provider for Non-coverage" will be completed by Admitting.

REFERENCES:

1. State Operations Manual: Survey protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-beds in CAHs, Section 485.645 and 483.10

CROSS REFERENCE P&P:

1. Advance Directive P&P
2. Discharge P&P
3. Admission, Discharge, Transfer of Patients: Continuum of Care
4. Swing Bed Patients Inter-disciplinary Care Conference
5. Education of Swing Bed Patients and Family
6. Rights of Swing Bed Patients

~~**REFERENCES:**~~

~~1. CAH and Swing Bed Regulations~~

~~**CROSS REFERENCE P&P:**~~

~~1. Advance Directive P&P~~
~~Discharge P&P~~

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~~Admission, Discharge, Transfer of Patients: Continuum of Care~~
~~Swing Bed Patients Inter-disciplinary Care Conference~~
~~Education of Swing Bed Patients and Family~~
~~1. Rights of Swing Bed Patients~~

Approval	Date
CCOC	~~10/14~~7/27/2020
Medical Services/ICU Committee	08/06/2020
MEC	~~11/14~~9/1/2020
Board of Directors	~~12/14~~
Last Board of Director review	04/18/2018

Developed: 1/21/07
Reviewed: 5/11, 9/12, 6/16, 1/17 la, 4/18AK
Revised: 10/14, 6/20 JN

Field Code Changed
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NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Adult Oxygen Protocol	
Scope: NIHD	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen, Respiratory
Source: Director of Respiratory Care	Effective Date: October 31, 2013

PURPOSE:
To provide protocol driven respiratory therapy for the administration of oxygen at concentrations greater than that in ambient air, with the intent of treating or preventing the symptoms and manifestations of hypoxia.

This protocol is limited to oxygen administration for the acute care patient.
The following patients are excluded from the O2 protocol.
- Laboring patients
- Surgery patients
- Emergency Department patients

POLICY:

1. The Oxygen Protocol will be initiated on patients by a Computerized Physician Order Entry (CPOE) or written order from the provider for any type of oxygen therapy, including Ventilators, BiPAP, CPAP, Vapotherm High Flow Nasal Cannula, and Heated / Cool Aerosol. The Oxygen Protocol may be ordered as Oxygen Protocol.

2. In addition, the Oxygen Protocol may be ordered in forms other than specified by this protocol by entering an order that specifies:
   a) The type of oxygen delivery device
   b) Liter flow or FIO_2.

3. Registered Nurses may also set up oxygen as ordered by provider. ~~. If oxygen is determined to be necessary for a patient, the RN must notify the provider, and obtain an order for Oxygen Protocol before placing the patient on oxygen . . is started by an RN, the RN must follow this protocol, obtain an order~~ RN must ~~and~~ inform Respiratory Care Practitioner (RCP) that the patient has an oxygen order. ~~is on oxygen.~~

4. After the provider has entered an order, the RCP will:
   a) Evaluate the patient upon receipt of the provider order.
   b) Place a high or low flow system on the patient depending upon the assessment criteria.
   c) Titrate the FIO_2 to keep the $SpO_2 \geq$ ~~92%~~ 90% ~~-~~or within the provider specified limits. The RCP will contact the provider to initiate an ABG if condition indicates.
   d) Notify the provider whenever a patient goes from a Low Flow system to a High Flow system.

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~~e) Notify the provider if the SpO_2 is < 92% 90%on Oxygen, or if the patient is demonstrating an increase in O2 requirement as described under guidelines and warnings.~~.

OVERVIEW:
The Oxygen Protocol will be initiated for patients in the following situations once ordered by the provider:~~:~~

1. Documented hypoxemia defined as a decreased PaO_2 in the blood below normal range, PaO_2 of < 60 torr or SpO_2 of < 90 in patients' breathing room air.

~~2. An acute care situation in which hypoxemia is suspected. Substantiation of hypoxemia is required following initiation of therapy.~~
~~a) Severe trauma~~
~~b) Acute Myocardial infarction~~.

3. For comfort measures as ordered by a provider. This is written for patients that have DNR orders and are usually near death. The goal of comfort measures is to wean from a High Flow system to a Low Flow system, keeping the patient and family members comfortable. It is important that the RCP communicate with both the patient's provider and nurse as to what is going to be a proper liter flow for the patient's "comfort". SpO_2 checks are not documented unless ordered.

4. The patient will be placed on a Low Flow system if the requirement is determined to be 6 liters of oxygen or less, a respiratory rate of less than 25, and a regular and consistent ventilator pattern.

5. The patient will be placed on a High Flow system if the requirement is determined to be more than 6 liters. The respiratory rate > 25, room air PaO_2 < 60, or unable to meet the ordered SpO_2.

6. If the patient is ordered on a CPAP device and needs oxygen, 1-6 LPM may be bled-in.

7. Notify the provider if a patient has been set-up on a high flow system, or anytime the FIO_2 is increased by 10%, for a sustained amount of time, > one hour. Document that the provider has been notified, noting any change in orders.

8. After the initial evaluation, (which will include a room air SpO_2, RR, HR, breath sounds) the RCP will place the patient on a nasal cannula or Oxi-Mask at 1-6

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L/min and titrate the oxygen liter flow to maintain a $SpO_2 \geq$ ~~92%~~ 90% or within providers ordered goals~~. Patient will be place on a continuous SpO_2 monitor, and the oxygen liter flow will be increased 1 L/min Q5 minutes until the ordered SpO_2 range is met.~~

9. If greater than 6 L/min is needed to maintain the ordered SpO_2, and a high flow system is indicated, the provider will need to be notified. Oxygen therapy via traditional nasal cannula should not be used at flows higher than 6 LPM. Adequate humidification is required to maintain ciliary activity, prevent squamous epithelial changes, prevent dehydration and thickening of secretions, minimize atelectasis and tracheitis and decrease heat loss.

10. When a Low Flow system is indicated, the RCP will place the patient on one of the following:
    a. Traditional nasal cannula at 1-6 LPM
    b. Oxi-Mask at 1-6 LPM

11. When a High Flow system is indicated, the RCP will place the patient on one of the following:
    a) Simple mask.
    b) Venturi mask.
    c) Aerosol mask, tracheostomy collars, t-tube adapters, face tents and large bore generator, Heated or Cool depending on application.
    d) Non-rebreather mask.
    e) Oxi-Mask.
    f) Vapotherm Hi-flow nasal cannula, an FDA approved device designed to comfortably deliver flow of 1-40 LPM for Adults and 1-6 LPM for Infants, of heated, humidified oxygen through a nasal cannula interface.

12. When a patient has been ordered to be on a BiPAP or a Ventilator, the FIO_2 will initially be set at 100%. Once the patient is stable the FIO_2 will be weaned to maintain the ordered SpO_2. During suctioning and other events that cause the SpO_2 to drop lower than the ordered SpO_2, the FIO_2 will be adjusted (increased) to maintain the ordered SpO_2. If unable to return to the previous FIO_2 after the event, > one hour, the provider will be notified.

GUIDELINES AND WARNINGS

1. The responsible provider and R.N. will be contacted:
    a. If the RCP is unable to determine appropriate care upon evaluation

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b. If the patient demonstrates an increase in oxygen requirement (increases in oxygen of 10% after the high flow system has been set-up or increases of ≥ 3 L/min on traditional nasal cannula or Oxi-Mask when the patient has been set-up on a low flow system.
c. If the patient demonstrates an increase in CO2 (e.g., disoriented, somnolence, or stupor).
d. If the SpO_2 of ≥ ~~92%~~ 90% or the provider's specified limits cannot be maintained.

2. Provider will be notified in the event that a ~~The PaCO2 of~~ chronically hypercapnic patient will be placed on oxygen. ~~with COPD often does rise acutely after these patients are given oxygen. But it is important to note that the diagnosis of COPD on a patient's medical record does not automatically mean the patient has a chronically high PaCO2 or that administration will induce hypercapnia. In order to prevent hypoxia but avoid hypoventilation in these patients, we should aim for an arterial PO2 between 50 and 60 torr, or a SpO_2 of 80-90%.~~

~~3. In any event, O2 should never be withheld from acutely hypoxemic patients with COPD for fear of inducing hypoventilation and hypercapnia. Tissue oxygenation is an overriding priority; oxygen must never be withheld from exacerbated, hypoxemic patients with COPD for any reason. This means the clinician must be prepared to mechanically support ventilation if O2 administration induces severe hypoventilation.~~

4. ~~Consider obtaining ABG's~~ ~~I~~if the patient exhibits signs of increased disorientation, somnolence, or stupor. The RCP will contact the provider to initiate an ABG if condition indicates

WEANING OF OXYGEN:

1. When a patient has been ordered on Oxygen with a SpO_2 order, the RCP will do a room air SpO_2 check Q AM and PRN on clinically stable patients to see if a patient can be left on room air.
   a. RCPs assessment will determine if the patient is stable and able to attempt a RA trial.
   ~~a.~~b. First assess the patient on oxygen.
   ~~b.~~c. Place a ~~continuous~~ SpO_2 monitor on the patient, document liter flow, SpO_2.

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Source: Director of Respiratory Care	Effective Date: October 31, 2013

~~c.~~d. Remove the nasal cannula and observe the patient to see if they de-sat below the ordered SpO_2. When determining room air SpO_2, the patient must be off oxygen for at least 15 minutes prior to obtaining reading.

2. When the patient's oxygen is <= 6 L/min, the oxygen will be titrated by 1 L/min, every 5 minutes, keeping the SpO_2 >= ~~92%~~ 90%or within the provider specified limits, until the patient is on room air.

3. When the patient is on a high flow system, the oxygen will be titrated by 5 L/min, every 5 minutes, keeping the SpO_2 >= ~~92%~~ 90%or within the provider specified limits, until the patient can be weaned to a nasal cannula or Oxi-Mask at 6 L/min or less.

4. When the patient is on the Vapotherm, start by weaning the FIO_2 to 50% first, then wean flow.

5. If a patient in ICU or Medical Surgical units has been on room air for 48 hours, SpO_2 checks will be changed to Q Shift unless otherwise ordered by the Provider.

6. In the OB department, if the mom has been on room air for 24 hours, SpO_2 will be discontinued.

7. Adult patients on low flow oxygen 1-3LPM may be checked on a Qshift basis at night.

8. Patients on home oxygen will be titrated to their baseline and have SpO2 checks Qday.

DOCUMENTATION:

1. All documentation will be done in ~~the Clinical CareStation~~ ~~Athena~~ the electronic health record under Respiratory ~~RT~~notes~~,~~. ~~and Group Notes or Progress Notes.~~
2. All discussions regarding the patient with providers and nurses need to be documented.
3. All telephone orders must be documented per policy "Verbal Orders"

REFERENCES:

1. AARC Clinical Practice Guideline, Oxygen Therapy for adults in the Acute Care Facility (2002)
2. Egan's Fundamentals of Respiratory Care 10th Edition, (2013)

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Adult Oxygen Protocol	
Scope: NIHD	Manual: Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen, Respiratory
Source: Director of Respiratory Care	Effective Date: October 31, 2013

Committee Approval	**Date**
CCOC	2/24/20
Peri-Peds Committee	6/30/20
Medical Services – ICU Committee	5/21/20
Pharmacy and Therapeutics Committee	07/30/20
Medical Executive Committee	9/1/20
Board of Directors	
Last Board of Directors Review	

Revised: 2/2020as
Reviewed: 1/18/17

6

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Cardiopulmonary Department Cardiac Stress Tests	
Scope: Cardiopulmonary	Department: Cardiopulmonary
Source: Cardiopulmonary Manager	Effective Date: May 22, 2020

PURPOSE

The purpose of this guideline is to assist the EKG Technician in performing Cardiac Stress Tests.

POLICY

Cardiac Stress Testing will be performed only with a Physician's order for the following tests; Treadmill (ETT), Nuclear Treadmill (MPIET), Regadenoson Stress Test (MPIRX) or Stress Echo (STE).

INDICATIONS:

1. Assessment of cardiovascular risk in screening.
2. Detection of Coronary Artery Disease (Ischemic Heart Disease).
3. Evaluation of Coronary Artery Disease.
4. Assessment of therapeutic response. Exercise testing can be used to evaluate the effect of medications or interventions such as PCI, CABG, CRT, etc.
5. Assessment of perioperative risk for non-cardiac surgery.
6. Exercise prescription.
7. Determine degree of disability.
8. Evaluation of arrhythmias (for exercise stress tests only).
9. Evaluation of a positive Exercise Stress Test and the need for a more sensitive Cardiovascular Stress Test (for Nuclear Studies only).

ABSOLUTE CONTRAINDICATIONS:

1. Acute MI (within 2 days).
2. Unstable Angina.
3. Uncontrolled arrhythmia causing symptoms or hemodynamic instability
4. Symptomatic severe Aortic Stenosis.
5. Uncontrolled symptomatic Heart Failure.
6. Acute Pulmonary Embolus.
7. Acute Myocarditis or Pericarditis.
8. Acute Aortic Dissection.
9. Caffeine within at least 12 hours of the exam and/or food and beverages within 4 hours of the exam (Nuclear Studies only).

RELATIVE CONTRAINDICATIONS

1. Left Main Coronary Stenosis.
2. Moderate Stenotic Valvular Heart Disease.
3. Electrolyte abnormalities.
4. Severe arterial hypertension.
5. Tachyarrhythmia's or Bradyarrhythmias.
6. Hypertrophic Cardiomyopathy and other forms of outflow tract obstruction.
7. Mental or physical impairment leading to inability to exercise adequately.
8. High-degree Atrioventricular Block.
9. LBBB for ischemic evaluation.

Title: Cardiopulmonary Department Cardiac Stress Tests	
Scope: Cardiopulmonary	Department: Cardiopulmonary
Source: Cardiopulmonary Manager	Effective Date: May 22, 2020

PROCEDURE

1. Have patient read and sign consent form.
2. Explain the stress test procedures to the patient.
3. Have patient remove all clothing from the waist-up. For women who are going to be walking on the treadmill, they should be placed in a gown with either a sports bra/tank top/web vest or breast binder underneath. For chemical stress tests or stress echoes, women should be placed in a gown only.
4. Have patient lie on the bed.
5. Ask the patient if they have any allergies to tape, alcohol wipes or medications.
6. If male patient, shave chest hair with razor where electrodes are to be placed.
7. Clean electrode sites with soap and water and then alcohol wipes to remove any lotions, oils and dirt, and let dry.
8. Place electrodes in appropriate positions.
9. Clip lead wires from acquisition module to the appropriate electrodes.
10. Place blood pressure cuff on the patients left arm if possible.
11. Place the pulse ox monitor on the patient's finger, usually on the right hand.
12. The red box labeled "Reversal of Regadenoson-induced adverse reactions", containing Aminophylline 250 mg/10mL, an Albuterol Inhaler, Nitroglycerin 0.4 tab unopened #25, Albuterol Nebule 2.5 mg/3 ml, an OptiChamber Spacer, 12 ml syringe, 18G needle and an alcohol swab, should be placed in the room.
13. The crash cart is located right outside the door to the EKG room.

TREADMILL STRESS TEST (ETT)

1. Turn on the blood pressure monitor and wait until it is completely on before turning on the computer.
2. Select user and enter password – password is "User" with capital U.
3. Select new test.
4. Type the last name of the patient and search for previous tests.
5. If no previous tests, select new patient.
6. Enter name, Patient ID (this is the patient's medical record number), DOB, height, weight, gender and race.
7. Select new test.
8. In patient information tab, select BRUCE protocol (located at the top of the screen).
9. If any other protocol is requested, notify the Attending MD.
10. Then type in information for:

    Med History - List family members who have had heart disease or stroke (parents, siblings, grandparents), along with any personal history of heart disease or stroke.

    Reason for test – select from the drop down menu or enter information.

    Test type – Treadmill Stress Test

    Ordering MD

    Attending MD – the Physician who will be present and monitoring the exam.

Tech Name

Comments – List smoking history

11. Medications (Heart, Blood Pressure, Cholesterol and Thyroid).
12. Select OK.

PERFORMING TREADMILL TESTS

1. If the patient is able to lie flat, place them in the supine position, press the Pretest button (this should change the status on the monitor to say "Supine") and then press the Enter BP button to take a blood pressure. Once the blood pressure is complete and you have recorded it on the Treadmill Interpretation form, press the 12SL Analysis button. This will print a one page EKG. Record the heart rate listed on the EKG onto the Treadmill Interpretation form. Record the patient's oxygen saturation level at rest.
2. Have the patient sit on the edge of bed, press Pretest (this should change the status on the monitor to "Sitting") and then obtain a blood pressure by pressing the Enter BP button. Once the blood pressure is complete and you have recorded it on the Treadmill Interpretation form, press the 12 Lead button. This will print a one page EKG. Record the heart rate listed on the EKG onto the Treadmill Interpretation form. Record the patient's oxygen saturation level while sitting.
3. If the patient is male, place a webbed vest over the patients head to cover the electrodes on the chest.
4. Have the patient stand.
5. Secure the belt attached to the acquisition module to the patient. Check to make sure the leads hang down properly and are not caught on anything.
6. Press the Pretest button (this should change the status on the monitor to say "Standing") and then press the Enter BP button to take a blood pressure. Once the blood pressure is complete and you have recorded it on the Treadmill Interpretation form, press the 12 Lead button. This will print a one page EKG. Record the heart rate listed on the EKG onto the Treadmill Interpretation form. Record the patient's oxygen saturation level while standing.
7. Have patient step onto the treadmill.
8. At the top of the screen on the monitor, select Lead Check from the tabs.
9. Press the Arrhy Doc button to turn on the arrhythmia documentation. This will remain on throughout the test.
10. When the patient, doctor and tech are ready, press the Pretest button. This will change the status on the monitor to say "Warm-up". Hit the Start Treadmill button and then the Exercise button.
11. Record the start time of the test on the Treadmill Interpretation form.
12. Document heart rate and pulse oxygen saturation every one minute and blood pressure every three minutes on the Treadmill Interpretation form. The machine will automatically start to take the blood pressure. If you need to manually start a blood pressure, press the Enter BP button. The computer will record a 12 lead EKG every three minutes and print out a tracing. If needed or at the Physician's request, print a 12 lead EKG or rhythm strip.

13. Speed and incline will increase every three minutes.
14. When the patient has reached their target heart rate with appropriate systems (or as close to it as possible) or if the patient is unable to continue exercising, the physician will tell the Tech to slow down or stop the treadmill. Press the Recovery button.
15. In an emergency and the patient cannot continue walking, press the large red STOP button on the treadmill.
16. When the treadmill is level, press the Stop Treadmill button and have patient continue to walk in place for a short period.
17. Record the stop time on the Treadmill Interpretation form.
18. Record the start time of the recovery phase on the Treadmill Interpretation form.
19. Run an EKG as soon as possible after the recovery phase begins by pressing the 12 Lead button.
20. When instructed by the physician, have the patient step off the treadmill and lie down on the bed.
21. Continue to record the heart rate and oxygen saturation level every one minute and blood pressure every three minutes.
22. Once the physician has hit the End Test button, the patient can be unhooked and get dressed.
23. Record the end time of the recovery phase on the Treadmill Interpretation form.
24. Give the Treadmill Interpretation and Consent forms to the physician to sign.

NUCLEAR MEDICINE TREADMILL TEST (MPIET)

1. Turn on the blood pressure monitor and wait until it is completely on before turning on the computer.
2. Select user and enter password – password is “User” with capital U.
3. Select new test.
4. Type the last name of the patient and search for previous tests.
5. If no previous tests, select new patient.
6. Enter name, Patient ID (this is the patient’s medical record number), DOB, height, weight, gender and race.
7. Select new test.
8. In the patient information tab, select BRUCE protocol (located at the top of the screen).
9. If any other protocol is requested, notify the Attending MD.
10. Then type in information for:

    Med History - List family members who have had heart disease or stroke (parents, siblings, grandparents), along with any personal history of heart disease or stroke.

    Reason for test – select from the drop down menu or enter information.

    Test type – Nuclear Stress Test

    Ordering MD

    Attending MD – the Physician that will be present and monitoring the exam.

Tech Name

Comments – List smoking history

11. Medications (Heart, Blood Pressure, Cholesterol or Thyroid)
12. Ask the Nuclear Medicine Tech the dose of Sestamibi and record it on the Treadmill Interpretation form next to Mci.
13. Select OK.

PERFORMING NUCLEAR TREADMILL EXAMS

1. Verify that the patient has not had any caffeine with in at least twelve hours and has been NPO for at least four hours prior to the exam. This is in case the exercise portion of the test needs to be converted to a chemical stress test only.
2. If the patient is able to lie flat, place them in the supine position, press the Pretest button (this should change the status on the monitor to say "Supine") and then press the Enter BP button to take a blood pressure. Once the blood pressure is complete and you have recorded it on the Treadmill Interpretation form, press the 12SL Analysis button. This will print a one page EKG. Record the heart rate listed on the EKG onto the Treadmill Interpretation form. Record the patient's oxygen saturation level at rest.
3. Have the patient sit on the edge of bed, press Pretest (this should change the status on the monitor to "Sitting") and then obtain a blood pressure by pressing the Enter BP button. Once the blood pressure is complete and you have recorded it on the Treadmill Interpretation form, press the 12 Lead button. This will print a one page EKG. Record the heart rate listed on the EKG onto the Treadmill Interpretation form. Record the patient's oxygen saturation level while sitting.
4. If the patient is male, place a webbed vest over the patients head to cover the electrodes on the chest.
5. Have the patient stand.
6. Secure the belt attached to the acquisition module to the patient. Check to make sure the leads hang down properly and are not caught on anything.
7. Press the Pretest button (this should change the status on the monitor to say "Standing") and then press the Enter BP button to take a blood pressure. Once the blood pressure is complete and you have recorded it on the Treadmill Interpretation form, press the 12 Lead button. This will print a one page EKG. Record the heart rate listed on the EKG onto the Treadmill Interpretation form. Record the patient's oxygen saturation level while standing.
8. The Nuclear Medicine Tech will start an IV. The IV should be placed on the opposite arm from the blood pressure cuff. If it is necessary to have them on the same side, remove or disconnect the blood pressure cuff during the injection, if needed.
9. Have patient step onto the treadmill.
10. At the top of the screen on the monitor, select Lead Check from the tabs.
11. Press the Arrhy Doc button to turn on the arrhythmia documentation. This will remain on throughout the test.

12. When the patient, doctor and tech are ready, press the Pretest button. This will change the status on the monitor to say "Warm-up". Hit the Start Treadmill button and then the Exercise button.
13. Record the start time of the test on the Treadmill Interpretation form.
14. Document heart rate every one minute and blood pressure every three minutes on the Treadmill Interpretation form. The machine will automatically start to take the blood pressure. If you need to manually start a blood pressure, press the Enter BP button.
15. Speed and incline with increase every three minutes. The computer will record a 12 lead EKG every three minutes and print out a tracing. If needed or at the Physician's request, print a 12 lead EKG or rhythm strip.
16. Once the patient reaches the target heart rate and is able to continue exercising for one full minute, the Nuclear Medicine Tech will inject the isotope after the Physician's verbal order.
17. Record the time of the injection on the Treadmill Interpretation form and time for one minute after the injection. Let the physician know in fifteen second intervals until one minute is up.
18. Press the Recovery button.
19. When the treadmill is level, press the Stop Treadmill button and have patient continue to walk in place for a short period.
20. In an emergency and the patient cannot continue walking, press the large red STOP button on the treadmill.
21. Record the stop time on the Treadmill Interpretation form.
22. Record the start time of the recovery phase on the Treadmill Interpretation form.
23. Run an EKG as soon as possible after the recovery phase begins by pressing the 12 Lead button.
24. When instructed by the physician, have the patient step off the treadmill and lie down on the bed.
25. Continue to record the heart rate and oxygen saturation level every one minute and blood pressure every three minutes.
26. Once the physician has hit the End Test button, the patient can be unhooked and get dressed.
27. Record the end time of the recovery phase on the Treadmill Interpretation form.
28. Give the Treadmill Interpretation and Consent forms to the physician to sign.
29. Leave three electrodes on the patient (right arm, left arm and left leg). The Nuclear Medicine Tech needs them for their portion of the exam.
30. The Nuclear Medicine Tech will escort the patient to Diagnostic Imaging for their scan.

REGADENOSON STRESS TEST (MPIRX)

1. Turn on the blood pressure monitor and wait until it is completely on before turning on the computer.
2. Select User and enter password – password is "User" with capital U.
3. Select New Test.
4. Type the last name of patient and search for previous tests.
5. If no previous tests, select New Patient.

6. Enter Name, Patient ID (this is the patient's medical record number), DOB, height, weight, gender and race.
7. Select New Test.
8. In patient information tab, select Regadenoson.
9. In Test/Personnel tab:

   Med History – List family members who have had heart disease or stroke (parents, siblings, grandparents), along with any personal history of heart disease or stroke.

   Reason for test – Select from the drop down menu or enter information.

   Test type – Regadenoson Stress Test

   Ordering MD

   Attending MD – the Physician that will be present and monitoring the exam.

   Tech Name

   Comments – List smoking history

10. Medication (Heart, Blood Pressure, Cholesterol, Thyroid).
11. Select OK.

PERFORMING REGADENOSON STRESS TEST EXAM

1. Verify that the patient has not had any caffeine with in at least twelve hours and has been NPO for at least four hours prior to the exam.
2. If the patient is able to lie flat, place them in the supine position, press the Pretest button (this should change the status on the monitor to say "Supine") and then press the Enter BP button to take a blood pressure. Once the blood pressure is complete and you have recorded it on the Treadmill Interpretation form, press the 12SL Analysis button. This will print a one page EKG. Record the heart rate listed on the EKG onto the Treadmill Interpretation form. Record the patient's oxygen saturation level at rest.
3. Notify the Physician so that they can enter the room before the exam for patient education.
4. The Nuclear Medicine Tech will start an IV. If they are unavailable and to avoid a prolonged wait, have Outpatient Nursing, start the IV. If it is necessary to have them on the same side, remove or disconnect the blood pressure cuff during the injection, if needed.
5. When the Doctor, Nurse and the Nuclear Medicine Tech are ready, press the Exercise button at the time of the first infusion (Regadenoson, given by Outpatient Nursing or physician) and document the injection time on the Treadmill Interpretation sheet.
6. Press the Exercise button at the time of the second injection (Sestamibi, given by the Nuclear Medicine Tech) and document the injection time on the Treadmill Interpretation sheet.

31. Document heart rate and oxygen saturation level and blood pressure every minute on the Treadmill Interpretation Sheet. The computer will record a 12 lead EKG every three minutes and print out a tracing. If needed or at the Physician's request, print a 12 lead EKG or rhythm strip.
7. The automatic post infusion will begin one minute after the last medication is given.
8. Document the time of the end of the test and the beginning of the recovery period.
9. Continue to document vitals every one minute.
10. The physician will review the test and push Test End and the patient can be unhooked and get dressed.
11. Record the end time of the recovery phase on the Treadmill Interpretation form.
12. Give the Treadmill Interpretation and Consent forms to the physician to sign.
13. Leave three electrodes on the patient (right arm, left arm and left leg). The Nuclear Medicine Tech needs them for their portion of the exam.
14. The Nuclear Medicine Tech will escort the patient to the cafeteria or to the patient's room (Inpatients) to get a tray of food and have some caffeine (if needed).
15. After approximately one hour, the Nuclear Medicine Tech will escort the patient to Diagnostic Imaging for their scan.

STRESS ECHO (STE)

1. This exam will be performed in the Echo room.
2. Turn on the computer.
3. Select User and enter password – password is "User" with capital U.
4. Select New Test.
5. Type the last name of patient and search for previous tests.
6. If no previous tests, select New Patient.
7. Enter Name, Patient ID (this is the patient's medical record number), DOB, height, weight, gender and race.
8. Select New Test.
9. In patient information tab, select Bruce protocol (located at the top of the screen).
10. If any other protocol is requested, notify the Attending MD.
11. In Test/Personnel tab:

    Med History – List family members who have had heart disease or stroke (parents, siblings, grandparents), along with any personal history of heart disease or stroke.

    Reason for test – Select from the drop down menu or enter information.

    Test type – Stress Echo

    Ordering MD

    Attending MD – the Physician that will present and monitoring the exam.

    Tech Name

Comments – List smoking history

11. Medication (Heart, Blood Pressure, Cholesterol, Thyroid).
12. Select OK.

PERFORMING STRESS ECHO EXAM

1. If the patient is able to lie flat, place them in the supine position. The Echocardiographer will use ultrasound to locate the spot that they will be obtaining the images. Use a black sharpie to mark those locations so that an electrode is not placed over that area.
2. Place the electrodes on the patient, using a slightly modified placement to accommodate the locations the Echocardiographer will be using and hook the patient to the module.
3. The Echocardiographer will obtain a manual blood pressure.
4. Press the Pretest button (this should change the status on the monitor to say "Supine"). Hit the Enter BP button. Enter the blood pressure reading obtained by the Echocardiographer and hit ok. Once the blood pressure is complete and you have recorded it on the Treadmill Interpretation form, press the 12SL Analysis button. This will print a one page EKG. Record the heart rate listed on the EKG onto the Treadmill Interpretation form. Record the patient's oxygen saturation level at rest.
5. The Echocardiographer will obtain pre-exercise images.
6. Once the pre-exercise images are complete, have the patient sit on the edge of bed and press Pretest (this should change the status on the monitor to "Sitting"). The Echocardiographer will obtain a blood pressure. Hit the Enter BP button. Enter the blood pressure into the computer and hit enter. Once the blood pressure is complete and you have recorded it on the Treadmill Interpretation form, press the 12 Lead button. This will print a one page EKG. Record the heart rate listed on the EKG onto the Treadmill Interpretation form. Record the patient's oxygen saturation level while sitting.
7. Have the patient stand.
8. Secure the belt attached to the acquisition module to the patient. Check to make sure the leads hang down properly and are not caught on anything.
9. Press the Pretest button (this should change the status on the monitor to say "Standing"). The Echocardiographer will obtain a manual blood pressure. Press the Enter BP button. Enter the blood pressure into the computer and hit enter. Once the blood pressure is complete and you have recorded it on the Treadmill Interpretation form, press the 12 Lead button. This will print a one page EKG. Record the heart rate listed on the EKG onto the Treadmill Interpretation form. Record the patient's oxygen saturation level while standing.
10. Secure the belt attached to the acquisition module to the patient. Check to make sure the leads hang down properly and are not caught on anything.
11. Have the patient step onto the treadmill.
12. At the top of the screen on the monitor, select Lead Check from the tabs.
13. Press the Arrhy Doc button to turn on the arrhythmia documentation. This will remain on throughout the test.
14. When the Patient, Physician, Echocardiographer and EKG Tech are ready, hit the Start Treadmill button and then the Exercise button.
15. Record the start time of the test on the Treadmill Interpretation form.

32. Document heart rate and pulse oxygen saturation every one minute and blood pressure every two minutes on the Treadmill Interpretation form. The Echocardiographer will take a manual blood pressure each time. Enter the blood pressure readings into the computer when the prompt appears. The computer will record a 12 lead EKG every three minutes and print out a tracing. If needed or at the Physician's request, print a 12 lead EKG or rhythm strip.
16. Speed and incline will increase every three minutes.
17. When the patient has reached their target heart rate with appropriate symptoms (or as close to it as possible) or if the patient is unable to continue exercising, the treadmill will be stopped abruptly and patient will be moved over to the bed and placed in the left lateral decubitus position for post-exercise images. Simultaneously press the red Stop button on the treadmill and the Recovery button on the computer.
18. Once the patient is off the treadmill, pull out the large, red Stop button on the treadmill so it can return to its original position.
19. Record the stop time on the Treadmill Interpretation form.
20. Record the start time of the post-recovery images on the Treadmill Interpretation form.
21. Record the start time of the recovery phase on the Treadmill Interpretation form.
22. Run an EKG as soon as possible after the recovery phase begins by pressing the 12 Lead button.
23. Record the stop time of the post-recovery images on the Treadmill Interpretation form.
24. Once the physician has hit the End Test button, the patient can be unhooked and get dressed.
25. Record the end time of the recovery phase on the Treadmill Interpretation form.
26. Give the Treadmill Interpretation and Consent forms to the physician to sign.

PAPERWORK

1. Complete all sections of the Treadmill Interpretation form.
2. Make one copy of the Treadmill Interpretation form for the file cabinet.
3. If the ordering physician and/or PMD is a local physician that is not on NIH Medical Staff and have a mailbox at NIH or any Physician's office that request a paper copy be placed in their box, make an additional copy of the Treadmill Interpretation form.
4. Include with the copies are:
    - Exercise Stress Test Report.
    - EKG
5. The Physician signs the original EKG Treadmill form. Both the Physician and the EKG Tech. sign the original Stress Test Report. All other supporting documents are placed along with the Treadmill Interpretation form and Stress Test Report, in manila folder for Medical Records after all charges are entered and the documents are scanned into the Medical Records chart. If PMD/Ordering physician is from a NIH clinic, scan into the clinic side also and put into review for the appropriate physician.
6. For Stress Echo's include a final copy of the Stress Echo Report with each set of the above Stress Test paperwork.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Cardiopulmonary Department Cardiac Stress Tests	
Scope: Cardiopulmonary	Department: Cardiopulmonary
Source: Cardiopulmonary Manager	Effective Date: May 22, 2020

REFERENCES:

1. http://www.onlinejacc.org/content/accj/30/1/260.full.pdf
2. https://ecgwaves.com/topic/exercise-stress-test-ecg-indications-contraindications-preparation/#Indications_for_exercise_stress_test

CROSS REFERENCE P&P:

1. Cardiac Stress Test Protocol and Procedure
2. Stress Echo

Approval	**Date**
CCOC	6/15/2020
EKG Department	5/29/2020
Medical Services/ICU Committee	8/6/2020
Medical Executive Committee	9/1/2020
Board of Directors	
Last Board of Directors Review	

Developed: 5/2020mh
Reviewed:
Revised:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Chemotherapy Administration And Precautions	
Scope: Emergency Dept, ICU, Med Surg, Outpatient	Manual: CPM - Medication (MED)
Source: DON Perioperative Services	Effective Date: 9/2009

PURPOSE:
To provide guidelines for the safe handling and administration of chemotherapy.

POLICY:
Orders for chemotherapy should be sent to the Outpatient Department. Complete orders must be written / signed by the physician before the chemotherapy can be scheduled. As soon as the orders are completed, a copy should be sent to Pharmacy so the medications will be available as needed. ***Unless the ordering physician has full oncology privileges, oncologist recommendations also must be in the patient's hospital file before chemotherapy is scheduled. These recommendations shall include dosages, method of administration, and frequency of cycles.***

Staffing must be arranged so that patients receiving IV push or initiation of IV piggyback chemotherapy are not left unattended while receiving the chemotherapy agents. Inpatients will be considered a higher acuity level for the shift in which chemotherapy is initiated.

All chemotherapy agents will be prepared in the Pharmacy by a pharmacist and will be checked by two pharmacists or one pharmacist and one RN before the medication leaves the Pharmacy. The RN will calculate dosage based on height and weight if appropriate and will check reference material for dose ranges. Any discrepancy will be reported to the Pharmacist.

Prior to the administration of the first cycle of any chemotherapy (first cycle of each new regimen) the orders from Northern Inyo Hospital will be checked against the chemotherapy protocol from the oncologist and initialed / dated by two RNs that have completed the ONS Chemotherapy & Biotherapy course.

All chemotherapeutic infusions will be double checked by two RNs and signed in the electronic health record or the chemotherapy flow sheet (or medication profile for inpatients).

IV push, IV piggyback and continuous IV infusion chemotherapy will be given by the physician or an RN familiar with the chemotherapy agents, potential side effects and extravasation treatment for the particular medications ordered.

<u>IV chemotherapy will be administered by infusion pump. The only exceptions would be IV push and some short IVPB chemotherapy regimens that have been preapproved by pharmacy for gravity administration.</u>
(Vesicant chemotherapy agents should be administered IV push through a central line.)

<u>Extravasation of a vesicant or irritant will be treated promptly by the RN in accordance with the protocol that follows this chemotherapy policy procedure.</u>

EQUIPMENT:
Chemotherapy gloves
Face shield or goggles (if needed).
Barrier gown
Biohazard container
Chux

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Chemotherapy Administration And Precautions	
Scope: Emergency Dept, ICU, Med Surg, Outpatient	Manual: CPM - Medication (MED)
Source: DON Perioperative Services	Effective Date: 9/2009

PRECAUTIONS:
The majority of antineoplastic drugs are toxic compounds. Many are known to cause carcinogenic, mutagenic or teratogenic effects. On direct contact, some antineoplastic drugs may cause irritation to the skin, eyes, mucous membranes, ulceration and necrosis of tissues. The potential hazards involved with handling of antineoplastic agents are associated with inhalation or skin contact with these agents. The following guidelines should be followed to minimize these possibilities.

Pregnant personnel, those attempting to become pregnant and those suspected of being pregnant should avoid administering chemotherapy. (Cal-Osha recommendation).

When handling chemotherapy agents the RN will wear one or two pairs of gloves. When administering an IV push chemotherapy and when initiating or discontinuing an infusional chemotherapy medication, goggles or a face shield and a long sleeved, nonpermeable cover gown should be worn if splashing may occur.

Gloves will be worn when urine and other patient excreta is handled during treatment and 48 hours after the conclusion of therapy. Goggles or a face shield should be worn when emptying any urine container for a patient that has had chemotherapy within the last 24.

PROCEDURE:
1. A chemotherapy consent should be signed by the patient for each protocol.

2. A patient assessment will be performed including a review of the most recent lab work and evidence of side effects from prior chemotherapy. Chemotherapy administration may proceed after approval by the physician prior to each cycle. (Note: Preapproval parameters may be ordered by the physician in written form). Vital signs will be taken prior to administration of each cycle, and then on a routine basis unless otherwise ordered or as indicated for each medication and/or patient tolerance.

3. If patient does not have a central line, start IV per hospital policy. Choose larger deeper veins; they are less prone to phlebitis and extravasation. If possible, avoid veins on back of hands and antecubital fossa). Don appropriate apparel and place Chux under patient's IV arm.

~~4.~~ The tubing is primed with normal saline in the Pharmacy. A safety connection device (Equashield) will be used for each chemotherapy agent administered regardless of route (intravenous, IM, SQ, intraperitoneal)

5. Administer premedications as ordered.

6. Vesicants will be administered after the premedication (before other non-vesicant chemotherapy) unless the oncologist has specified a different order of administration.

7. <u>Peripheral IV sites:</u>

   a. The IV site and blood return must be checked before starting the chemotherapy.

b. IV push chemotherapy: Assess patency every 2-3 cc during the administration with gentle aspiration checking for ease of flow, lack of subcutaneous swelling, absence of pain and burning, and blood return.

c. IV piggyback or infusion chemotherapy: blood return will be checked at the start of the infusion. The site will be closely watched, blood return will be checked 5 minutes after the start of the infusion and every 1 hour thereafter during the infusion.

d. Stop infusion if a change in sensation, pain, burning, stinging or swelling occurs at the IV site. Follow the extravasation protocol if infiltration is suspected.

Central IV Lines:

a. Flush as outlined in policy/procedure for that particular catheter type.

b. Check for blood return. If blood return noted follow steps under "Peripheral IV Sites".

c. If blood return is absent or sluggish, reposition patient (have patient raise arm, have patient take a deep breath, try drawing blood with patient in trendelenberg position. If a good blood return is noted, follow steps under "Peripheral IV Sites". If blood return is absent or sluggish, and a declotting agent (Alteplase) is orderered; administer per manufacturer instructions or call physician. A chest x-ray may be needed to verify placement. Proceed with use if possible when approved by physician. Follow steps under "Peripheral IV Sites".

d. After chemotherapy flush has been completed, flush central line with solution (sterile normal saline or heparin solution) as appropriate for the particular type of central line.

8. The patient should be instructed to report any burning, stinging or swelling at the IV site.

9. Extravasation Procedure:

IF EXTRAVASATION OCCURS: Follow extravasation policy / procedure in Lippincott

10. Disposal of chemotherapeutic equipment.

a. Any unused chemotherapy medication will be returned to the pharmacy in a labeled zip lock bag.

b. All syringes, IV bags and IV tubing contaminated with a chemotherapy agent will be treated as infectious waste and must be disposed of intact and placed in red biohazard container labeled as ***chemotherapy waste*** in room. [**Note:** Contaminated needles must be removed from tubing (using a hemostat), and placed in a screw cap specimen container. Close lid securely and place in

biohazard container in room. Do not recap needles. Needles should not be used in chemotherapy administration under normal circumstances.]

c. **All disposable items such as gloves, gown, alcohol swabs, syringes, Chux, urinals, etc. shall be considered hospital waste and placed in the regular trash.** Gloves should be removed slowly and carefully, folding inside out to limit contamination.

d. Wash hands after completion of administration and PPE removal.

DOCUMENTATION:

1. All medications should be charted in the Electronic Health Record (Medication Administration Record) or Chemotherapy Flow Sheet for outpatients. Patient assessment, teaching, and discharge instructions should be completed and a copy saved in patient chart. ~~IV injection and~~ IV infusion start and stop times must be documented.

2. Charges based on infusion times, procedures, IVs, supplies, medications and oxygen as used.

REFERENCES:

- OSHA Guidelines for Handling Cytotoxic Drugs
- Oncology Nurses' Society Chemotherapy and Biotherapy Guidelines and Recommendations for Practice, 2001

CROSS REFERENCES:

- Chemotherapy Agents in the OR
- Infiltration and Extravasation Management (Lippincott)

Approval	**Date**
CCOC	6/1/20
P&T	7/30/20
MEC	9/1/20
Board of Directors	
Last Board of Director review	1/17/18

Initiated: 12/16/08
Revised: 10/96, 5/97, 6/00, 11/02, 9/07, 8/31/2009, 4/20aw
Reviewed: 05/11AW, 09/12 AW
Approved: 8/95, 4/11
Index listings: Chemotherapy; Chemotherapy Administration and Precautions; Intravenous Medications-Chemotherapy Administration and Precautions.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Chemotherapy Administration And Precautions	
Scope: Emergency Dept, ICU, Med Surg, Outpatient	Manual: CPM - Medication (MED)
Source: DON Perioperative Services	Effective Date: 9/2009

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Discharging a patient with a hospital administered metered dose inhalers(MDI)	
Scope: Cardiopulmonary	Manual:
Source: Cardiopulmonary	Effective Date:

PURPOSE:

To ensure that when patients are discharged from the hospital with an MDI, they are able to use the inhaler properly. Correct technique will deliver the medication to the lungs and provide the intended therapeutic effect.

POLICY:

Metered dose inhalers are a convenient and effective way to administer medication to treat conditions such as COPD and Asthma. However, it is vital to have proper education and technique to maximize the amount of medication delivered to the lungs.

PROCEDURE:

Indications

Patients who have been issued an MDI during their hospital stay which will continue to be used as part of their home medication regimen.

Contraindications

Patients who are unable to use the MDI properly.

Steps

1. Verify that there is an order for the patient to use the MDI at home.
    a. Verify that the order is complete and has the medication, number of inhalations, and frequency.
2. Verify that the medication has been labeled for home use.
3. Introduce yourself to patient and verify patient using two patient identifiers.
4. Provide privacy
5. Assess patient's understanding of the medication, its purpose, side effects, and technique.
6. Provide education and instruction as needed.
    a. If medication is given, follow protocol for administering and documenting an MDI.
7. Request a demonstration from the patient of their technique with the MDI and spacer (if applicable).
8. Document
    a. Patient's verbalization of understanding and any education given to the patient.
    b. Patient's technique with the MDI and spacer (if applicable).
9. Medication must be dispensed by pharmacy or medical provider, not by nursing staff.

REFERENCES:

1. Patient education: Inhaler techniques in adults (Beyond the Basics). (2019). Uptodate Website.
2. Lippincott procedure: Metered-Dose Inhaler use, https://procedures.lww.com/lnp/view.do?pId=3260117&hits=metered&a=false&ad=false

CROSS REFERENCES:

1. Discharge Medications

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Discharging a patient with a hospital administered metered dose inhalers(MDI)	
Scope: Cardiopulmonary	Manual:
Source: Cardiopulmonary	Effective Date:

Approval	**Date**
CCOC	2/24/2020
P&T	7/30/2020
MEC	9/1/2020
Medical Services/ICU Committee	5/26/2020
Board of Directors	
Last Board of Directors Review	

Developed:
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: OmniCell Automated Dispensing Unit (ADU)	
Scope: Hospital Wide	**Department:** Emergency Dept, ICU, Infusion Center, Medical/Surgical, Nursing Administration, PACU, Perinatal, Pharmacy
Source: Pharmacy Director ~~FGL~~	**Effective Date:**

PURPOSE:

To ensure that the automated dispensing unit ~~(ADU)~~ is utilized for the safe storage, handling, security, disposition and return to storage of medications. ~~For the remainder of the policy "Omnicel", "ADU" and Automatic Dispensing Unit are synonymous.~~

POLICY:

1. Pharmacy, Nursing Services, and other designated departments will utilize the ~~OmniCell~~ aAutomated dDispensing uUnit ~~(ADU)~~ to store dispense, charge and account for controlled substance and non-controlled substance medications used in patient care areas where ~~an OmniCell ADU has been~~ installed.
2. In accordance with established policies and procedures for medication use, all record keeping requirements and dispensing practices will conform to federal and state laws and regulations.
3. The Director of Pharmacy shall be responsible for determining what classes of medications may be stored in these units ~~ADUs~~ and may exclude individual medications or whole classes of medications from storage and availability ~~in the ADUs~~.
4. Medications that may not be stored in the Automatic Dispensing Unit~~DU~~ include, but are not limited to:
    a. Cancer Chemotherapeutic agents
    b. Concentrated Electrolytes
    c. Sample Medications
5. All medications, solutions, and components used in preparation of medications stored ~~in the ADUs~~ will be labeled with the contents, expiration date, lot numbers, and when necessary applicable warnings.
6. Expiration dates of each medication, solution and component used in preparation of medications stored in the automatic dispensing units~~ADU's~~ shall have their expiration dates electronically retrievable from the units~~recorded in the computer control of the ADUs~~ or the pharmacy computer system. ~~.~~ Items stored in the units~~ADU's~~ will be removed before their expiration dates by the pharmacy.
7. Each unit~~The contents of each ADU~~ will be inspected monthly for expiring medications, damaged, recalled, or contaminated medications which shall be removed and quarantined in the pharmacy.
8. All a~~A~~ccess to these units ~~ADUs~~ will be controlled by the Director of Pharmacy or designee via identification number and secure password.
   Specific levels of access will be assigned by the Director of Pharmacy so that licensed staff will only have access to those classes of medications predefined by their licensure and role,~~Access to the ADUs and to specific storage portions of ADUs will be limited to licensed personnel by role-based access rules controlled by the Director of Pharmacy or designee,~~ e.g., respiratory therapists will not have access to controlled substances.
9.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: OmniCell Automated Dispensing Unit (ADU)	
Scope: Hospital Wide	**Department:** Emergency Dept, ICU, Infusion Center, Medical/Surgical, Nursing Administration, PACU, Perinatal, Pharmacy
Source: Pharmacy Director ~~FGL~~	**Effective Date:**

~~**Procedures**~~

~~**1. User Access**~~

ACCESS

All Employees

1. New employees must obtain/complete the following prior to independent use of the automated dispensing unit:

   a. Confidential login credentials
   b. Education from super user.
   c. Successful completion of competency to be kept on file in nursing office.

~~**New Employees**~~

~~1. New employees must obtain/complete the following prior to independent use of the automated dispensing unit:~~

~~a. Confidential login credentials.~~

~~b. Education from super user.~~

~~c. Successful completion of competency.~~

ID Codes and Passwords

1. The employee's sign-on identification will be the employee's unique payroll number. The employee's identification number and secure personal password will serve as the employee's confidential electronic signature in the automatic dispensing unit~~ADU~~. It is the employee's responsibility to protect their access codes and divulging, sharing, or any other inappropriate use of the employee's electronic signature is prohibited. Transaction records will be used for trending data and will be available to regulatory agencies.
2. Should any user believe that another person has knowledge of their ID and password, it is their duty~~responsibility~~ to report this to their department manager and immediately change their password in the unit~~on the ADU~~.

Title: OmniCell Automated Dispensing Unit (ADU)	
Scope: Hospital Wide	**Department:** Emergency Dept, ICU, Infusion Center, Medical/Surgical, Nursing Administration, PACU, Perinatal, Pharmacy
Source: Pharmacy Director ~~FGL~~	**Effective Date:**

3. The Director of Pharmacy or designee shall be the Pharmacy System Administrator and shall maintain a record of user sign-on identification numbers, which shall be available in the system software and stored securely. This record shall be available for inspection to authorized persons, such as Drug Enforcement Administration and the California State Board of Pharmacy.
4. The Pharmacy System Administrator will enter users into the ADU system and assign levels of security including but not limited to:
    a. Access to drug classes
    b. Access to individual ADU's
    c. Override ability
    d. Witness ability
5. On weekends or holidays, or in the case of emergencies, the Nursing Supervisor or Unit Manager may provide access by assigning a temporary user code. The Pharmacy Director will be responsible for training new personnel to these positions.

~~**Permanent Staff**~~

~~1. For assignment of access for permanent staff, a request will be submitted to Human Resources and Information Technology. These will be routed to the Pharmacy System Administrator for processing.~~

~~2. The user will be prompted to enter a password when the user logs onto the system for the first time. Only the user knows the password. The password shall comply with the hospital password policy.~~

~~3. The Pharmacy System Administrator shall enter new users who are current employees only upon the request of a unit or department director or manager.~~

~~4. On weekends or holidays, or in the case of emergencies, the Nursing Supervisor or Unit Manager may provide access by assigning a temporary user code.~~

Temporary Staff

1. Unit Managers and Nursing Supervisors may assign a temporary access code to temporary staff or "float" for a period of 24 hours. This password will be created at the ADU using "Add Temp Nurse" procedure. All temporary access codes established in this manner shall expire in 24 hours.

Deletion of Codes

~~2.~~ Whenever a user is terminated, Human Resources will notify the Pharmacy System Administrator via ~~a~~ email. The Pharmacy System Administrator shall delete the user when notified as such~~immediately~~.

Title: OmniCell Automated Dispensing Unit (ADU)	
Scope: Hospital Wide	**Department:** Emergency Dept, ICU, Infusion Center, Medical/Surgical, Nursing Administration, PACU, Perinatal, Pharmacy
Source: Pharmacy Director ~~FGL~~	**Effective Date:**

~~3.~~ **Verification of Users**

1. ~~_____~~At least twice a year, in January and June, the user list will be generated by the System Administrator and updated by Human Resources.
2. The Pharmacy System Administrator will correct any discrepancies in the system. This shall act as a failsafe for deletion of users.

~~4. _____ and and will be updated by Human Resources. The Pharmacy System Administrator will correct any discrepancies in the system. This shall act as a failsafe for deletion of users.~~

Medication Removals, Returns and Wastes

Medication Removal and Administration

1. Personnel accessing the automatic dispensing unit~~ADU~~ shall select the patient and the appropriate medications and quantities to be removed.
2. Check the expiration date of all medications removed from the unit~~automated dispensing machine~~.
~~2.~~3. Check each item for any evidence of damage or tampering.
~~3.~~4. Upon completion of the transaction, the person shall document medication administration in the patient's electronic health record or other approved system i.e. anesthesia.~~record through the approved mechanism (MAR, anesthesia record, etc).~~

Controlled Substance Waste

1. When controlled substances are unusable, the dose should be discarded in the stericycle drug disposal bin found in the med room and the "WASTE" function should be used to document the waste.
2. Two licensed personnel shall document wasted controlled substances, the person who wastes the medication and a witness. The witness must physically witness all wastes

Controlled Substance Medication Return

1. If a User removes a medication but does not administer it to the patient, it must be returned to the dispensing unit to avoid charging the patient for medications not administered. The "Return Med" function is used both to return the medication and to credit the patient.
2. After accessing the above function, the medication is returned to the "Return Bin", never to the drawers in the ADU.
3. For controlled substances, a witness is required to return medications that are reusable. The witness must physically observe the medication's placement in the "Return Bin".
4. The "Return Bin" will be emptied at each restock and a "Return Bin" receipt will be printed.

5. Medications in the bin shall be adjudicated~~reconciled~~ daily against the reconciliation report by a pharmacy technician with oversight by a pharmacist. Discrepancies will be investigated immediately.

Inventory Maintenance

Restocking Cabinets

1. Pharmacy will be responsible for the refill and loading of medications in each automatic dispensing unit~~ADU~~. A complete list of medications stored in any unit may either be viewed on that unit screen or in the pharmacy~~printed on that unit~~. The Pharmacy System Administrator or their designee may add or remove controlled or non-controlled drugs ~~stocked items~~ from the automatic dispensing unit~~ADU~~.

Controlled Medications

~~2.~~ Inventory levels will be checked via the pharmacy computer system, delivered and loaded into each unit~~ADU~~ by pharmacy personnel. ~~Routine refills of controlled substances by pharmacy personnel will not require a signature since all transactions are automatically recorded and saved in memory.~~ Each time a unit is refilled, an inventory report will be generated to verify that medications dispensed have been loaded into the automatic dispensing unit~~ADU~~. The first withdrawal of a dose serves to confirm the delivered inventory.

1.

~~3.~~ Pharmacy will generate a hard copy of the Reconciliation~~Transaction by Date~~ R~~r~~eport on a daily basis for review to serve as a permanent record of controlled substances transactions, as well as electronically archiving all data generated in the system on a daily basis. Such reports will be kept for 3 years. The Controlled Substance Officer (a pharmacist) will report to the Director of Pharmacy any variance to these reports as soon as identified.

2.

3. When a controlled substance not previously stocked on that automatic dispensing unit~~ADU~~ is needed, pharmacy personnel must load it onto that location before being accessible to the nursing unit.
4. Medications not available to be furnished to the units will be brought to the attention of the Director of Pharmacy.

Non-Controlled Medications

~~5.~~1. Inventory levels will be checked via the pharmacy computer system, delivered and loaded into each automatic dispensing unit~~ADU~~ by pharmacy personnel to maintain par levels daily.

~~6.~~2. A Pharmacist will verify the accuracy of medications and quantity stocked by checking the fill list with the drug to be loaded.

3. At time of refill, pharmacy personnel will perform an actual inventory of those items being refilled, comparing actual physical inventory with the report. If discrepancies are discovered, a "Discrepancy Report" shall be generated.

Title: OmniCell Automated Dispensing Unit (ADU)	
Scope: Hospital Wide	**Department:** Emergency Dept, ICU, Infusion Center, Medical/Surgical, Nursing Administration, PACU, Perinatal, Pharmacy
Source: Pharmacy Director ~~FGL~~	**Effective Date:**

4. Medications that are not available to be furnished to the units will be brought to the attention of the Director of Pharmacy.

Reports and Discrepancies

1. The pharmacy department will maintain records of all ~~legend~~ medications dispensed from the automatic dispensing units~~administered to a patient from the unit~~ADU~~~~. These records will be maintained for a minimum of 3 years.

~~1.~~

~~2.~~ **Daily Batch Reports**

~~3.~~1. ~~A pharmacy t~~~~The Restocking T~~echnician will run the Transaction by Item by Par level report. This report is used to ~~i~~I identify the medications needing to be replaced on each unit. ~~determine the need for medication replacement on each dispensing uni~~ The report can be discarded after the refill procedures. Stocking reports will be generated automatically by the system each morning. A critical item report will be generated automatically near the end of each day to ensure an adequate inventory during each night.

~~4.~~2. When emptying an automatic dispensing unit~~ADU~~ return bin, t~~he Restocking T~~echnician will generate a Waste and Return Drawer Reconciliation Report. The quantities returned from the bin will be verified against the quantities on the report ~~and will be signed by a pharmacist~~.

~~5.~~3. The ~~te Restocking T~~echnician will run the Transaction by patient report. This report shall be separated by medication class for Unscheduled medications, Schedule II medications, and those in schedules III-V. It will be reconciled with the MAR or other report of administrations each day providing 100% reconciliation of controlled substances..

Daily Discrepancy Reports

~~6.~~1. If a discrepancy in inventory is discovered during restocking of the automatic dispensing unit~~ADU~~ or during reconciliation of the return bin, a discrepancy report shall be generated at the unit and the department manager or designee will be notified.

Title: OmniCell Automated Dispensing Unit (ADU)	
Scope: Hospital Wide	**Department:** Emergency Dept, ICU, Infusion Center, Medical/Surgical, Nursing Administration, PACU, Perinatal, Pharmacy
Source: Pharmacy Director ~~FGL~~	**Effective Date:**

~~7.~~2. Assigned pharmacy personnel will print and review all discrepancy reports for all locations, verifying that all discrepancies have been resolved.

~~8.~~3. The Director of Pharmacy (or designee in the absence of the Director) will be notified of unresolved discrepancies. The Director of Pharmacy shall report unexplained losses in accordance with applicable law.

~~9.~~4. Discrepancy reports shall be filed and retained for 3 years.

Monthly Procedures:

1. Pharmacy personnel will perform an inventory of medications in the automatic dispensing unit~~ADU~~ monthly and remove all medications that will expire in less than 30 days. The soon to expired medications will be returned to the Pharmacy and placed in the area designated for expired medications. Restocking of expired medications will occur at the next filling sequence.

~~10.~~

Problem Solving

~~1.~~ Each user shall be competent in loading paper into the automatic dispensing unit~~ADU~~. Refer to the OmniCell Color Touch Quick Reference Guide or the OmniCell Pharmacy System User Guide.

1.

~~2.~~ Cleanliness is essential to proper functioning of the Omni-Cell units. No food or drinks are allowed in the vicinity of the unit, nor should they be placed on top of any unit. Liquid spills and plastic tabs from drug packaging should be cleaned up and removed immediately, as they are a primary source of "drawer jams".

2.

~~3.~~ The user will refer to the "Quick Reference" guide to resolve malfunction problems.

3.

~~4.~~ The user will next contact the pharmacy.

4.

~~5.~~ Only the pharmacy will call the Omni-Cell Help Line for assistance. The number is affixed to each unit. The number is 1 (800) 910-2220.

5.

6. When a problem restricts the ability to access and document medication use appropriately, down time procedures shall be used until the unit is functional.

Down Time

1. The normal downtime procedure for inoperable ADU's is for the pharmacy to dispense any needed medication from the pharmacy.

2. If the inventory is only accessible from an ADU, and the ADU is inoperable (all problem resolution strategies have been tried), the manual lock override system can be used to unlock the unit.
3. The manual lock override can only be performed by a pharmacist, or pharmacy technician authorized by a pharmacist.
4. The pharmacist may, during an emergency situation leave the automatic dispensing unit unlocked with a sign out log for staff to list and affirm all non-controlled items removed while unit electronically inaccessible.~~unlocking the unit is responsible for putting the Manual sign out log on the unit so that items removed can be documented manually.~~
5. Upon restoration of the system, the person responsible for unlocking the unit is assigned responsibility for relocking it ~~and conducting a witnessed inventory of all controlled substances~~, as well as sending the manual sign out log to pharmacy so that items can be recorded and charged.
6. Upon arrival onsite to repair an automatic dispensing unit~~ADU~~, and Omni~~C~~ell representative shall report to the Pharmacy Department to obtain keys to the Omni-Cell unit and to obtain information regarding the nature of the malfunction.
7. If the representative opens the unit a pharmacy technician or pharmacist will be present at all times.
8. If the unit is inoperable for an extended period of time, the pharmacists shall issue controlled substances in accordance with the controlled substance policy and procedures for units without automatic dispensing units~~ADUs~~.
9. All automatic dispensing units with the exception of Diagnostic Imaging run on "red plugs" which will continue to furnish generator power if commercial electrical utilities are interrupted~~In the event of a power loss to the ADU~~, additionally each unit is equipped with a battery back up that will allow 20 ~~minutes~~ more minutes of power to complete transactions in ~~in~~ progress. ~~–~~Once battery power is exhausted the unit will automatically shut down and re-boot once power is restored. The unit will return to its last working state without user intervention.
10. Information stored on each dispensing unit is also stored in the central unit in the pharmacy. In the event that information on an automatic dispensing unit~~ADU~~ is lost, the central unit can re-transmit the necessary files back to the individual unit~~ADU~~. Each unit operates independently. If one unit~~ADU~~ is down, it does not affect the operation of other units.
11. If the Omni Center (central unit) is not operating, each unit has the ability to continue functioning independently without communication with the central unit. Once the Omni Center is back on line and communication between the Omni Center and the units is restored, all units automatically reconnect to the center and have their transactions updated.

~~**Disasters**~~

~~1. Since all components of this system are connected to the emergency power supply, function of the system shall be maintained during an external disaster. In the event that power to the system is interrupted during the disaster, downtime procedures shall be initiated to perform and document transactions. It is noteworthy that backup battery power supply is limited to 20 minutes of operation.~~

REFERENCES

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: OmniCell Automated Dispensing Unit (ADU)	
Scope: Hospital Wide	**Department:** Emergency Dept, ICU, Infusion Center, Medical/Surgical, Nursing Administration, PACU, Perinatal, Pharmacy
Source: Pharmacy Director ~~FGL~~	**Effective Date:**

Annals of American Hospital Association June 2016

ISMP Preventing Medication Errors 2006

CROSS REFERENCE

NIHD Controlled Substance Policy

NIHD Pharmacy Downtime Procedure

Committee Approval	**Date**
CCOC	5/18/20
Pharmacy and Therapeutics Committee	7/30/20
Medical Executive Committee	9/1/20
Board of Directors	
Last Board of Directors Review	

Revised 4-7-15
Reviewed 10/06,10/09,10/11, 10/13, 4/20
Supercedes

Responsibility for Review: Pharmacy / Compliance
Index Listings: OmniCell; Automated Dispensing Unit ~~(ADU)~~; Medication-OmniCell

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Potassium Intravenous Administration**	
Scope: **Nursing, Pharmacy & Medical Staff**	Department: **Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical, PACU, Perinatal, Surgery**
Source: Director of Pharmacy	Effective Date:

PURPOSE:
Intravenous Potassium is a therapeutic high-risk medication, which requires careful administration and oversight to avoid serious or fatal consequences.

POLICY:

1. Potassium solutions shall be administered via IV Pump only.
2. 100 ml IVPB (K-rider) will contain no more than 10 mEq's of Potassium (0.1 mEq/ml).
3. 1000ml bags will contain no more than 40 meq of Potassium (0.04mEq/ml).
4. The rate of administration of potassium up to 10 mEq per hour does not require cardiac monitoring.
5. Patients receiving more than 10mEq/hr. shall be on continuous cardiac monitoring. This includes patients receiving total parenteral nutrition.
6. The maximum rate of infusion without the presence of a physician shall be no more than 20mEq/hr. An infusion greater than 20mEq/hr. must be administered via a central line with an MD present during the administration.
7. The pharmacy shall stock pre-mixed, ready to administer solutions available from IV solution manufacturers containing various amounts of potassium for administration at NIH. Only pharmacy staff shall mix IV solution containing electrolytes that are not available pre-mixed. See "Concentrated Electrolytes After Hours Policy."
8. Rate of Potassium in excess of 10 mEq/hr require central line route of administration as well as timely prior labs.
9. Potassium rates per hour will not exceed 40 meq/hr.
10. All K-Riders will be Y-lined into the primary IV solution.
11. Patients IV site to be checked every 2 hours and with advice to patient to notify RN/LVN if site becomes painful.
12. Lidocaine will not be used as an anesthetic palliative in any solution containing potassium.
13. Documentation of the infusion will be maintained via smart pump and EHR technology.

REFERENCES:

1. Mount D.B. Disorders of Potassium Balance. Brenner and Rector's The Kidney 2016
2. Gennari FJ Hypokalemia N Engl J Med 1998; 339;451
3. Pezhouman A, Singh, N, Song Z. et al Molecular Basis of Hypokalemia in Atrial Fib. 2015
4. Arora S, Cheng D. Wyler B. Prevalence of Hypokalemia in ED Am J Emerg Med 2012; 30:481

CROSS REFERENCES:

1. Dignity Health Potassium Supplementation Guidelines 2015
2. Fairchild Medical Center Policy and Procedure Intravenous Medications
3. Concentrated Electrolytes After Hours Policy

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Potassium Intravenous Administration**	
Scope: **Nursing, Pharmacy & Medical Staff**	Department: **Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical, PACU, Perinatal, Surgery**
Source: Director of Pharmacy	Effective Date:

Committee Approval	**Date**
Policy and Procedure Committee	6/1/2020
Pharmacy and Therapeutics Committee	7/30/2020
Medical Executive Committee	9/1/2020
Board of Directors	
Last Board of Directors Review	3/18/2020

Revised 9/07, 5/20 fl
Reviewed 9/09jk, 06/11 rs
Supercedes 4/98

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Potassium Intravenous Administration**	
Scope: **Nursing, Pharmacy & Medical Staff**	Department: **Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical, PACU, Perinatal, Surgery**
Source: Director of Pharmacy	Effective Date:

Administration of Intravenous Potassium
Supplemental Information

EXAMPLES

- **For example, if the MD orders 40 mEq KCL in 100ml over 4 hr. it will need to be mixed as 4 x 100 ml with 10 mEq in each piggyback. (K-rider)**

The rate of administration of potassium shall be no more than 10 mEq per hour unless the patient is monitored by telemetry.

- **For example, the maximum rate of administration of a (1000ml) solution containing 40 mEq KCL per liter would be 250 ml/hr.**
- **For a solution containing 30 mEq Potassium Phosphate per liter the maximum rate would be 333ml/hr.**

PRE-MIXED KCl SOLUTIONS AVAILABLE AT NIH

BASE SOLUTION	AVAILABLE WITH KCl ____mEq
NORMAL SALINE	20mEq, 40mEq
D-5-W	20mEq, 40mEq
D-5 ½ N.S.	10mEq, 20mEq, 30mEq, 40mEq
D-5 ¼ N.S.	20mEq
D-5 LR	20mEq
STERILE WATER **50 ml**	10 mEq
STERILE WATER **100ml**	20mEq

INDEX LISTING: Potassium Chloride Infusion, IV Potassium

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Procedural Sedation*	
Scope: Clinical Services	Manual: Anesthesia
Source: DON Perioperative Services	Effective Date: 2/1/16

PURPOSE:

To provide a consistent standard for the administration of sedation during procedures performed at Northern Inyo Hospital

DEFINITIONS:

1) Minimal Sedation – A drug-induced state in which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilator and cardiovascular functions are unaffected. 'Minimal Sedation' includes analgesia, anxiolysis and/or the use of a soporific for the purpose of performing a procedure.
    a. Analgesia – Pain control, often with a narcotic, which is expected to have no significant effect on the patient's level of consciousness.
    b. Anxiolysis – Control of anxiety, most commonly with a benzodiazepine, which is expected to have no effect on a patient's level of consciousness.
    c. Soporific – A sleeping agent, which, at the usual dose and route, is expected to induce sleep from which a patient can be easily aroused.
2) Dissociative Sedation – A trance-like state of unconsciousness in which the patient is unresponsive to pain and of which the patient will have no memory. Airway reflexes are maintained and vital signs remain stable. This state is unique to Ketamine in appropriate doses.
3) Moderate Sedation – A drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or with light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Medications to be used may include, but are not limited to, benzodiazepines, narcotics and barbiturates.
4) Deep Sedation - A drug-induced depression of consciousness during which patients are not easily aroused, but respond purposely after repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Medications to be used may include, but are not limited to, all of the above plus propofol and etomidate.
5) General Anesthesia – A drug-induced unconsciousness during which it is expected that respirations, motor tone and protective airway reflexes may be abolished, requiring complete airway and respiratory support. General anesthesia may only be administered by an Anesthesiologist or a Certified Registered Nurse Anesthetist (CRNA) with appropriate clinical privileges. ED physicians may induce general anesthesia only when the goal is endotracheal intubation, as in Rapid Sequence Intubation, and as delineated in their Hospital privileges.

POLICY:

1) Procedural sedation in the hospital shall be monitored and evaluated by the Surgery, Tissue, Transfusion and Anesthesia Committee according to the policy and performed to assure optimal patient outcomes. The physician providing sedation must be thoroughly familiar with the use and potential complications of the drugs used.
2) This policy applies in the hospital when patients receive, by any route, for any purpose, moderate, deep or dissociative sedation.

3) This policy does not apply to situations which do not constitute procedural sedation, such as: patients receiving medications for pain control, seizures, insomnia, preoperative medications, anxiety management, or medications given to intubated patients while on ventilatory support. This policy also does not apply to anesthesiologists or CRNAs providing General Anesthesia.
    a. Minimal sedation, as defined above, does not require any special monitoring or facilities other than maintaining verbal or visual contact with the patient until the effects of the medication have reached their peak, but continuous Pulse Oximetry may be considered.
4) Sedation may only be performed by a practitioner with the appropriate privileges at NIH. Medications ordered for the purpose of sedation may be administered by the RN; medications for moderate or deep sedation must be administered under the direct supervision of the ordering practitioner who must be present in the department.
5) The following resources shall be available in all locations where medications are administered to induce sedation:
    a. Equipment to monitor vital signs including pulse, respiratory rate and oxygenation.
    b. Appropriately sized equipment for establishing and providing airway maintenance, including a selection of laryngoscope blades with handle and endotracheal tubes.
    c. Suction and supplemental oxygen with the appropriately sized adjuncts.
    d. Crash cart equipped with a defibrillator.
    e. Appropriate selection of masks and airways.
    f. Means to administer positive-pressure ventilation (e.g. ambu bag).
    g. Pharmacologic antagonists, including naloxone and flumazenil.
6) Because deep sedation carries a high level of risk, the administration must be carefully planned. A sedation plan will be developed to meet patient needs identified through a pre-sedation assessment.
7) Practitioners providing moderate or deep sedation must have training and experience in:
    a. Evaluating patients prior to performing moderate or deep sedation.
    b. Performing the sedation, including methods and techniques required to rescue those patients who unavoidably or unintentionally slip into a deeper level of sedation than desired.
    c. Managing an unstable cardiovascular system as well as a compromised airway and inadequate ventilation.
8) All physicians requesting privileges in moderate, dissociative and deep sedation must meet the following criteria:
    a. Satisfactory completion of the sedation reading list or tutorial and completion of the post-test at least every 2 years.
    b. Documentation of 6 successful sedation procedures within 2 years.
    c. Current ACLS certification and/or Emergency Medicine Board Certification.

    EXCEPTIONS
    Anesthesiologists who have completed an anesthesiology residency and CRNAs who have completed an accredited nurse anesthesia program are considered qualified to administer moderate, dissociative, and/or deep sedation and analgesia by virtue of their training and experience. They are therefore exempt from the requirements listed in Section 8a of this document.

9) The Registered Nurse administering the medications to be used for sedation must be competent in the following areas:
    a. Basic arrhythmia recognition

b. Airway management
c. Current in BLS, ACLS and PALS ~~(if providing sedation for a pediatric patient)~~
d. Clinical pharmacology and hemodynamic variables of the medications to be used and their antagonists
e. Knowledge of the appropriate monitoring equipment.

10) Sufficient numbers of qualified personnel will be present during sedation to:
    a. Appropriately evaluate the patient prior to sedation.
    b. Provide the sedation. The sedation nurse will have no additional responsibilities during the procedure.
    c. Perform the procedure.
    d. Monitor the patient.
    e. Recover and discharge the patient from the department where sedation has been administered.
11) The patient's response to sedation and the procedure will be documented in the patient's record.
12) Outcomes of patients undergoing moderate, dissociative or deep sedation will be collected and analyzed within the Peer Review process in order to identify opportunities to improve.

PROCEDURE:

PRE-SEDATION:

The nurse will complete a pre-procedure assessment with documentation to include:

- Patient identified using 2 patient identifiers (MR#, DOB, Name or Acct#)
- Baseline vital signs including oxygen saturation
- Physical assessment including age, weight, level of consciousness and pregnancy status
- Allergies
- Current medications
- Current medical problems
- Preferred NPO status
    - May not be obtainable due to nature of emergency
    - Consider addition of Reglan or Bicitra 20-30 minutes prior to procedure for patients with a full stomach
    - Pregnancy greater than 20 weeks, obesity and prior history of reflux should always be considered a potential full stomach
    - Non-emergency NPO guidelines:

Previous 2 hours - clear liquids
Previous 4 hours – breast milk
Previous 6 hours - light meal
Previous 8 hours - heavy meal

- Signed consent for the procedure including sedation, if condition permits
- IV status (patent, running, saline lock)
- Verification that a responsible adult is available to transport the patient home

- Equipment available
- Reversal agents

Physician documentation will include:

- Focused history and physical for the chief complaint
- History of patient or family complications to sedation
- Risks, benefits and alternatives of the procedure and types of sedation have been discussed with the patient and family prior to administration.
- An immediate pre-procedure assessment including a review of vital signs and patient status.
- Airway assessment with classification based on the American Society of Anesthesiology (ASA) classification system listed below. Any patient assessed an ASA-IV or greater requires consultation from the anesthesiologist or CRNA.

SEDATION:

1) The patient will be monitored continuously throughout the procedure. Monitoring will be done by the medication/monitoring RN who will not assist with the procedure.
    a. Vital signs, including sedation scale and oxygen saturation levels will be recorded every 5 minutes throughout the procedure.
        a. For deep sedation, vital signs should be monitored more closely, at least every 3 minutes.
    b. Medications given, including dose, route and response will be documented throughout the procedure.
    c. A change of 20% or more from baseline in pulse, heart rate or oxygen saturation should be reported to the physician.
    d. Documentation should also include the patient's tolerance of the procedure, estimated blood/fluid loss, acute changes in the patient's status, interventions performed and disposition of the patient.
2) A respiratory therapist will be at the bedside for any moderate or deep sedation in the ED.
3) ETCO2 Monitoring will be used for deep sedation, if available.

POST-PROCEDURE:

1) Immediately after the procedure, the physician will document the outcome of the procedure, the patient's response to the sedation and any complications.
2) Routine nursing recovery care will include, but not be limited to:
    a. Admission Aldrete score
    b. Blood pressure, respirations and heart rate every 15 minutes
    c. Continuous monitoring of oxygen saturation, respirations, and cardiac rhythm
    d. Documentation of vital signs will continue every 15 minutes until the patient reaches discharge criteria defined as an Aldrete score of 8 for 30 minutes or achieves a score equivalent to pre-procedure levels. If a reversal agent was administered, this monitoring time will be extended to at least one hour after the last reversal agent was administered.
3) Any abrupt deterioration of the patient's condition will be reported to the physician immediately. These include, but are not limited to:

a. Respiratory rate greater than 20 or less than 10
b. Oxygen saturation less than 90% or less than pre-procedure levels
c. Stridor, wheezing or croup symptoms
d. Shallow or inadequate tidal volumes
e. Sudden onset of cyanosis
f. Repeated respiratory obstruction
g. Systolic blood pressure less than 80% under or more than 20% over preoperative values
h. Pulse greater than 120 or less than 50
i. Any cardiac dysrhythmias
j. Any deterioration in mental status

DISCHARGE:

1) Patients who have received procedural sedation may be discharged when the following criteria are met:
   a. Discharge order from the physician
   b. Vital signs to within +/- 20% of pre-procedure level
   c. Level of consciousness returned to pre-procedure state
   d. Return of baseline motor function, including able to ambulate without assistance (if applicable)
   e. Able to tolerate oral fluids (unless contraindicated)
   f. Pain is manageable
   g. Oxygen saturation maintained at 94% or greater or is stable at pre-procedural level
2) Patient and family education and discharge planning is done and validation that learning took place is documented. Written discharge instructions should cover the following:
   a. Limitations of activity (including operating a motor vehicle or heavy machinery)
   b. Dietary precautions
   c. Medications
   d. Signs and symptoms of complications with a course of action to take
   e. Name and phone number of physician and hospital
   f. Follow-up instructions
3) Transportation home shall be by a responsible adult other than the patient.

Approvals	**Date**
Surgery Tissue	~~10/26/16~~07/22/2020
Pharmacy & Therapeutics	7/30/2020
Medical Executive Committee	9/1/2020
Board of Directors	1/18/17
Last Board of Director review	1/17/18

Title: Procedural Sedation*	
Scope: Clinical Services	Manual: Anesthesia
Source: DON Perioperative Services	Effective Date: 2/1/16

ASA SCORING:

American Society of Anesthesiologists grading for anesthetic assessment

1. ASA I - A normal healthy patient without medical problems
2. ASA II - A patient with mild systemic disease (that does not limit activity)
3. ASA III - A patient with moderate or multiple controlled systemic diseases (limits activity, but not incapacitating)
4. ASA IV - A patient with severe systemic disease that is incapacitating and is a constant threat to life
5. ASA V - A moribund patient who is not expected to survive with or without the operation

If any of the above categories is an emergency, it is suffixed with 'E'.

ALDRETE SCORING:

ACTIVITY
Able to move 4 extremities voluntarily or on command = 2
Able to move 2 extremities voluntarily or on command = 1
Able to move 0 extremities voluntarily or on command = 0

RESPIRATION
Able to deep breathe and cough freely = 2
Dyspnea or limited breathing = 1
Apneic = 0

CIRCULATION
BP" 20% of Preanesthetic level = 2
BP" 20-50% of Preanesthetic level = 1
BP" 50% of Preanesthetic level = 0

CONSCIOUSNESS
Fully Awake = 2
Arousable on calling = 1
Not responding = 0

COLOR
Pink = 2
Pale, dusky blotchy, jaundiced, other = 1
Cyanotic = 0

Title: Procedural Sedation*	
Scope: Clinical Services	Manual: Anesthesia
Source: DON Perioperative Services	Effective Date: 2/1/16

DOSING STANDARDS:

Maximum doses are for procedures without the presence of Anesthesiologist or CRNA

Moderate Sedation Agents - Intravenous Administration

Trade Name	Generic Name	Initial Dose	Repeat Dose	Minimal Repeat Dose Interval	Maximum Dose Per Hour
Morphine	morphine sulfate	0.025mg/kg-0.1mg/kg	0.025mg/kg	2 minutes	20 mg
Sublimaze	fentanyl	0.5-1mcg/kg	0.5mcg/kg	2 minutes	500 mcg
Demerol	Meperidine	25-50mg		5-10 minutes	100mg
Versed	midazolam hydrochloride	0.025mg/kg-0.05mg/kg	0.025mg/kg	2 minutes	10mg*

Midazolam (Versed)

*The Physician may exceed the upper dose limit of midazolam (10mg) if in his/her judgement a higher upper limit dose is indicated and the physician remains at the bedside until the patient is transferred to an appropriate level of care.

For Midazolam and Fentanyl given together:

- Use smaller doses and longer intervals between doses in the elderly and patients with compromised hepatic or renal function
- Fentanyl may cause chest wall rigidity, apnea, respiratory depression or hypotension; elicits minimal cardiovascular depression; may cause dysphoria, nausea or vomiting, reversed by naloxone
- Midazolam may cause respiratory depression or hypotension, particularly when administered with a narcotic, reversed by flumazenil

Pediatric Moderate Sedation Agents

Name/Route	Initial Dose	Repeat Dose	Minimal Repeat Dose Interval	Onset/Duration	MAX Dose Per Procedure
Morphine IV	0.05-0.1mg/kg	0.05mg/kg	2 minutes	Duration 60 minutes	0.3mg/kg
Fentanyl IN	2mcg/kg			Onset 10 min	
Fentanyl IV	0.5-1mcg/kg	0.5mcg/kg	2 minutes		5mcg/kg
Versed Oral	0.5-1mg/kg	0.5mg/kg	*	Onset 20-30 minutes Duration 60-90 min	20 mg
Versed IN	0.2-0.4mg/kg	0.2mg/kg	*	Onset 10 min Duration 60 min	*
Versed IV	0.025-0.05mg/kg	0.025-0.05mg/kg	2 minutes	Onset 1-2 minutes Duration 30-60min	*

***Check current pediatric sedation references**

Title: Procedural Sedation*	
Scope: Clinical Services	Manual: Anesthesia
Source: DON Perioperative Services	Effective Date: 2/1/16

Reversal Agents - Intravenous or Intranasal Administration

Trade Name	Generic Name	Initial Dose	Repeat Dose	Minimal Repeat Dose Interval	MAX Dose Per Procedure
Narcan	naloxone	0.1- 0.4 mg SC/IM/IV	0.4mg	3 minutes	2mg/dose May need continuous drip
Romazicon	flumazenil	0.2 mg IV over 15 seconds	0.2mg	1 minute	1mg/dose & 3mg/hr Repeat doses may be given at 20-minute intervals

- Rebound sedation can occur with either reversal agent and may require repeat doses.
- Naloxone can precipitate acute withdrawal symptoms in chronic opioid users.
- Flumazenil can precipitate acute withdrawal seizures in chronic benzodiazepine users which are unresponsive to benzos.

Dissociative Sedation Agent - Ketamine

Route	Initial Dose	Repeat Dose	Minimal Repeat Dose Interval	Onset/Duration	MAX Dose Per Procedure
IM	4-5mg/kg	2mg/kg	5 minutes	5-10 minutes 30 minutes	
IV	1-1.5mg/kg over 1-2 minutes	0.5mg/kg	3 minutes	1-2 minutes 20 minutes	

- Increases bronchial and salivary secretions, heart rate, blood pressure and intracranial pressure, emergence hallucinations observed >15 yo, NOT reversible
- May add atropine 0.01mg/kg (min 0.1mg, max 0.5mg) to same syringe to decrease salivation
- May add midazolam 0.1mg/kg IM or 0.05mg/kg IV for emergence reactions or agitation, will slow recovery time.
- May cause vomiting during recovery

Deep Sedation Agents

Trade Name	Generic/Route	Initial Dose	Repeat Dose	Min Interval	Onset/Duration	MAX Dose Per Procedure
Brevital	Methohexital -Rectal	25mg/kg			Onset 15 min	500mg
	Methohexital -IV	1-1.5mg/kg slow IVP	0.5mg/kg	3 minutes	Duration 5-7 min	
Amidate	Etomidate -IV	0.1-0.2mg/kg	0.1mg/kg	2 minutes	Onset <1 min Duration 5-10 min	
Diprivan	Propofol IV	0.5-1mg/kg	0.5mg/kg	1 minute	Onset <1 min Duration 5-10 min	4mg/kg

Title: Procedural Sedation*	
Scope: Clinical Services	Manual: Anesthesia
Source: DON Perioperative Services	Effective Date: 2/1/16

- Methohexital is an ultra-short-acting barbiturate providing good immobilization and hypnosis, paradoxical excitation may occur, NOT reversible
- Etomidate commonly causes myoclonus and pain upon injection; may cause adrenal suppression, nausea, vomiting, or lower the seizure threshold; no hemodynamic effect; causes a slight to moderate decrease in intracranial pressure for several minutes; useful for patients with trauma and hypotension, NOT reversible
- Propofol provides rapid onset and recovery phase of deep sedation with brief duration of action, has anticonvulsant properties; causes cardiovascular depression and hypotension, NOT reversible
    - ~~Requires one physician dedicated to the airway while another provider performs the procedure~~

Reviewed: AW 9/12, 10/16 AW

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Pulmonary Function Testing	
Scope: Cardiopulmonary	Manual: Cardiopulmonary
Source: Pulmonary Function Technician	Effective Date:

PURPOSE: Pulmonary Function Tests provide physiologic data to assess the pulmonary status.

POLICY:

1. It is the objective of the pulmonary function laboratory to provide accurate diagnostic measurements of pulmonary function. This will be achieved through quality control, quality assurance, compliance, and standardization set forth by the ATS, AARC, ITS, and other medically recognized publications.

Indications:

1. Investigation of patients with symptoms/signs/investigations that suggest pulmonary disease e.g.(cough, wheeze, breathlessness, crackles, abnormal CXR)
2. Monitoring patients with known pulmonary disease for progression and response to treatment e.g. (Interstitial fibrosis, COPD, Asthma, Pulmonary vascular disease)
3. Investigation of patients with disease that may have a respiratory complication e.g.(connective tissue disorders, neuromuscular diseases)
4. Preoperative evaluation prior to e.g.(lung resection, abdominal surgery, Cardiothoracic surgery)
5. Evaluation of patients at risk of lung diseases e.g.(exposure to pulmonary toxins such as radiation, medication, or environmental or occupational exposure)
6. Surveillance following lung transplantation to assess for acute rejection, infection, obliterative bronchiolitis.

Contraindications:

1. Myocardial infarction within the last month
2. Unstable angina
3. Recent thoraco-abdominal surgery
4. Recent ophthalmic surgery
5. Thoracic or abdominal aneurysm
6. Current pneumothorax
7. Acute Respiratory Symptoms

PROCEDURE:

1. **Preparing PFT Machine**
    1. Filling chemical absorbers
    2. Appropriate gases are turned on and connected with adequate pressure
2. **Calibration**
    1. QC Gas Analyzers
    2. QC Pneumotachometer
    3. QC Spirometer
3. **Pulmonary Function Tests**
    1. Basic spirometry
    2. Spirometry Pre – Post Bronchodilator
    3. DLCO / Lung Diffusion
    4. Helium Dilution / Lung Volumes
    5. Compas contents Manual has detailed steps on performing all tests and Quality Control

Title: Pulmonary Function Testing	
Scope: Cardiopulmonary	Manual: Cardiopulmonary
Source: Pulmonary Function Technician	Effective Date:

REFERENCES:

1. American Thoracic Society 2019
2. American Association of Respiratory Care 2011
3. Global Lung Initiative 2005-2017
4. Compas Contents Manual 2020

CROSS REFERENCE P&P:

1. Lippincott Procedures, Spirometry, pre- and post-bronchodilator administration, respiratory therapy https://procedures.lww.com/lnp/view.do?pId=3261232&disciplineId=5686
2. Lippincott Procedures, Helium dilution functional residual capacity measurement, respiratory therapy https://procedures.lww.com/lnp/view.do?pId=3260212&disciplineId=5686
3. Lippincott Procedures, Basic spirometry, Respiratory therapy https://procedures.lww.com/lnp/view.do?pId=3261447&disciplineId=5686
4. Lippincott Procedures, Carbon monoxide diffusing capacity, single-breath measurement, respiratory therapy https://procedures.lww.com/lnp/view.do?pId=3260728&disciplineId=5686
5. Lippincott Procedures, Thoracic gas volume measurement, helium dilution, respiratory therapy https://procedures.lww.com/lnp/view.do?pId=3261217&disciplineId=5686

Approval	**Date**
Cardiopulmonary Committee	6/9/2020
CCOC	6/15/2020
Medical Services/ICU Committee	8/6/2020
Infection Control Committee	7/8/2020
Medical Executive Committee	9/1/2020
Board of Directors	
Last Board of Directors Review	

Developed: 6/2020mn
Reviewed:
Revised:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Vortran GO2VENT use as emergency ventilator	
Scope: Respiratory Therapy	Manual: Respiratory Therapy
Source: Cardiopulmonary Manager	Effective Date:

PURPOSE: To provide clinically appropriate recommendations and guidelines for the use of the GO2VENT device, including clinical indications, device set up, and bedside application.

POLICY: This policy is intended for use with patients requiring ventilator support, short-term and in the event of an emergency. The GO2VENT provides constant flow; pressure cycled ventilator support in pressure control mode on patients weighing 10kg (22 pounds) and above. The GO2VENT will function in any position as long as the final adjustments are made in a secured position-strapped or taped to the patient. The GO2Vent is completely gas driven, requiring no electrical power and will deliver 100% oxygen to the patient.

Indications:
Patients in need of emergency, short term, constant flow, pressure cycled ventilator support.
Patients unable to maintain an adequate acid-base status during unassisted ventilation.

Individuals who have adequate training in CPR techniques and the operation of gas-powered resuscitators should use the GO2VENT; the Respiratory Therapist will be setting up and operating the GO2VENT

Contraindications:
None.

Precautions:
Patients will be monitored continuously by a Respiratory Therapist-patients are not to be left unattended, not meant for use as an unattended automatic ventilator.

PROCEDURE:

Select desired FiO2-the Go2VENT has the capability to deliver either 50% or 100%.

Set flow to 10-25 L/min; connect the supply tubing to either an appropriate cylinder or wall source.

A good starting point is 10 L/min-adjust as needed. The GO2VENT is designed to automatically deliver 40 L/min when connected directly to a 50 PSIG gas source. The flow controls the inspiratory time-the higher the flow, the shorter the I-time; the lower the flow, the longer the i-time.
Table 1- Estimated Tidal Volume (mL) Delivered at Various Flow (L/min) and Inspiratory Time (Seconds)

Title: Vortran GO2VENT use as emergency ventilator	
Scope: Respiratory Therapy	Manual: Respiratory Therapy
Source: Cardiopulmonary Manager	Effective Date:

Flow (L/min)	Inspiratory Time (Seconds)					
	0.5	1	1.5	2	2.5	3
15	125	250	375	500	625	750
20	167	333	500	667	833	1000
25	208	417	625	833	1042	1250
30	250	500	750	1000	1250	1500
35	292	583	875	1167	1458	1750
40	333	667	1000	1333	1667	2000

The Respiratory Therapist will be mindful of how long a tank will last depending on liter flow for which size of a tank that is being used, and will change the tank as necessary. See Table 1.

TABLE 1 - LENGTH OF USE FOR COMPRESSED OXYGEN TANKS

Tank	D	E	M	H
(Liters)	387	662	3028	6905
Flow (L/Min)	Length of use (minutes)			
6	65	100	500	1150
8	50	80	380	860
10	40	60	300	690
12	30	50	250	570
15	25	40	200	460
20	20	30	150	340
25	15	25	120	270
30	13	20	100	230
35	11	18	80	190
40	10	16	70	170

Set patient's peak inspiratory pressure or PIP. Verify PIP at approximately 25 cm-H2O (factory pre-set). Adjust pressure dial to achieve desired peak pressure, adjust the pressure dial to the desired setting. Indicated peak pressure is printed on the pressure dial. PEEP is about $1/5^{th}$ of the set PIP. I-time is counted manually or with a watch. Use a minimum flow of 10 liters for best results.

Once flow and pressure have been set, perform a function check on the unit before connecting it to the patient. This is done by occluding the patient connection port and verifying that the modulator opens and the pressure does not exceed 60 cm-H2O.

Adjust the rate dial to achieve desired respiratory rate. Observe rise and fall of the chest corresponding to patient's inhalation and exhalation. Listen for expiratory flow from the modulator, listen to breath sounds.

The GO2VENT is pressure limited and is equipped with a redundant pressure pop-off valve, which will activate at a maximum of 60 cm-H2O.

Title: Vortran GO2VENT use as emergency ventilator	
Scope: Respiratory Therapy	Manual: Respiratory Therapy
Source: Cardiopulmonary Manager	Effective Date:

Changes in patient's lung compliance will result in a change in the respiratory rate; the Respiratory Therapist will make appropriate clinical changes.

Adjust flow, PIP, and rate-Observe the rise and fall of the chest corresponding to inhalation and exhalation of the patient. Listen to breath sounds, the Respiratory Therapist will be adjusting and making changes based on clinical assessment.

REFERENCES:

1. Vortran Medical GO2VENT User's Guide

CROSS REFERENCE P&P:

1. Medical/Compressed Gas Cylinders & Storage Rooms EC.02.05.01 EP18 & EC.02.05.09 EP12

Approval	**Date**
Respiratory Committee	5/29/2020
CCOC	6/15/2020
Medical Services Committee	8/6/2020
Emergency Services Committee	7/6/2020
Medical Executive Committee	9/1/2020
Board of Directors	
Last Board of Directors Review	

Developed: 5/2020as
Reviewed:
Revised:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Management of the Diabetic Patient (Insulin and Hypoglycemia Protocol)	
Scope: Northern Inyo Hospital, excluding Perinatal Department	Manual: Pharmacy and Therapeutics
Source: Pharmacy	Effective Date:

PURPOSE: The purpose of this policy is to provide evidence based guidelines for the care and Management of non-pregnant Diabetic Mellitus (DM) patients at Northern Inyo Hospital

POLICY: Providers at Northern Inyo Hospital will utilize the guidelines outlined in this policy for managing the care of Diabetic patients. Pharmacist will review all orders.

PROCEDURE:

1. The goal blood glucose for non-critically ill medical/surgical patients is pre-prandial Blood Glucose (BG) <140 mg/dl, with all random BG<180 mg/dl.
2. Determine dosing of subcutaneous insulin
    a. Calculate the patients Total Daily Dose (TDD) of insulin, assuming the patient is taking 100% of their nutritional need.
        i. Total Daily Dose Calculation
            1. Type 1 DM or insulin treated Type 2 DM
                a. Continue Outpatient insulin regimen if Blood Glucose (BG) is well controlled
                b. consider modest 25-50% dose reduction since nutritional intake likely to be more restrictive as inpatient
                c. If BG poorly controlled, discontinue outpatient regimen and start home Basal insulin with 0.2-0.3 units/kg/day and start Nutritional (meal coverage) insulin with 0.05-0.1 units/kg/meal, continue with correctional (sliding scale) insulin based on suspected sensitivity.
            2. Type 2 DM not treated with insulin
                a. Continue outpatient regimen if glucose well controlled and no contraindications are present.
                b. If patient uses a GLP-1 agonist pen, Provider may order patient to self-administer home medication once identified/reviewed/verified by pharmacy.
                c. Be cautious with metformin
                d. Consider modest 25-50% dose reduction since nutritional intake likely to be more restrictive as inpatient
                e. If BG poorly controlled, discontinue outpatient regimen and start Basal insulin with 0.2-0.3 units/kg/day and start Nutritional (meal coverage) insulin with 0.05-0.1 units/kg/meal, add correctional (sliding scale) insulin beginning with Sensitive Dose Scale.
            3. If BG not controlled (too high or too low) with above insulin regimen make the following adjustments
                a. Increase/decrease basal insulin dose by approximately 10-20% every 2-3 days to achieve glucose target
                b. Increase/decrease Nutritional (meal coverage) dose by 1-2 units/dose every 1-2 days

c. Increase/decrease Correction (sliding scale) scale by 1-2 units/dose every 1-2 days

b. Determine Insulin Sensitivity
   - **i.** Sensitive: TDD<40 units
   - **ii.** Moderate: TDD 40-80 units
   - **iii.** Resistant: TDD >80 units

c. Allocate the TDD of insulin
   - **i.** In general, 50% of the TDD of insulin should be Basal and 50% Nutritional(meal coverage)
   - **ii.** Specify the dose of long-acting insulin for Basal Coverage
     1. Basal Sensitive Dose insulin glargine (Lantus) 0.1 Units/kg/day, subcutaneous, Nightly
     2. Basal Moderate Dose insulin glargine (Lantus) 0.2 Units/kg/day, subcutaneous, Nightly
     3. Basal Resistant insulin glargine (Lantus) 0.3 Units/kg/day, subcutaneous, Nightly
     4. Basal Custom (Usually 50% of TDD) Dose insulin glargine (Lantus) injection subcutaneous Nightly
   - **iii.** Divide Nutritional (meal coverage) dose by 3 to determine meal dose of short-acting insulin, Insulin lispro (Humalog)
     1. Provider to order Nursing adjustment for Nutritional (meal coverage) dose
        - **a.** Nursing will adjust amount of nutritional (meal coverage) insulin administration based on a patient's nutritional intake per standardized administration instructions.
          - **i.** Adjust Dose As Follows:
            - Eating normally: Full prescribed dose
            - NPO (or <1/4 of meals): Do NOT give this dose of insulin
            - Less than half of meal: Give HALF of this dose
            - If patient is eating predictably, give insulin dose immediately before meal.
            - If intake uncertain or inconsistent, give Nutritional (meal coverage)/Correctional (sliding scale) dose within 15 minutes after finishing meal.

d. Select Correction (sliding scale) Insulin: Specify based on degree of insulin sensitivity
   i. Sensitive Dose: Insulin lispro (Humalog) injection 0-6 units, Subcutaneous 4 times daily with meals and nightly

      Correction Scale:
      BG<150: None
      BG 150-200: AC: 1 units. HS: 0 units
      BG 201-250: AC: 2 units. HS: 1 units

BG 251-300: AC: 3 units. HS: 2 units
BG 301-350: AC: 4 units. HS: 3 units
BG 351-400: AC: 5 units. HS: 4 units
BG>400: AC: 6 units. HSs: 5 units. **AND CALL PROVIDER**
If BG is not checked before the patient starts eating do not give correctional insulin

ii. Moderate Dose: Insulin lispro (Humalog) injection 0-12 units, Subcutaneous, 4 times daily with meals and nightly

Correction Scale:
BG 150-200: AC: 2 units. HS: 0 units
BG 201-250: AC: 4 units. HS: 2 units
BG 251-300: AC: 6 units. HS: 4 units
BG 301-350: AC: 8 units. HS: 6 units
BG 351-400: AC: 10 units. HS: 8 units
BG>400: AC 12 units. HS 10 units. **AND CALL PROVIDER**
If BG is not checked before the patient starts eating do not give correctional insulin

iii. Resistant Dose**:** Insulin lispro (Humalog) injection 0-18 units, Subcutaneous 4 times daily with meals and nightly

Correction Scale:
BG 150-200: AC: 3 units. HS: 0 units
BG 201-250: AC: 6 units. HS: 3 units
BG 251-300: AC: 9 units. HS: 6 units
BG 301-350: AC: 12 units. HS: 9 units
BG 351-400: AC: 15 units. HS: 12 units
BG>400: AC 18 units. HS 15 units. **AND CALL PROVIDER**
If BG is not checked before the patient starts eating do not give correctional insulin

3. Hypoglycemia Protocol
   a. The Hypoglycemia Protocol will be initiated by Provider order for all patients receiving glycemic controlling agents and or glucose monitoring
   b. The below outlines the Hypoglycemia Protocol

NIH Adult Management of Hypoglycemia Protocol

USE:

- Hospital wide excluding newborns and pediatrics.

DEFINITIONS:

Hypoglycemia: A blood glucose of less than 70 mg/dL. Some patients may have symptoms at higher levels. Severe hypoglycemia is less than 50 mg/dL.

ASSESSMENT:

Signs as symptoms of hypoglycemia include the following:

Title: Management of the Diabetic Patient (Insulin and Hypoglycemia Protocol)	
Scope: Northern Inyo Hospital, excluding Perinatal Department	Manual: Pharmacy and Therapeutics
Source: Pharmacy	Effective Date:

• Sweating • Facial pallor • Shakiness/Tremors • Increased appetite • Nausea • Dizziness or light-headedness • Weakness	• Rapid heart rate • Headache • Tingling around mouth and tongue • Seizures • Change in level of consciousness • Drowsy, Sleepiness

- ❑ In any suspected hypoglycemia situation, obtain a STAT finger stick blood glucose level.
- ❑ If glucometer "low", get lab confirmation but DO NOT DELAY TREATMENT.
- ❑ Treat as below.
- ❑ Initiate seizure precautions if the patient has altered level of consciousness.

TREATMENT/INTERVENTIONS

- ❑ Do not wait for lab confirmation to begin treatment.
- ❑ After immediate treatment is performed, notify the physician.
- ❑ After treatment and follow-up treatment complete, document the episode including all blood glucose results and treatment administered.
- ❑ Intravenous dextrose infusion may be required for prolonged hypoglycemia due to long acting insulin or sulfonylureas.

BG **< 70 mg/dL** and patient **unconscious or uncooperative or NPO**

Immediate Actions/Treatment	**Repeat**	**Follow-up Treatment**
IV access: ● BG 50-69 give D50 x 25 ml (12.5 gm) D50 over 2 min ● BG < 50 give D50 x 50 ml (25 gm) IVP over 2-5 min **No IV access AND BG < 60** ● Give 1 mg Glucagon SC x 1 and start IV access STAT ● Notify Physician ● Staff to remain with patient ● Turn patient on their side to prevent aspiration	● Repeat BG and repeat treatment q 15-30 min until BG > 100. ● Add order to check BG in 1 hour 1 x 2 checks. ● If patient has persistent or recurrent hypoglycemia, notify the provider. ● Resume regular scheduled blood glucose monitoring when BG > 100 on 2 or more consecutive checks. *__Glucagon__: should only be repeated once	● Contact provider to order maintenance fluids with IV dextrose. ● If pt. unable to maintain BG > 70 after 2 rounds of treatment, contact provider, consider D10W.

Title: Management of the Diabetic Patient (Insulin and Hypoglycemia Protocol)	
Scope: Northern Inyo Hospital, excluding Perinatal Department	Manual: Pharmacy and Therapeutics
Source: Pharmacy	Effective Date:

Patient **NOT NPO, conscious, cooperative and able to swallow safely**

BG Level	Immediate Action/Treatment	Repeat	Follow-up Treatment
BG **< 45** mg/dL	Give **30 gm** carbs ● 8 oz juice or regular soda **OR** ● 2 tubes dextrose gel (Glucose) *Staff to remain with patient	For ALL Cases: ● Repeat BG and repeat q 15-30 min until BG > 100 ● Add order to check BG in 1 hour 1 x 2 checks. ● If patient has persistent or recurrent hypoglycemia, notify the provider. ● Resume regular scheduled blood glucose monitoring when BG > 100 on 2 or more consecutive checks.	For ALL cases, Feed patient carbohydrates to avoid recurrent hypoglycemia. ● If more than 1 hr until next meal/snack, give 15 gm of carbohydrates (ex either 3 graham crackers or, 6 saltine crackers or, 8 oz skim milk) ● If more than 2 hrs until next meal/snack give 15 cm carbs with protein (ex either ½ sandwich or 3 graham crackers with 1 tbsp. of peanut butter.
BG **45-59** mg/dl	Give **20 gm** carbs ● 6 oz juice or soda **OR** ● 1.5 tubes dextrose gel *Staff to remain with patient		
BG **60-100** mg/dl and **Symptomatic**	Give **15 gm** carbs ● 4 oz juice or soda **OR** ● 1 tube dextrose gel		
BG **60-70** and **NO Symptoms**	No treatment if meal is within 30 min and willing to eat. If mealtime> 30 min Give **15 gm** carbs ● 4 oz juice or soda **OR** ● 1 tube dextrose gel		

REFERENCES:

1. ACE/ADA. (2009). American College of Endocrinology and American Diabetes Association Consensus on Inpatient Diabetes and Glycemic Control. Diabetes Care, 32:1119-1131.
2. Allina Wide System Wide Protocol Hypoglycemia Adults Management Protocol 3/2012.
3. American Diabetes Association Workgroup on Hypoglycemia. (2005). Defining and reporting hypoglycemia in diabetes. Diabetes Care. 28:1245-1249.
4. Providence Hypoglycemia Management Protocol for Adult Patients Feb 2019.
5. Inzucchi S. Management of diabetes mellitus in hospitalized patients. Up To Date 2020.

CROSS-REFERENCE P&P:

1. Administration of Drugs and Biologics
2.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Management of the Diabetic Patient (Insulin and Hypoglycemia Protocol)	
Scope: Northern Inyo Hospital, excluding Perinatal Department	Manual: Pharmacy and Therapeutics
Source: Pharmacy	Effective Date:

Committee Approval	**Date**
CCOC	
Pharmacy and Therapeutic Committee	**7/30/2020**
Medical Services ICU Committee	**08/06/2020**
Peri Peds Committee	**8/25/2020**
MEC	**9/1/2020**
Board of Directors	

Developed:
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedure – Adult Health Maintenance Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

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

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

PROCEDURE:
1. Definition: health maintenance, health promotion and prevention activities which promote the physical, psychosocial and developmental well-being of adults.
    a. Includes health assessment and disease prevention utilizing:
        i. physical exam
        ii. diagnostic testing
        iii. immunizations
        ~~iii.~~iv. developmental screening
        ~~iv.~~v. health education
2. Data base:
    a. Subjective:
        i. Obtain complete histories on all first-time patients; interval histories on subsequent visits.
    b. Objective:
        i. At each visit obtain vital signs, weight, allergy history and pain assessment.
        ii. Risk assessment when establishing care and as indicated.
        iii. Perform complete physical examinations as indicated.
        iv. Perform appropriate psychosocial assessment.
        v. Laboratory/diagnostic testing as needed.
3. Plan:
    a. Diagnosis established utilizing current coding standards in CPOE format.
        i. Health maintenance
        ii. Acute illness
        iii. Current assessment of chronic illness
    b. Therapeutic regimen
        i. Diet as appropriate for age/nutritional status

ii. Medications
1. Vitamins/mineral supplements
2. Immunizations as indicated
3. Hormonal replacement as indicated
4. Medications appropriate to address acute and chronic health problems.

iii. Activity/exercise as appropriate for age/health status
iv. Health education related to age/health status, preventative health behaviors.
v. Interventions appropriate to address acute and chronic health problems.
~~v.~~vi. Refer to specialist or other community resource indicated

c. Physician consultation is to be obtained under the following circumstances
~~i. Physician consult to be obtained under the circumstances:~~
~~ii.~~i. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
~~iii.~~ii. Acute decompensation of patient situation.
~~iv.~~iii. Problem which is not resolving as anticipated.
~~v.~~iv. History, physical, or lab finding inconsistent with the clinical picture.
1. Upon request of patient, nurse, or supervising physician.
~~Refer to specialist or other community resource indicated~~.

d. Follow-up
i. According to adult health maintenance schedule, sooner as indicated.

e. Record keeping
i. Appropriate documentation to be maintained in patient's chart.
ii. Allergic reaction to vaccine/medication

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

~~4. Contraindications to immunization~~
~~a. Live virus vaccines contraindicated (consult with physician first):~~
~~i. Patient with disorder of immune system~~
~~ii. Household member of patient with disorder of immune system~~
~~iii. Patient who received immune globulin in last 3 months~~
~~iv. During pregnancy~~
~~v. PPD should not be administered for 3 months following MMR~~
~~5. Management of anaphylactic reactions to immunizations~~
~~a. Mild anaphylaxis involving skin (immediate):~~
~~i. Pruritus, flush, urticaria, angioedema~~
~~ii. Emergency treatment~~
~~1. Maintain patient airway~~
~~2. Administer 1:1000 (aqueous) Epinephrine SQ or IM 0.01 ml/kg.~~
~~3. Repeat dose every 15-20 minutes.~~
~~4. Consult with physician.~~

~~b. Systemic – in addition to skin rash, rhinitis, redness, tearing of eyes, bronchospasm, laryngeal spasm, shock with cardiovascular collapse.~~

~~i. Treatment~~

~~1. Maintain patient airway, administer CPR if necessary.~~
~~2. Administer 1:1000 (aqueous) Epinephrine SQ or IM 0.01 ml/kg.~~
~~3. Refer to M.D.~~
~~4. Call Code Blue if indicated~~
~~5. Report adverse reaction to local health department/manufacturer of vaccine.~~

REFERENCES:

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

Approval	**Date**
Interdisciplinary Practice Committee	06/10/2020
Medicine/Intensive Care Committee	08/06/2020
Medical Executive Committee	09/01/2020
Board of Directors	
Last Board of Directors Review	02/20/2019

Developed:
Reviewed:
Revised: 05/2018 dp, 12/2018 dp, 6/2020 dp
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedure – Adult Health Maintenance Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

APPROVALS

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

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedure – Adult Health Maintenance Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

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

1. _____ _____
   NAME DATE
2. _____ _____
   NAME DATE
3. _____ _____
   NAME DATE
4. _____ _____
   NAME DATE
5. _____ _____
   NAME DATE
6. _____ _____
   NAME DATE
7. _____ _____
   NAME DATE
8. _____ _____
   NAME DATE
9. _____ _____
   NAME DATE
10. _____ _____
    NAME DATE

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Protocol – Adult Health Maintenance for the Physician Assistant	
Scope: Physician Assistant	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 11/2014

PURPOSE:
This standardized protocol developed for use by the Physician Assistant is designed to establish guidelines for the management of adult health maintenance~~.~~ (specific chronic diseases – protocols i.e. ~~HTN, DM~~hypertension, diabetes).

POLICY:
1. This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the *General Policy for the Physician Assistant.*
2. Function: management of adult health maintenance.
~~2.~~3. Circumstances:
    1. Patient population: Adult patients
    2. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations
~~3.~~4. Supervision: Physicians indicated in Delegation of Services Agreement

PROTOCOL:
1. Definition: health maintenance, health promotion and prevention activities which promote the physical, psychosocial and developmental well-being of adults.
    a. Includes health assessment and disease prevention utilizing:
        i. physical exam
        ii. diagnostic testing
        iii. immunizations
        iv. developmental screening
        v. health education.
2. Data Base:
    a. Subjective:
        i. Obtain complete histories on all first time patients; interval histories on subsequent visits.
    b. Objective:
        i. At each visit obtain vital signs, weight, pain assessment and allergy history.
        ii. Risk assessment when establishing care and as indicated.
        iii. Perform complete physical examinations as indicated.
        iv. Perform appropriate psychosocial assessment.
        v. Laboratory/diagnostic testing as needed.
3. Plan:
    a. Diagnosis established utilizing current coding standards in CPOE format.
        i. Health maintenance
        ii. Acute illness
        iii. Current assessment of chronic illness
    b. Therapeutic regimen
        i. Diet as appropriate for age/nutritional status

ii. Medications
1. Vitamins/mineral supplements
2. Immunizations as indicated
3. Hormonal replacement as indicated
4. Medications appropriate to address acute and chronic health problems.

iii. Activity/exercise as appropriate for age/health status
iv. Health education related to age/health status, preventive health behaviors.
v. Interventions appropriate to address acute and chronic health problems.
vi. Refer to specialist or other community resource indicated.

c. Physician consultation is to be obtained under the following circumstances:
i. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
ii. Acute decompensation of patient situation.
iii. Problem which is not resolving as anticipated.
iv. History, physical, or lab finding inconsistent with the clinical picture.
v. Upon request of patient, nurse, or supervising physician.

d. Follow-up
i. According to adult health maintenance schedule sooner as indicated.

e. Record keeping
i. Appropriate documentation to be maintained patient's chart.
ii. Allergic reaction to vaccine/medication.

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

~~4. Contraindications to immunization~~
~~a. Live virus vaccines contraindicated (consult with physician first):~~
~~i. Patient with disorder of immune system~~
~~ii. Household member of patient with disorder of immune system~~
~~iii. Patient who received immune globulin in last 3 months~~
~~iv. During pregnancy~~
~~v. PPD should not be administered for 3 months following MMR~~
~~5. Management of anaphylactic reactions to immunizations~~
~~a. Mild anaphylaxis involving skin (immediate):~~
~~i. Pruritus, flush, urticaria, angioedema~~
~~ii. Emergency treatment~~
~~1. Maintain patient airway~~
~~2. Administer 1:1000 (aqueous) Epinephrine. Repeat dose every 15-20 minutes. Usual dose: 0.3 ML Subcutaneously~~
~~b. Systemic – in addition to skin rash, rhinitis, redness, tearing of eyes, bronchospasm, laryngeal spasm, shock with cardiovascular collapse.~~
~~i. Treatment:~~
~~1. Maintain patient airway, administer CPR if necessary.~~
~~2. Administer Epinephrine as outlined above.~~

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Protocol – Adult Health Maintenance for the Physician Assistant	
Scope: Physician Assistant	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 11/2014

~~3. Refer to physician. Call Code Blue if indicated call for EMS Paramedics~~
~~4. Report adverse reaction to local health department/manufacturer of vaccine.~~

REFERENCES:

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

ATTACHMENTS:

1. List of Authorized Physician Assistants and Supervising Physicians

Approval	**Date**
Interdisciplinary Practice Committee	06/10/2020
Medicine/Intensive Care Service Committee	08/06/2020
Medical Executive Committee	09/01/2020
Board of Directors	
Last Board of Directors Review	02/20/2019

Developed:
Reviewed:
Revised: 12/2018 dp, 6/2020 dp
Supersedes: *Adult Health Maintenance Policy for Rural Health Clinic Physician Assistants*
Index Listings:

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

Date: 9/10/20

Title: **REVIEW OF PROPOSED MEDICAL STAFF BYLAWS**

Synopsis: It is recommended that the Board of Directors consider the proposed Medical Staff Bylaws for approval. Medical Staff legal counsel and District legal counsel find the proposed Bylaws to be in compliance with the Joint Commission standards for Critical Access Hospitals.

Prepared by: _____
Dianne Picken
Medical Staff Support Manager

Reviewed by: _____
William Timbers, MD
Chief Medical Officer

Approved by: _____
William Timbers, MD
Chief Medical Officer

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: 9/10/20 Submitted by: _____
Chief Officer

Northern Inyo Healthcare District
Medical Staff Bylaws

TABLE OF CONTENTS

NORTHERN INYO HEALTHCARE DISTRICT

MEDICAL STAFF BYLAWS

PREAMBLE

These bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the medical staff and the Northern Inyo Healthcare District board of directors in protecting the quality of medical care provided in Northern Inyo Healthcare District and assuring the competency of the district's medical staff. The bylaws provide a framework for the independent self-governance of the medical staff, which is a collegial and democratic body with extensive knowledge in medical care. The bylaws assure an organization of the medical staff that permits the medical staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of medical staff functions supportive of those purposes, and to account to the board of directors for the effective performance of medical staff responsibilities. These bylaws provide the professional and legal structure for medical staff operations, organized medical staff relations with the board of directors, and relations with applicants to and members of the medical staff.

Accordingly, the bylaws address the medical staff's responsibility to establish criteria and standards for medical staff membership and privileges, and to enforce those criteria and standards; they establish clinical criteria and standards for quality assurance, utilization review, and other medical staff activities including, but not limited to, periodic meetings of the medical staff, its committees and departments, and review and analysis of patient medical records; they describe the standards and procedures for selecting and removing medical staff officers; and they address the respective rights and responsibilities of the medical staff.

Finally, notwithstanding the provisions of these bylaws, the medical staff acknowledges that the board of directors must act to protect the quality of medical care provided and the competency of the medical staff, and to ensure the responsible governance of Northern Inyo Healthcare District. In adopting these bylaws, the medical staff commits to exercise its responsibilities with diligence and good faith; and in approving these bylaws, the board of directors commits to fulfilling its functions and responsibilities with respect to an organized self-governing medical staff.

ARTICLE I: PURPOSE AND TERMS

1.1 PURPOSE OF THE BYLAWS

These bylaws are adopted in order to provide for the organization of the medical staff of Northern Inyo Healthcare District and to provide a framework for self-government in order to permit the medical staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes.

1.2 NAME

The name of this organization is the Medical Staff of Northern Inyo Hospital, a 501(c)(6) recognized organization.

1.3 PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

The medical staff's purposes are:

(a) To assure that all patients admitted or treated in any of the Northern Inyo Healthcare District services receive a uniform standard of quality patient care, treatment and efficiency consistent with generally accepted standards attainable within the district's means and circumstances.

(b) To support professional education and community health education.

(c) To initiate and maintain rules for the medical staff to carry out its responsibilities for the professional work performed in Northern Inyo Healthcare District.

(d) To provide an avenue for the medical staff, board of directors, and administration to discuss issues of mutual concern.

(e) To exercise its rights and responsibilities in a manner that does not jeopardize the district's license, Medicare and Medi-Cal provider status, accreditation, and other credentialed statuses.

The medical staff's responsibilities are:

(a) To provide quality patient care.

(b) To assure for the benefit of the public, and also to account to the board of directors for, the quality of patient care provided by all members authorized to practice in Northern Inyo Healthcare District through the following measures:

(1) Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;

(2) A credentials program, including mechanisms of appointment, reappointment and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the applicant;

(3) Participating in a utilization review program to provide for the appropriate use of all medical services.

(c) To establish and enforce professional standards related to the delivery of healthcare within Northern Inyo Healthcare District.

(d) To initiate and pursue corrective action with respect to members where warranted.

(e) To cooperate with other community health facilities and/or educational institutions or efforts that strive to improve the quality of scope of patient care within Northern Inyo Healthcare District.

(f) To establish and amend as needed medical staff bylaws and policies.

(g) To select and remove medical staff officers.

(h) To assess and utilize medical staff dues as appropriate for the purposes of the medical staff.

1.4 DEFINITIONS

ACTIVE STAFF means the category of medical staff members who regularly provide care at Northern Inyo Healthcare District and meet the qualifications and prerogatives as listed in these bylaws.

AD HOC COMMITTEE means a committee created for a particular purpose for a finite amount of time, as necessary.

ADVERSE ACTION means an action which is reportable under Business and Professions Code 805.

ADMINISTRATOR or CHIEF EXECUTIVE OFFICER means the person appointed by the board of directors to serve in an administrative capacity in the overall management of the district.

ADVANCED PRACTICE PROVIDER or APP means an individual, other than a licensed physician, dentist, or podiatrist, who exercises independent judgement within the areas of his or her professional competence and the limits established by the board of directors, the medical staff, and the applicable State Practice Act, who is qualified to render direct or indirect medical care under the supervision or direction of a medical staff member (with the exception of certified registered nurse anesthetists, who are APPs that practice under an independent license as per current California regulations).

AUTHORIZED REPRESENTATIVE means the individual(s) designated by the district and approved by the medical executive committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws.

BOARD OF DIRECTORS means the governing body of Northern Inyo Healthcare District.

CHAIR means the individual practitioner elected to preside over a committee or meeting.

CHIEF EXECUTIVE OFFICER see ADMINISTRATOR.

CHIEF OF STAFF means the chief officer of the medical staff elected by members of the medical staff.

CONTRACT PRACTITIONER means a practitioner who is party to a clinical services agreement with the district.

CONSULTING STAFF means the category of medical staff members who treat and otherwise care for patients at Northern Inyo Healthcare District and meet the qualifications and prerogatives as listed in these bylaws.

CORE COMMITTEE MEMBER means a practitioner designated to regularly attend the departmental committee meetings to which they are assigned in order to represent their specialty.

COURTESY STAFF means the category of medical staff members who do not utilize Northern Inyo Healthcare District as the principle location of their practice but are given privileges and meet the qualifications and prerogatives as listed in these bylaws.

CURRENT COMPETENCE means a combination of observable and measurable knowledge, skills, abilities and personal attributes that constitute a practitioner's performance within the last twenty-four (24) months.

DATE OF RECEIPT means the date any notice, special notice, or other communication was delivered personally; or if such notice was sent by mail, it shall mean seventy-two (72) hours after the notice, special notice, or communication was deposited postage prepaid, in the United States mail.

DAYS means calendar days, unless otherwise specified.

DEPARTMENT or CLINICAL DEPARTMENT is a group of practitioners holding privileges in a designated clinical practice area.

DEPARTMENT CHIEF is the individual practitioner who is the elected leader of the designated clinical department.

DISTRICT means Northern Inyo Healthcare District (NIHD) and includes all inpatient and outpatient services operated by Northern Inyo Healthcare District.

EX-OFFICIO means service by virtue of office or position held. An ex-officio appointment is without vote unless otherwise specified.

HONORARY STAFF means those former medical staff members or other physicians, dentists or podiatrists who do not actively practice at Northern Inyo Healthcare District but are deemed deserving of membership as described in these bylaws.

IN GOOD STANDING means a member has unrestricted clinical privileges, is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws or policy of the medical staff.

INVESTIGATION means a process specifically instigated to determine the validity, if any, to a concern or complaint raised against a practitioner, and does not include activity of the physician wellness committee.

LEAD APP means the elected representative of the Advanced Practice Providers (APPs).

LIMITED LICENSE PRACTITIONER means a practitioner who is not a physician or an APP, but who practices under a license such as a dentist or podiatrist.

MEDICAL EXECUTIVE COMMITTEE means the executive committee of the medical staff.

MEDICAL DIRECTOR means the administratively-appointed physician leader of the medical or district department(s) or group(s).

MEDICAL STAFF means those Northern Inyo Healthcare District physicians (MD or DO), dentists, and podiatrists who have been granted recognition as members pursuant to the terms of these bylaws.

MEDICAL STAFF YEAR means the twelve-month period beginning July 1 through the subsequent June 30.

MEMBER means any physician, dentist, or podiatrist who has been appointed to the medical staff.

NOTICE means a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the medical staff or the district.

PHYSICIAN means an individual with an MD or DO degree who is currently licensed to practice medicine.

PRACTITIONER means, unless otherwise expressly limited, any currently licensed physician (MD or DO), limited license practitioner, or Advanced Practice Provider.

PREROGATIVES means the specific governance rights to which a member or APP may be entitled, depending upon the practitioner's category, including without limitation, rights to vote on medical staff and medical staff committee matters, hold medical staff office, or serve on medical staff committees.

PRIVILEGES or CLINICAL PRIVILEGES means the permission granted to a medical staff member or APP to render specific patient services.

PROCEDURAL RIGHTS means rights to a hearing and appeal in accordance with Article VII to which a practitioner becomes entitled to as the result of adverse actions taken or recommended which constitute grounds for a hearing.

TELEMEDICINE means the remote diagnosis and treatment of patients by means of telecommunications technology.

UNFAVORABLE ACTION means an action which adversely affects the practitioner but, unlike an adverse action, is not reportable as defined under Business and Professions Code 805.

ARTICLE II: MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

No practitioner, including those in a medical-administrative position by virtue of a contract with the district, shall admit or provide medical or health-related services to patients of Northern Inyo Healthcare District unless the practitioner is a member of the medical staff or advanced practice provider with corresponding privileges or has been granted temporary, telemedicine or disaster privileges in accordance with the procedures set forth in these bylaws. Appointment to the medical staff shall confer only such clinical privileges and rights as have been granted by the board of directors in accordance with these bylaws. Privileges shall be granted and maintained only if the requested privileges are within Northern Inyo Healthcare District's patient care needs.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

Membership and privileges shall be extended only to practitioners who are professionally competent and continuously meet the qualifications, standards, and requirements as described in this article.

2.2-2 BASIC QUALIFICATIONS

A practitioner must demonstrate compliance with all basic standards set forth in this Section in order to have an application for medical staff membership or privileges accepted for review, except in the instance of appointment to honorary staff. The practitioner must:

(a) Qualify to practice in California as follows:

(1) Physicians must hold an MD or DO degree or their equivalent and a valid and unrestricted license to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Examiners. For purposes of this Section, "or their equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the California Board of Osteopathic Examiner;

(2) Podiatrists must hold a DPM degree and a valid and unrestricted certificate to practice podiatry issued by the Medical Board of California;

(3) Dentists must hold a DDS or equivalent degree and a valid and unrestricted license to practice dentistry issued by the California Board of Dental Examiners;

(b) Where applicable to their practice, have a valid and unrestricted federal Drug Enforcement Administration (DEA) certificate.

(c) Have professional liability insurance in not less than the minimum amounts as from time to time may be jointly determined by the board of directors and medical executive committee.

(d) Be board certified or board eligible as determined by the individual service and in the criteria for privileging.

(e) Be eligible to receive payments from the federal Medicare and state Medicaid (Medi-Cal) programs.

(f) If requesting privileges only in departments operated under an exclusive contract, be a member, employee, or subcontractor of the group or person that has the contract.

(g) Not have been convicted of, or plead guilty or no contest to, a felony related directly to his/her professional practice, or patient relationships, or involving moral turpitude, within the past seven (7) years.

A practitioner who does not meet these basic standards is ineligible to apply for medical staff membership or privileges, and the application shall not be accepted for review, except that the honorary medical staff do not need to comply with any of the basic standards. If it is determined during processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these bylaws.

2.2-3 ADDITIONAL QUALIFICATIONS FOR MEMBERSHIP

In addition to meeting the basic standards, the practitioner must, through the credentialing and privileging processes:

(a) Demonstrate his or her:

(1) Adequate education, training and experience in the requested privileges;

(2) Current professional competence;

(3) Good judgment; and

(4) Adequate physical and mental health status to demonstrate to the satisfaction of the medical staff that he or she is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality of care.

(b) Be determined to:

(1) Adhere to the lawful ethics of his or her profession;

(2) Work cooperatively with others in the district setting so as to not adversely affect patient care or district operations, as well as abide by the policy on professional conduct and prohibition of disruptive or discriminatory behavior;

(3) Keep as confidential, as required by law, all information or records received in the physician-patient relationship; and

(4) Participate in and properly discharge medical staff responsibilities.

2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership or privileges in the medical staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization,

is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this district.

2.4 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, physical or mental impairment, or sexual orientation if it does not pose a threat to the quality and safety of patient care.

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for honorary staff, the ongoing responsibilities of each practitioner shall include:

(a) providing patients with the quality of care meeting the professional standards of the medical staff of this district;

(b) abiding by the medical staff bylaws, applicable Joint Commission (or other applicable accrediting body) standards, and applicable medical staff and district policies and procedures, including those related to the security of electronic health records;

(c) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of medical staff membership or privileges, including committee assignments, serving as a proctor, or performing peer review;

(d) preparing and completing in timely fashion medical records for all the patients to whom the practitioner provides care in the district;

(e) abiding by the ethical principles of the appropriate state medical or other professional association(s);

(f) working cooperatively with members, nurses, district administration and others so as not to adversely affect patient care, as well as complying with medical staff policy on professional conduct;

(g) making appropriate arrangements for coverage of that member's patients;

(h) refusing to engage in improper inducements for patient referral;

(i) participating in and documenting continuing education programs as determined by the medical staff for maintenance of privileges;

(j) discharging such other reasonable staff obligations as may be lawfully established from time to time by the medical staff or medical executive committee;

(k) performing and documenting, if granted the requisite privileges, or arranging for the performance of, a history and physical on every patient he/she admits. As further detailed in medical staff policy, a medical history and physical examination shall be completed no more than thirty (30) days before, or twenty-four (24) hours after, admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination is completed

within thirty (30) days before admission or registration, the physician must complete and document an updated examination of the patient within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The history and physical must be completed and documented by a practitioner in accordance with state law and medical staff policy.

(l) paying applicable dues and/or fees, if required; and

(m) promptly notifying the medical staff office in writing as soon as reasonably possible, but within 30 days:

(1) the initiation of formal proceedings by a medical licensing authority or the DEA to suspend, revoke, restrict or place on probation a license or DEA certificate;

(2) an action by the medical staff executive committee or the governing body of another hospital or health care entity to suspend, revoke, restrict, or deny clinical privileges for reasons related to professional competence or conduct;

(3) the practitioner's exclusion from participation in Medicare, Medi-Cal or any federal health care program or conviction of a criminal offense related to the provision of health care items or services;

(4) any formal allegations of fraud or abuse or illegal activity relating to the practitioner's professional practice or conduct made by any State or Federal government agency;

(5) any report filed with the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank,

(6) any injury, disability, or illness that would significantly interfere with his/her medical practice;

(7) the filing of any malpractice claim or action in which the Practitioner is a named defendant; or

(8) any other action that could affect his/her medical staff standing and/or clinical privileges at the healthcare district.

Failure to abide by the above-listed duties may result in adverse action.

2.6 CONTRACT PRACTITIONERS

2.6-1 MEMBERSHIP AND PRIVILEGES REQUIRED

A contract practitioner may provide services authorized pursuant to the applicable specified clinical services contract only if the specified clinical services are within the scope of privileges which the contract practitioner has been granted in accordance with these bylaws. Also, a practitioner who is an employee or subcontractor of a contract practitioner or a medical group or other professional entity which is a party to a contract at the district may be granted temporary privileges to serve as locum tenens for a contract practitioner, provided the practitioner otherwise meets applicable bylaws requirements for the granting and exercise of such temporary privileges.

2.6-2 EFFECT OF SPECIFIED CLINICAL SERVICES CONTRACT TERMINATION

The termination or expiration of the applicable specified clinical services contract shall automatically terminate only the practitioner's rights to provide services on such basis as specified in the contract, and

(a) Expressly shall not, of itself, affect the medical staff membership or privileges granted to the practitioner, and

(b) Accordingly, shall not entitle the contract practitioner to procedural rights unless otherwise required by law or expressly provided in the applicable specified clinical services contract.

The affected individual who wishes to maintain medical staff membership or privileges after termination of a contract must continue to comply with and adhere to the requirements set forth in these bylaws. Failure to comply will be deemed a voluntary resignation from medical staff membership and privileges. Such deemed resignation shall not entitle the practitioner to procedural rights.

2.6-3 MEDICAL STAFF ROLE IN SPECIFIED CLINICAL SERVICES CONTRACTING

Prior to approving, renewing, or modifying and, to the extent reasonably practical, prior to terminating, a specified clinical services contract, the board of directors or administrator shall give notice of the planned action to the medical staff by transmitting the notice to the medical executive committee. The medical staff and/or the medical executive committee may review and make recommendations to the board of directors regarding quality of care issues related to specified clinical services contractual arrangements for physician and/or professional services, prior to the district board taking final action in the matter.

2.7 ADMINISTRATIVE PRACTITIONERS

Members may be assigned duties by the district board which are solely administrative in nature, provided that such duties are reasonably related to the member's official medical staff responsibilities. The district board, in its sole discretion, may terminate such assignment at any time. Unless otherwise required by law, such purely administrative service assignment and termination is independent of, and shall have no effect on, the member's membership or privileges, shall not entitle the member to procedural rights, and records of such assignment or termination shall not be deemed part of the member's credentials files or any other medical staff records.

The medical executive committee may make recommendations to administration in the selection of and assignment of responsibilities to department medical directors or other practitioners contracted by the district to provide administrative services.

ARTICLE III: CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES

The categories of the medical staff shall include the following: active, courtesy, consulting, and honorary. At appointment and each time of reappointment, the member's staff category shall be determined.

There are several groups of practitioners who, due to the nature of their practice, do not require assignment to a medical staff category. The scope and extent of these practitioners' relationships with the healthcare district can be found in Article IV of these bylaws.

3.2 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the credentials committee, or pursuant to a request by a member under Section 5.6-1(b), or upon direction of the board of directors as set forth in Section 6.2-6, the medical executive committee may recommend a change in the medical staff category of a member consistent with the requirements of these bylaws.

3.3 ACTIVE STAFF

3.3-1 QUALIFICATIONS

The active staff shall consist of members who:

(a) meet the qualifications for membership set forth in Section 2.2;

(b) when on duty, are located close enough to the healthcare district to provide appropriate quality care, as per the policies of the specific department; and

(c) are regularly involved in patient care in this healthcare district and regularly involved in medical staff functions, as determined by the medical staff.

3.3-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

Except as otherwise provided, the rights and responsibilities of an active member shall be to:

(a) exercise such clinical privileges as are granted pursuant to these bylaws;

(b) attend and vote on matters presented at general and special meetings of the medical staff and of the department and committees to which the member is duly appointed;

(c) hold staff or department office and serve as a voting member of committees to which the member is duly appointed or elected by the medical staff or duly authorized representative thereof, so long as the activities required by the position fall within the member's scope of practice;

(d) pay medical staff membership dues in the amount as determined by the medical executive committee; and

(e) exercise other such rights and responsibilities at outlined in Table 3.8.

3.3-3 TRANSFER OF ACTIVE STAFF MEMBER

After two consecutive ongoing professional practice evaluation (OPPE) cycles as per policy in which a member of the active staff fails to regularly care for patients in this healthcare district or be regularly involved in medical staff functions as determined by the medical staff, that member shall be referred to the credentials committee to determine the appropriate category, if any, for which the member is qualified.

3.4 COURTESY STAFF

3.4-1 QUALIFICATIONS

The courtesy staff shall consist of members who:

(a) meet the general qualifications set forth in Section 2.2;

(d) when on duty, are located close enough to the healthcare district to provide appropriate quality care, as per the policies of the specific department;

(b) do not utilize this healthcare district as the principle location in their practice and are not regularly involved in medical staff functions; and

(c) are members in good standing of the active medical staff of another licensed hospital, and at the time of appointment and reappointment, are able to provide proof of continued membership and privileges at the primary hospital. Exceptions to this requirement may be made by the medical executive committee for good cause.

3.4-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

Except as otherwise provided, the rights and responsibilities of the courtesy staff shall be to:

(a) care for patients of the healthcare district and exercise such clinical privileges as are granted pursuant to these bylaws;

(b) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs, when available. Courtesy staff have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment;

(c) provide patient activity and quality review information from his or her primary facility as may be requested at the time of appointment and reappointment;

(d) pay application fees, as determined by the medical executive committee; and

(e) exercise other such rights and responsibilities at outlined in Table 3.8.

Courtesy staff members shall not be eligible to hold office in the medical staff.

3.4-3 LIMITATIONS

Courtesy staff members who regularly admit patients or regularly care for patients at the district shall, upon review of the credentials committee and medical executive committee, be obligated to seek appointment to the appropriate staff category.

Courtesy staff members who do not maintain active staff membership at another licensed hospital shall be referred to the credentials committee to determine the appropriate category, if any, for which the member is qualified.

3.5 CONSULTING STAFF

3.5-1 QUALIFICATIONS

Any member of the medical staff in good standing may consult in that member's area of expertise; however, the consulting medical staff shall consist of such practitioners who:

(a) meet the qualifications set forth in Section 2.2 and are not otherwise members of the medical staff;

(b) possess adequate clinical and professional expertise;

(c) are called upon periodically by a practitioner at Northern Inyo Healthcare District to render care to patients treated at or admitted to this facility.

3.5-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

The rights and responsibilities of the consulting staff shall be to:

(a) treat and otherwise care for patients at this facility on request of the patient's practitioner;

(b) exercise such additional clinical privileges as are granted pursuant to these bylaws;

(c) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs, when available. Consulting staff have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment;

(d) pay application fees, as determined by the medical executive committee; and

(e) exercise other such rights and responsibilities at outlined in Table 3.8.

Consulting staff members shall not be eligible to hold office in the medical staff.

3.6 HONORARY STAFF

3.6-1 QUALIFICATIONS

The honorary staff shall consist of physicians, dentists, or podiatrists who do not actively practice at the district but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the district, and who continue to exemplify high standards of professional and ethical conduct. Members who have retired from active practice and, at the time of their retirement, were members in good standing of the

medical staff, and who continue to adhere to appropriate professional and ethical standards, shall also be eligible for appointment to honorary staff upon recommendation of the medical executive committee.

3.6-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

Honorary members are not eligible to admit patients to the hospital or to exercise clinical privileges in the district, or to vote or hold office in this medical staff organization, but they may serve upon committees without vote at the discretion of the medical executive committee. They may attend staff and department meetings, including open committee meetings and educational programs. Appointment to honorary staff shall be indefinite, unless otherwise requested by the member.

3.7 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the medical staff, limited license members (i.e., podiatrists and dentists):

(a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the medical executive committee; and

(b) shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 4.7.

3.8 TABLE OF PREROGATIVES BY MEDICAL STAFF CATEGORY

	Active	Courtesy	Consulting	Honorary
Exercise privileges	Yes	Yes	Yes	No
General voting rights	Yes	No	No	No
Attendance at general medical staff meeting required	Yes	No	No	No
May be committee member	Yes	Yes	Yes	Yes
Vote in committee	Yes	No, unless specified at time of appointment to committee	No, unless specified at time of appointment to committee	No
May hold medical staff office	Yes	No	No	No
May be committee chair	Yes	No	No	No
May be department chief	Yes	No	No	No
Pay dues	Yes	No	No	No
Pay application fee	No	Yes	Yes	No
Must have malpractice insurance	Yes	Yes	Yes	No
Must file for reappointment	Yes	Yes	Yes	No

ARTICLE IV: CLINICAL PRIVILEGES

4.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws, a practitioner providing clinical services at this healthcare district shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to applicable policies and the authority of the department chief. Medical staff privileges may be granted or continued by the board of directors only upon recommendation of the medical staff and following the procedures outlined in these bylaws. Medical staff privileges may be modified or terminated by the mechanisms as outlined in these medical staff bylaws.

4.2 PRIVILEGE REQUESTS

Each application for privileges must contain a request for the specific clinical privileges desired by the applicant. A request for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

4.3 LAPSE OF APPLICATION

If a practitioner requesting initial or additional clinical privileges fails to furnish the information necessary to evaluate the request within thirty (30) days (or as otherwise agreed upon), the application shall be regarded as incomplete and lapse as detailed in Section 5.5-4, and the applicant shall not be entitled to a hearing.

4.4 BASIS FOR PRIVILEGE DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, current demonstrated professional competence and judgment, clinical performance, physical and mental health affecting the ability to perform duties, and the documented results of patient care and other quality review and monitoring as per ongoing and focused professional practice evaluations (OPPE and FPPE). If current competency cannot be demonstrated, an applicant may be eligible for re-entry per the current policy. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges. The decision to grant or deny a privilege and/or to renew an existing privilege shall include peer recommendations which address the applicant's:

1. Patient care
2. Medical/clinical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems-based practice

Privileges shall be granted and maintained only if the requested privileges are within the district's patient care needs. Furthermore, no specific privilege may be granted to a practitioner if the task, procedure or activity constituting the privilege is not available within the district despite the practitioner's qualifications or ability to perform the requested privilege, except as provided for under emergency privileges Section 4.11.

4.5 CRITERIA FOR "CROSS-SPECIALTY" OR NEW PRIVILEGES WITHIN THE DISTRICT

Any request for clinical privileges that are new to the district shall initially be reviewed by the appropriate departments and administration in order to establish the need for, and appropriateness of, the new procedure or services. Any request for new clinical privileges that overlap more than one department shall initially be reviewed by the appropriate departments in order to address criteria for the procedure. The medical executive committee shall facilitate the establishment of district-wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the medical executive committee may establish an ad hoc committee with representation from all appropriate departments.

Further details regarding the development and approval process for new privileges or new services can be found in applicable policy.

4.6 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

4.6-1 FPPE FOR INITIAL PRIVILEGES

(a) General Provisions:

(1) All initial appointees to the medical staff and all practitioners granted new clinical privileges shall be subject to a period of initial review and evaluation as further described in the medical staff's Focused and Ongoing Professional Practice Evaluation (FPPE and OPPE) policy.

(2) Until an initial appointee has been evaluated for core privileges and released from FPPE for these core privileges, he or she cannot be considered for a medical staff leadership position and cannot vote on any medical staff issues.

(b) Failure to Complete FPPE:

(1) If FPPE for core privileges is not completed due to an insufficient amount of clinical activity as per the FPPE and OPPE policy, the practitioner's membership and privileges will automatically expire, unless otherwise recommended by the credentials committee and medical executive committee. Such expiration shall not entitle the practitioner to procedural rights.

(2) If FPPE for special privileges is not completed due to an insufficient amount of clinical activity, FPPE can be extended as recommended by the proctor(s), the credentials committee, and the medical executive committee. In this instance, the practitioner's core privileges and eligibility for reappointment shall not be affected. Additionally, such extension of FPPE shall not be considered a limitation or restriction of privileges entitling the practitioner to procedural rights.

(3) If FPPE for any privilege (core or special) is not completed satisfactorily due to competency or quality of care concerns, the relevant privilege, and the membership if the privileges under question are core privileges, may be terminated and/or revoked. In this instance, the practitioner shall be entitled to the procedural rights outlined in these bylaws.

4.6-2 FPPE ARISING FROM CONCERNS

FPPE may also be initiated when the performance or outcomes of a practitioner are questionable, which may become evident with the occurrence of a single or sentinel event and/or patterns or trends indicating potentially unsafe patient care. The initiation of FPPE arising from concerns differs from FPPE for new privileges described under Section 4.6-1. Practitioners subject to FPPE arising from concerns may be entitled to procedural rights if such action is a reportable action.

4.7 CONDITIONS FOR PRIVILEGES OF PRACTITIONERS

4.7-1 ADMISSIONS

(a) The following categories of practitioners are eligible to independently admit patients to the hospital:

(1) Physicians (MDs or DOs)

(b) The following categories of practitioners are eligible to co-admit patients to the hospital:

(1) Dentists (non-MD)

(2) Podiatrists

(3) Certified Nurse Midwives

(c) Additionally, the following categories of APPs with admitting privileges (as per relevant standardized procedures/protocols) may admit patients upon order of a member of the medical staff who has admitting privileges and who maintains responsibility for the overall care of the patient:

(1) Physician Assistants

(2) Nurse Practitioners

4.7-2 RESPONSIBILITY FOR CARE OF PATIENTS

(a) The admitting practitioner shall establish at the time of admission, the patient's condition and provisional diagnosis.

(b) For patients admitted by or upon order of a limited license practitioner, a physician with appropriate privileges must assume responsibility for the care of the patient's medical or psychiatric problems that are present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

(c) Where a dispute exists regarding proposed treatment between a physician member and a practitioner with co-admitting privileges, the physician member's treatment plan shall be the recognized treatment plan.

4.7-3 SURGERY

Surgical procedures performed by limited license practitioners shall be under the overall supervision of the chief of the department of surgery or his or her designee.

4.8 TEMPORARY CLINICAL PRIVILEGES

Temporary privileges shall not exceed one hundred twenty (120) consecutive days, unless the medical executive committee recommends and the board of directors approves a longer period for good cause, and are allowed under two circumstances only: (1) to address a patient care need and (2) to permit patient care to be provided while an application is pending.

4.8-1 PATIENT CARE NEEDS

(a) Care of Specific Patient

Temporary clinical privileges may be granted to a practitioner where good cause exists to provide care to a specific patient or group of patients.

(b) Locum Tenens

Temporary clinical privileges may be granted to a practitioner serving as a locum tenens for a current member of the medical staff to meet the care needs of that member's patients or duties in his/her absence.

(c) Other Important Patient Care Needs

Temporary clinical privileges may be granted to allow a practitioner to fulfill an important patient care, treatment, or service need.

4.8-2 PENDING APPLICATION FOR MEDICAL STAFF MEMBERSHIP OR PRIVILEGES

Temporary clinical privileges may be granted to an applicant while his or her application for medical staff membership and/or privileges is completed and awaiting review and approval of the credentials committee, the medical executive committee or the board of directors.

4.8-3 PROCESS FOR GRANTING TEMPORARY CLINICAL PRIVILEGES

Applicants who appear to have qualifications, ability, and judgment consistent with Section 2.2 can qualify to be granted temporary clinical privileges for patient care needs or to permit patient care while an application is pending, provided that:

(a) The medical executive committee has not made a final recommendation that is adverse or with limitation.

(b) The applicant has no current or previously successful challenge to professional licensure or registration.

(c) The application has no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges.

(d) The applicant has no unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment adverse to the applicant.

(e) The following has been completed:

(1) Verification of current California licensure;

(2) Verification of the National Practitioner Data Bank report;

(3) Verification of relevant training and experience;

(4) Verification of current competence and ability to perform the privileges requested.

A decision to grant temporary privileges to an applicant under this Section shall not be binding or conclusive with respect to an applicant's pending request for appointment to the medical staff. No practitioner has any right to be granted temporary privileges.

The administrator is given authority to grant temporary privileges to an applicant. Such action, however, shall be on the recommendation of the following medical staff members:

(1) The applicable clinical department chief;

(2) The credentials committee chairperson; and

(3) The chief of staff.

4.8-4 GENERAL CONDITIONS OF TEMPORARY PRIVILEGES

(a) If granted temporary privileges, the applicant shall act under the supervision of the department chief (or designee) to which the applicant has been assigned.

(b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VI and/or VII of these bylaws or unless affirmatively renewed. A medical staff applicant's temporary privileges shall automatically terminate if the applicant's initial application is withdrawn.

(c) Notwithstanding any other provision of these bylaws to the contrary, an applicant shall not be entitled to procedural rights if the applicant's request for temporary privileges is refused, or if all or any portion of the applicant's temporary privileges are suspended, unless such action is a reportable action.

(d) All persons receiving temporary privileges shall be bound by the medical staff bylaws and policies, and all applicable district policies.

4.9 TELEMEDICINE PRIVILEGES

Practitioners who wish to provide approved types of telehealth services will be credentialed and privileged according with this Section but, unless they separately qualify, apply, and are approved for

membership in a staff category described in Article III of these bylaws, will not be appointed to the medical staff in any membership category.

4.9-1 TELEMEDICINE CREDENTIALING

(a) In processing a request for telemedicine privileges, the medical staff may follow the normal credentialing process described in Article V of these bylaws, including but not limited to the collection of information from primary sources. Alternatively, the medical staff may elect to rely upon the credentialing and privileging decisions made by distant-site hospitals and telemedicine entities when making recommendations on privileges for individual distant-site practitioners, subject to meeting the conditions required by law and those specified in these bylaws.

(b) Telemedicine privileges shall be for a period not to exceed two (2) years, and shall be subject to re-evaluation and renewal pursuant to the same principles and process described in these bylaws for the renewal of clinical privileges held by medical staff members.

(c) The direct care or interpretive services provided by the distant-site practitioner must meet the professional standards of the district and its medical staff at all times. Distant-site practitioners holding telemedicine privileges shall be obligated to meet all of the basic responsibilities that must be met by members of the medical staff, as described in these bylaws, modified only to take into account their distance from the hospital and the need to pay dues.

(d) Telemedicine privileges may be denied, restricted, suspended or revoked at the discretion of the medical executive committee or the chief of staff acting on its behalf, without hearing rights as described in Article VII of these bylaws, except as required by law.

(e) Recognizing that telemedicine physicians may be privileged at many healthcare facilities and entities, the district shall conduct the primary verification procedures for an adequate number of hospitals, health care organizations and/or practice settings with whom the telemedicine physician is or has previously been affiliated in order to ensure current competency. In order to assist in this credentialing and privileging process, the district may request information from the telemedicine physician's primary practice site to assist in evaluation of current competency. The district may also accept primary source verification of credentialing information from the physician's primary practice site or the telemedicine entity to supplement its own primary source verification.

4.9-2 RELIANCE ON DISTANT-SITE ENTITIES

The medical staff may rely upon the credentialing and privileging decisions made by a distant-site hospital or distant-site telemedicine entity if the district board ensures through a written agreement with the distant-site hospital or entity that all of the following provisions are met:

(a) The distant-site entity acknowledges that it is a contractor of services to this district and, in accordance with 42 CFR §485.635(c)(4)(ii), furnishes services in a manner that permits Northern Inyo Healthcare District to be in compliance with the Medicare Conditions of Participation and appropriate accreditation agencies.

(b) The distant-site entity is either a Medicare-participating hospital or a lawful provider of the telemedicine services in question, and it confirms that its credentialing and privileging processes and standards for practitioners meet the standards described in the Medicare Conditions of Participation 42 CFR §485.616(c).

(c) The distant-site entity acknowledges, or the district confirms, that the distant-site entity has a process that is consistent with the credentialing and privileging requirements of the Healthcare Facilities Accreditation Program standards for critical access hospitals (05.00.14 and 05.00.15).

(d) The individual distant-site practitioner holds privileges at the distant-site entity to provide the services involved, and the distant-site entity provides the district with a current list of the distant-site practitioner's privileges at the distant-site entity.

(e) The individual distant-site practitioner is licensed in California, or is otherwise authorized by California law, to provide the services at issue, and is covered by professional liability insurance meeting the standards that apply to medical staff members at this district as described in these bylaws.

(f) The medical staff of Northern Inyo Healthcare District performs, and maintains evidence of, peer review of the distant-site practitioners' performance as it relates to district patients and sends the distant-site telemedicine entity such performance information for use in the periodic appraisal of the individual distant-site practitioners. At a minimum, the information this district will provide must include all adverse events that result from the telemedicine services provided by the distant-site practitioners to this district's patients and all complaints this district has received about the distant-site practitioners.

When the district is not a party to a written agreement with a distant-site Medicare participating hospital or distant-site entity containing all of the requirements of the CMS Hospital Conditions of related to distant-site telemedicine credentialing, the telemedicine physician must be credentialed and privileged pursuant to the general credentialing and privileging procedures described in Article V of these bylaws.

4.10 ADVANCED PRACTICE PROVIDERS

Advanced Practice Providers (APPs) are not eligible for medical staff membership, as per California law. They may be granted practice privileges if they hold a license, certificate, or other legal credential in a category of APPs that the board of directors (after securing medical executive committee recommendations) has identified as eligible to apply for practice privileges as set forth in Article VIII.

4.11 EMERGENCY PRIVILEGES

In the case of an emergency involving a particular patient, any practitioner with clinical privileges, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save the patient from serious harm provided that the care provided is within the scope of the individual's license or training. Once the emergency has passed or assistance has been made available, further care of the patient shall be assumed by a practitioner of the appropriate department.

4.12 DISASTER PRIVILEGES

In the case of a disaster in which the disaster plan has been activated and the district is unable to handle the immediate patient needs, the following may grant disaster privileges to volunteer practitioners in accordance with the process outlined in the applicable medical staff policy:

(a) the chief of staff;

(b) any physician member of the medical executive committee;

(c) any department chief;

(d) any active medical staff member; or

(e) designee of any of the above.

The volunteer practitioner shall be required to submit identification and other such required documentation for verification as further detailed in policy. The medical staff shall oversee the performance of all volunteer practitioners. Once the care of disaster victims can be adequately assumed by the members of the regular medical staff, then disaster privileges of the volunteer will be terminated as further detailed in policy.

ARTICLE V: APPLICATION PROCEDURES FOR PRIVILEGES

5.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by Northern Inyo Healthcare District in administratively responsible positions) shall exercise clinical privileges in the district or via telemedicine link unless and until that person applies for and receives approval to exercise clinical privileges as set forth in these bylaws, or, with respect to advanced practice providers, has been granted a service authorization or privileges under applicable medical staff policies.

A request for an initial application will be reviewed by the chief of staff for appropriateness. By applying to the medical staff for privileges (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these bylaws and policies, and agrees to comply with the responsibilities of medical staff membership and with the bylaws and policies of the medical staff as they exist and as they may be modified from time to time.

5.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, privileges, or transfer of staff category, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's current competence, character, ethics, and other qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for the medical staff's refusal to take action on the application, which shall not be subject to appeal or review under Article VII of these bylaws. To the extent consistent with law, this burden may include submission to a medical or psychological examination as per relevant credentialing policy, at the applicant's expense, if deemed appropriate by the medical executive committee, which may select the examining physician. If current competency cannot be demonstrated, an applicant may be eligible for re-entry per the current policy.

5.3 APPOINTMENT AND AUTHORITY

The medical staff shall make recommendations to the board of directors for appointments, denials and revocations of appointments to the medical staff as set forth in these bylaws.

5.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Initial appointments and reappointments to the medical staff shall be for a period of up to two (2) years. Any recommendation for appointment or reappointment of less than two(2) years is at the sole discretion of the medical executive committee and is not subject to rights of appeal as set forth in Article VII.

5.5 APPLICATION FOR INITIAL APPOINTMENT, REAPPOINTMENT, AND PRIVILEGES

5.5-1 APPLICATION FORM

An application form shall be developed by the district and the medical staff. The form shall require detailed information which shall include, but not be limited to, information concerning:

(a) the applicant's qualification, including, but not limited to, professional education, training and experience, current licensure, current DEA registration (if applicable), and continuing

medical education information related to the clinical privileges to be exercised by the applicant;

(b) peer references familiar with the applicant's current professional competence and ethical character;

(c) requests for membership categories, departments, and clinical privileges;

(d) past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of medical staff membership or privileges or any licensure or registration, and related matters;

(e) any past or pending arrests, indictments, criminal charges, or convictions brought against the applicant;

(f) current physical and mental health status, to the extent necessary to determine the applicant's ability to perform obligations or requested privileges, or as otherwise permitted by law;

(g) final judgments, settlements, or arbitration awards made against the applicant in professional liability cases, and any filed and served cases pending;

(h) professional liability insurance coverage, in not less than the minimum amounts as from time to time may be jointly determined by the medical executive committee and board of directors; and

(i) any past, pending or current exclusion of suspension from a state or federal health care program, or any investigation or disciplinary action by any governmental agency relating to the applicant's professional license or practice.

Each application shall be in writing, or electronically submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, that person shall be given a copy of these bylaws and, as deemed appropriate by the medical executive committee, copies or summaries of any other applicable medical staff and district policies relating to clinical practice in the district. Failure to disclose the information requested in the application, or knowingly providing false or misleading information may result in disciplinary action, including suspension or termination of membership and/or privileges, or in a decision that the application does not qualify for credentialing consideration.

5.5-2 EFFECT OF APPLICATION

In addition to the matters set forth in Section 5.1, by submitting an application for privileges, each applicant:

(a) signifies willingness to appear for interviews in regard to the application;

(b) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

(c) consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

(d) releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

(e) releases from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

(f) consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the district or medical staff may have, and releases the medical staff and district from liability for so doing to the fullest extent permitted by law;

(g) if a requirement then exists for medical staff dues, acknowledges responsibility for timely payment;

(h) agrees to provide quality care for patients;

(i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the care of the applicant's patients, seeking consultation whenever indicated, refraining from providing illusory or unnecessary surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;

(j) pledges to be bound by the medical staff bylaws and policies, as well as applicable district policies; and

(k) agrees that if membership and/or privileges are granted, and for the duration of medical staff membership and/or privileges, the applicant has an ongoing and continuous duty to report to the medical staff office as soon as reasonably possible, but within thirty (30) days, any and all information that would otherwise correct, change, modify or add to any information provided in the application or most recent reapplication.

5.5-3 VERIFICATION OF INFORMATION

The applicant shall deliver a completely filled-in, signed, and dated application and supporting documents to the medical staff office and an advance payment of non-refundable medical staff dues or fees, if any is required. The administrator and chief of staff shall be notified of the application. The medical staff office shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The district's authorized representative shall query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the credentials committee for inclusion in the applicant's or member's credentials file. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain any reasonably requested information. Failure to provide any requested information within thirty (30) days of a request, or an otherwise agreed to timeframe, shall be deemed a

voluntary withdrawal of the application and no further action will be taken with respect to the application. When collection and verification of information is accomplished, all such information shall be transmitted to the credentials committee and the appropriate department(s). No final action on an application may be taken until receipt of the Data Bank report.

5.5-4 DETERMINE IF APPLICATION IS COMPLETE

The application will be deemed complete when all required information has been submitted by the applicant and all necessary verifications have been obtained. An application will become incomplete if the need arises for new, additional, or clarifying information at any time prior to final determination by the board. Notwithstanding any other provision of these bylaws, an application that is determined to be incomplete shall not qualify for privileging recommendations, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after thirty (30) days of a request, or an otherwise agreed-to timeframe, the credentialing and privileging process will be terminated. An incomplete application will not be processed. Termination of the credentialing and privileging process under this provision shall not entitle the applicant to any hearing or appeal under Article VII.

5.5-5 DEPARTMENT ACTION

After receipt of the application, the chief of each department to which the application is submitted shall review the application and supporting documentation, may seek additional information, and may conduct a personal interview with the applicant at the chief's discretion. The chief shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges requested, his/her clinical and technical skills, any relevant data available from district performance improvement activities, and the applicant's participation in relevant continuing education. The chief shall transmit to the credentials committee his or her recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The chief may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

5.5-6 CREDENTIALS COMMITTEE ACTION

The credentials committee shall review the application, evaluate and verify the supporting documentation, the department chief's recommendations, and other relevant information. The credentials committee may elect to interview the applicant and seek additional information. As soon as practicable, the credentials committee shall transmit to the medical executive committee a written report with its recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The credentials committee may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

5.5-7 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the credentials committee report and recommendation, or as soon thereafter as is practicable, the medical executive committee shall consider the report and any other relevant information. The medical executive committee may request additional information, return the matter to the credentials committee for further investigation, and/or elect to interview the applicant. The medical executive committee shall immediately forward to the administrator, for prompt transmittal to the board of directors, a written report with its recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The medical executive committee may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

5.5-8 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) Favorable recommendation: When the recommendation of the medical executive committee is favorable to the applicant, it shall be immediately forwarded to the board of directors and the supporting documentation shall be made available upon request.

(b) Unfavorable recommendation: When the recommendation of the medical executive committee is an unfavorable action, in whole or in part, the board of directors and the applicant shall be promptly informed by written notice. The applicant shall not be entitled to procedural rights as provided in Article VII.

(c) Adverse recommendation: When a final recommendation of the medical executive committee is an adverse action, in whole or in part, the board of directors and the applicant shall be promptly informed by written notice. The applicant shall be entitled to procedural rights as provided in Article VII. The board of directors shall not take action on the pending adverse recommendation until the applicant has exhausted or waived his/her procedural rights.

5.5-9 BOARD OF DIRECTORS ACTION

On favorable recommendation of the medical executive committee:

(a) A decision of the board to adopt a favorable recommendation of the medical executive committee shall be deemed as final action.

(b) If the board is inclined to reject or modify a favorable recommendation, the board shall refer the matter to the joint conference committee.

(c) If the board's resolution constitutes grounds for a hearing under Article VII of the bylaws, the administrator shall promptly inform the applicant and the chief of staff, and the applicant shall be entitled to the procedural rights as provided in that Article. Once the applicant has exhausted or waived his/her procedural rights, the board may then take final action.

On adverse recommendation of the medical executive committee:

(a) Once the applicant has exhausted or waived his or her procedural rights, the board may take final action in the matter or refer the matter to the joint conference committee.

5.5-10 NOTICE OF FINAL DECISION

(a) Notice of the final decision shall be given to the applicant, the chief of staff, the chief of each department concerned, and the administrator if not previously informed.

(b) A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the department to which that person is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

5.5-11 REAPPLICATION AFTER ADVERSE OR UNFAVORABLE ACTION

An applicant who has received a final adverse action, as defined in these bylaws, regarding an application for appointment, reappointment, or privileges shall not be eligible to reapply to the medical staff for a period of three (3) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

An applicant who has received an unfavorable action, as defined in these bylaws, is eligible to reapply once the deficiency has been corrected. The waiting period shall not apply.

5.5-12 TIMELY PROCESSING OF APPLICATIONS

Once an application is deemed complete, it is expected to be processed within one hundred twenty (120) days, unless it becomes incomplete at any point during processing as described in these bylaws. This time period is provided to assist in the processing of the application and not to create rights for applicants to have their applications processed within this specific time period.

5.6 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

Applicants for reappointment, renewal of privileges, and requests for modifications of staff status or privileges shall be subject to all of the general application provisions of these bylaws, subject only the following additional provisions:

5.6-1 REAPPLICATION DEADLINE AND CONTENT

(a) At least one hundred fifty (150) days prior to the expiration date of the current staff appointment or expiration of privileges for privileges-only practitioners (for example, telemedicine), a reapplication form shall be submitted to the member or privileged practitioner. At least one hundred twenty (120) days prior to the expiration date, each applicant shall submit to the medical staff office the completed application form for renewal of appointment to the staff and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant. However, an applicant for reappointment shall not be required to repeat information which has been provided and verified in a prior application and in which there has been no change during the period since the application submitted

the prior application. For such information, in response to each relevant portion of the application form, the applicant shall indicate that the information is unchanged.

(b) A medical staff member or privileged practitioner who seeks a change in medical staff status or modification of clinical privileges may submit such a request at any time.

(c) The timely processing of reapplications from receipt of the application to final action shall be one hundred twenty (120) days.

5.6-2 FAILURE TO FILE REAPPOINTMENT APPLICATION

If an application for reappointment is not received at least one hundred twenty (120) days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. The applicant may submit a request for extension to the medical executive committee for consideration.

If an applicant fails, without good cause, to submit the required application by the deadline, but submits it prior to the expiration date of the applicant's privileges, and no final decision has been rendered by the expiration date due to the delays caused by the applicant's failure to timely submit the complete application, the applicant's privileges and prerogatives shall be deemed to be automatically suspended upon the expiration date unless otherwise extended by the medical executive committee with the approval of the board of directors. The automatic suspension shall remain in effect until the district board makes a final decision on the application.

If an applicant fails, without good cause, to submit the required reappointment application by the expiration date of the applicant's privileges, or to provide information requested to complete the application after receiving a notice of incomplete application, the applicant shall be deemed to have voluntarily resigned from membership and relinquished all privileges, effective as of the expiration date of the applicant's term of appointment and/or privileges.

In the event membership terminates and/or privileges lapse for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

5.7 LEAVE OF ABSENCE

A practitioner taking any of the following leaves of absence for a duration exceeding one hundred eighty (180) days must notify the medical staff office prior to the start of leave, stating the approximate period of leave desired, which may not exceed one (1) year. Absence for longer than one (1) year shall result in automatic expiration of medical staff appointment and clinical privileges, unless an extension is requested in writing at least forty-five (45) days prior to the one-year date and granted by the medical executive committee. Reinstatement from any leave shall be subject to the provisions listed in Section 5.7-5.

5.7-1 ROUTINE LEAVE OF ABSENCE

A practitioner may take a routine leave of absence, giving consideration to his/her contractual obligations. The medical executive committee shall be notified of the leave.

5.7-2 MEDICAL LEAVE OF ABSENCE

A practitioner may take a medical leave of absence to accommodate treatment for, or recovery from, a behavioral health or physical health condition affecting his or her fitness to practice safely. The approximate period of leave needed shall be specified, and as reasonable during the leave, the medical executive committee shall be kept informed of changes to the projected date of return. The practitioner may be required to submit a letter of release from the treating physician as part of the reinstatement process confirming that his or her health is free from any impairment prior to exercising any patient care. The medical executive committee may, at its discretion, require a fit for duty evaluation be performed by a provider of its choosing and at the practitioner's cost.

5.7-3 MILITARY LEAVE OF ABSENCE

A practitioner may request a leave of absence to fulfill military service obligations. Such request shall be granted upon notice and review by the medical executive committee.

5.7-4 OBLIGATION UNDER LEAVE OF ABSENCE

During the period of the leave, the practitioner shall not exercise clinical privileges at Northern Inyo Healthcare District, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical executive committee.

Before any routine leave of absence may begin, all medical records must be completed and dues must be current, unless such dues are excused by the medical executive committee. Meeting attendance requirements will be waived during the period of leave.

5.7-5 REQUEST FOR REINSTATEMENT

At least forty-five (45) days prior to the termination of the leave of absence or as soon as reasonably known, the practitioner may request reinstatement of privileges by submitting a written notice to the medical executive committee (and in the case of an advanced practice provider, written notice to the interdisciplinary practice committee in addition to the medical executive committee). The medical executive committee shall make a recommendation concerning the reinstatement of the practitioner's privileges and prerogatives, which may take into consideration a summary of the practitioner's activities during the leave. Reinstatement may be granted subject to focused professional practice monitoring and/or evaluation as determined by the medical executive committee. A recommendation that a practitioner be denied reinstatement shall be considered a denial of privileges and may be appealed as such pursuant to these bylaws.

5.7-6 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff or advanced practice provider staff and shall result in automatic expiration of membership, privileges, and prerogatives. A practitioner whose membership and/or privileges automatically expires under this provision may contest this action to the medical executive committee by submitting a written statement or request a meeting before the committee. The medical executive committee's decision on the matter shall be final. A request for membership and/or privileges subsequently received from a member terminated under this provision shall be submitted and processed in the manner specified in these bylaws for initial appointments.

5.7-7 EXPIRATION OF APPOINTMENT WHILE ON LEAVE

If a practitioner's term of appointment is scheduled to expire during the period for which a leave is requested, the practitioner may:

(a) Seek and obtain reappointment prior to going on leave, which would result in an adjustment of the practitioner's subsequent term of appointment to reflect the new date of reappointment. The medical staff may require that supplemental information be produced to confirm current competence upon reinstatement; or

(b) Apply for reappointment at the scheduled time while on leave. The medical staff may require that supplemental information be produced to confirm current competence upon reinstatement; or

(c) Permit the current term of appointment to expire and reapply for membership and/or privileges as an initial applicant once the leave of absence has ended.

ARTICLE VI: PEER REVIEW AND CORRECTIVE ACTION

6.1 MONITORING AND PEER REVIEW

Medical staff departments and committees are responsible for carrying out delegated peer review and quality assessment functions as per applicable peer review and quality policies. They may counsel, educate, issue letters of warning or censure, or initiate focused review or retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admission and procedures) without initiating an investigation or formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. Informal actions, focused review, monitoring or counseling shall be documented in the practitioner's file and reviewed as part of their ongoing professional practice evaluation. Medical executive committee approval is not required for such actions, but the medical executive committee shall be notified if trends or concerns are noted. Such routine peer review and quality assessment functions shall not constitute an investigation and shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights as described in Article VII of these bylaws.

6.2 CORRECTIVE ACTION

Corrective action is separate from routine monitoring and peer review and can be initiated at any time as outlined in this Section. A practitioner is not required to have exhausted all monitoring and peer review activities prior to initiation of a corrective action.

6.2-1 CRITERIA FOR INITIATION

Any person may provide information to the medical staff office or officer of the medical staff about the conduct, performance, or competence of its members and practitioners, who will then take this information to the department chief, the chief of staff or medical executive committee. When reliable information indicates a practitioner may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the district; (2) unethical; (3) contrary to the medical staff bylaws; or (4) below applicable professional standards, an investigation or request for action may be initiated.

6.2-2 INITIATION

A request for an investigation or action against such practitioner may be initiated by the chief of staff or the medical executive committee. The request must be submitted to the medical executive committee, and supported by reference to specific activities or conduct alleged. If the medical executive committee initiates the request, it shall make an appropriate recording of the reasons in the minutes.

6.2-3 INVESTIGATION

If the medical executive committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The medical executive committee may conduct the investigation itself, or may assign the task to an ad hoc committee of the medical staff. If an ad hoc committee is formed, the chief of staff shall appoint the members of the ad hoc committee with the recommendation of the medical executive committee. If the investigation is delegated to an officer or committee other than the medical executive committee, such officer or committee shall proceed with the investigation in a

prompt manner and shall forward a written report of the investigation to the medical executive committee as soon as practicable. The report may include recommendations for appropriate corrective action. The affected practitioner shall be promptly notified by the chief of staff that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The body investigating the matter may, but is not obligated to:

(a) conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply; and

(b) review the practitioner's file.

Despite the status of any investigation, at all times the medical executive committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

6.2-4 EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigation, the medical executive committee shall take action which may include, without limitation:

(a) determining no corrective action be taken and, if the medical executive committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the practitioner's file;

(b) referring the practitioner to the Physician Wellness Committee for evaluation and follow-up as appropriate;

(c) deferring action for a reasonable time where circumstances warrant;

(d) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude committees or departments or their chiefs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected practitioner may make a written response which shall be placed in his or her file;

(e) recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;

(f) recommending reduction, modification, suspension or revocation of clinical privileges;

(g) recommending reductions of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care;

(h) recommending suspension, revocation or probation of medical staff membership; and

(i) taking other actions deemed appropriate under the circumstances.

6.2-5 SUBSEQUENT ACTION

The medical executive committee's action or recommendation following an investigation as described herein shall be presented to the board of directors at its next regularly scheduled meeting.

(a) If the medical executive committee has imposed or recommended corrective action as to which the affected practitioner may request a hearing, the board of directors may be advised of the action and hearing request at their next regularly scheduled meeting.

(b) If the medical executive committee decides not to take or recommend corrective action, or to take or recommend corrective action as to which the practitioner either has no rights of hearing or appeal or has waived such rights, and the board of directors questions or disagrees with the action of the medical executive committee, the matter may be remanded back to the medical executive committee for further consideration. If the decision of the board of directors is to take corrective action more severe than the action of the medical executive committee, and a hearing is required pursuant to Article VII, the procedure shall be as described in that Article for hearings that are prompted by action of the board of directors.

6.2-6 INITIATION BY BOARD OF DIRECTORS

If the medical executive committee fails to investigate or take disciplinary action in response to information about a practitioner's competence, performance, or conduct that is provided in accordance with the provisions of this Article, and if the board of directors determines that the medical executive committee's failure to proceed is contrary to the weight of the evidence, the board of directors may direct the medical executive committee to initiate investigation or disciplinary action. The board's request for medical staff action shall be in writing and shall set forth the basis for the request.

If the medical executive committee fails to take action in response to such direction from the board of directors, then the board may initiate the dispute resolution process as described in the Joint Conference Committee of these bylaws (unless immediate action is required to protect the health or safety or any individual, in which event the procedures for summary suspension shall apply). If the dispute resolution process does not result in action by the medical executive committee, and the board of directors still believes action is necessary, then the board of directors may initiate an investigation or corrective action after written notice to the medical executive committee, and shall fully comply with Articles VI and VII of these medical staff bylaws.

6.3 SUMMARY RESTRICTION OR SUSPENSION

6.3-1 CRITERIA FOR INITIATION

Whenever a practitioner's conduct is such that failure to take action may result in an imminent danger to the health of any individual, including but not limited to current or future patients, the chief of staff, the medical executive committee, or the chief of the department in which the practitioner holds privileges may summarily restrict or suspend the medical staff membership or clinical privileges of such practitioner. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the board of directors, the medical executive committee, the medical staff office, and the administrator.

In addition, the affected practitioner shall be provided with a written notice of the action that fully complies with the requirements of Section 6.3-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the practitioner's patients shall be promptly assigned to another practitioner by the department chief or by the chief of staff, considering where feasible, the wishes of the patient in the choice of a substitute practitioner. Summary suspension or restriction shall automatically constitute a request for investigation pursuant to this Article.

6.3-2 NOTICE OF SUMMARY SUSPENSION

The affected practitioner shall be promptly provided with written notice of such suspension within two (2) business days. This initial written notice shall generally describe the reasons for the action, the extent of the action, and the effective date and time of the action. Oral notice of summary suspension may be provided immediately to the affected practitioner and prior to the written notice if needed in order to assure patient safety.

This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3-1 (which applies in all cases where the medical executive committee does not immediately terminate the summary suspension). The notice under Section 7.3-1 may supplement the initial notice provided under this Section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

6.3-3 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as reasonably possible under all circumstances after such summary restriction or suspension has been imposed, a meeting of the medical executive committee shall be convened to review and consider the action. Upon request, the affected practitioner may attend and make a statement concerning the issues under investigation, on such terms and conditions as the medical executive committee may impose, although in no event shall any meeting of the medical executive committee, with or without the practitioner, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The medical executive committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the practitioner with notice of its decision within two (2) working days of the meeting. A copy of the notice shall be given to the administrator, the district board, and the relevant department chief.

6.3-4 PROCEDURAL RIGHTS

Unless the medical executive committee promptly terminates the summary restriction or suspension, it shall remain in effect during the pendency of the corrective action, hearing and appeal process, and the practitioner shall be entitled to the procedural rights afforded by Article VII.

6.3-5 INITIATION BY BOARD OF DIRECTORS

If the chief of staff, members of the medical executive committee and the chief of the department in which the practitioner holds privileges are not available to summarily restrict or suspend the practitioner's membership or clinical privileges, the board of directors (or the administrator on-call, as designee) may immediately suspend a practitioner's privileges if a failure to suspend those privileges is

likely to result in an imminent danger to the health of any person, provided that the board of directors (or administrator on-call) made reasonable attempts to contact the chief of staff, members of the medical executive committee and the chief of the department before the suspension.

A suspension under this Section is subject to ratification by the medical executive committee. If the medical executive committee does not ratify such a summary suspension within two (2) business days, the summary suspension shall terminate automatically. If the medical executive committee does ratify the summary suspension, all other provisions under Section 6.3 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the medical executive committee for purposes of compliance with notice and hearing requirements.

6.4 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the practitioner's privileges or membership may be suspended or limited as described, with no right to hearing unless reportable by law to the Medical Board of California. However, the practitioner may appear before the medical executive committee or submit a written statement addressing the question of whether grounds exist for the special action as set forth below. A practitioner may be eligible to reapply for reinstatement of privileges if the cause for such automatic action has been resolved.

6.4-1 LICENSURE

(a) Revocation and Suspension: Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked or suspended, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

(b) Restriction: Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the practitioner has been granted which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(c) Probation: Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

(d) Expiration: Whenever a practitioner's license is expired or evidence of renewal has not been received, the practitioner shall be automatically suspended until such time as evidence of current licensure has been received. Failure to reinstate such license or other legal credential within thirty (30) days of such lapse or expiration shall result in automatic termination of medical staff membership and/or clinical privileges.

6.4-2 DRUG ENFORCEMENT ADMINISTRATION (DEA) CERTIFICATE

(a) Whenever a practitioner's DEA certificate is revoked, limited, expired, or suspended, the practitioner shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(b) Probation: Whenever a practitioner's DEA certificate is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

6.4-3 MEDICAL RECORDS

Members of the medical staff and other clinically privileged practitioners are required to complete medical records within such reasonable time as may be prescribed by the district and the medical staff. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed may be imposed by the chief of staff after notice of delinquency for failure to complete medical records within such period has been given to the practitioner. For the purpose of this Section, "related privileges" means voluntary on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within Northern Inyo Healthcare District. Bona fide leave may constitute an excuse subject to approval by the medical executive committee. Practitioners whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the chief of staff or his or her designee. If within ninety (90) days after implementation of suspension the practitioner has not completed the delinquent records, the practitioner's membership and privileges shall be automatically terminated without right to a hearing unless reportable by law.

6.4-4 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance in the amounts indicated shall result in an automatic suspension of a practitioner's clinical privileges, and if within ninety (90) days after written warning of the delinquency the practitioner does not provide evidence of required professional liability insurance and evidence of coverage for the interim, the practitioner's membership and privileges shall be automatically terminated without right to a hearing unless reportable by law.

6.4-5 FAILURE TO PROVIDE INFORMATION OR SATISFY SPECIAL ATTENDANCE REQUIREMENT

Failure without good cause to provide information or appear when requested by a medical staff committee or department as described in these bylaws shall result in the referral to the medical executive committee for action, which may include automatic suspension of all privileges. The automatic suspension shall remain in effect until the practitioner has provided the requested information and/or satisfied the special attendance requirement.

6.4-6 FELONY CONVICTION OR PLEA

A practitioner who has been convicted of, or who has pleaded guilty or no contest to, a felony within the past seven (7) years shall not be eligible for privileges or initial appointment to the medical staff unless the medical executive committee determines, in its sole discretion, the felony was not directly related to the practitioner's professional practice or patient relationships,.

If a practitioner of the medical staff is convicted of, or pleads guilty or no contest to a felony, the practitioner's medical staff membership and privileges shall be automatically suspended pending review by the medical executive committee. If the medical executive committee, in its sole discretion, confirms that the felony was directly related to the practitioner's professional practice or patient relationships or

involving moral turpitude, the practitioner's staff membership and privileges shall terminate without right to a hearing. If the medical executive committee determines, in its sole discretion, the felony was not directly related to the practitioner's professional practice or patient relationships, the practitioner shall be permitted to request reinstatement as an initial applicant.

6.4-7 EXCLUSION FROM GOVERNMENTAL PROGRAM

A practitioner who is excluded as a provider from any governmental health care program (including but not limited to Medicare and Medi-Cal) may not apply for initial appointment to the medical staff. If a privileged practitioner is excluded as a provider from such governmental program during their appointment, the practitioner's medical staff membership and privileges shall be automatically terminated without right to a hearing.

6.4-8 NOTICE OF AUTOMATIC ACTION

No notice shall be required for an automatic action to become effective. However, as soon as reasonably practical after the automatic action becomes effective, written notice shall be provided to the affected practitioner, the administrator, the department chief, and the chief of staff.

6.4-9 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after automatic action is taken or warranted, the medical executive committee shall convene to review and consider the facts, and may recommend any further corrective action as it may deem appropriate in accordance with these bylaws.

ARTICLE VII: HEARINGS AND APPELLATE REVIEWS

7.1 GENERAL PROVISIONS

7.1-1 PROCESS TO CHALLENGE ADVERSE ACTIONS REPORTABLE UNDER BUSINESS AND PROFESSIONS CODE SECTION 805

The notice, hearing and appeal provisions available to a practitioner to contest an action or final recommended action which must be reported to the Medical Board of California under Business and Professions Code Section 805 shall be governed by the provisions of this Article commencing with Section 7.2 below.

7.1-2 PROCESS TO CHALLENGE UNFAVORABLE ACTIONS NOT REPORTABLE UNDER BUSINESS AND PROFESSIONS CODE SECTION 805

A practitioner who is adversely and significantly affected by an unfavorable action or recommended action for which a review process is not otherwise provided in these bylaws or in or policies, and which is not reportable under Business and Professions Code Section 805, may contest such actions or recommended actions by delivering a written request for review to the medical executive committee. In no event shall any meeting of the medical executive committee, with or without the practitioner, constitute a hearing within the meaning of Article VII, nor shall any procedural hearing rights apply. If the action or recommended action was made by the board of directors, the practitioner may contest the matter by providing written request for review to the board of directors. Any such request for review must be delivered within thirty (30) days from the practitioner's receipt of notice of the action or recommendation.

Examples of matters reviewable under this Section include, without limitation, restriction of clinical privileges for less than thirty (30) days in a twelve (12) month period; summary suspension of clinical privileges for fourteen (14) days or less; and termination, denial or restriction of privileges or membership rights for reasons other than medical disciplinary cause as defined in Business and Professions Code Section 805.

7.1-3 DUTY TO EXHAUST INTERNAL REMEDIES

All practitioners and applicants are obligated to exhaust all remedies provided in this Article or elsewhere in medical staff bylaws before initiating legal action. Any practitioner who fails to exhaust the remedies (including all hearing and appeal remedies) provided in these bylaws before initiating legal action, shall be liable to pay the full costs, including legal fees, required to respond to such legal action.

7.1-4 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within a reasonable time.

7.1-5 FINAL ACTION

Recommended adverse actions described in Section 7.2 shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived, and only upon being adopted as final actions by the board of directors.

7.2 GROUNDS FOR HEARING

Except as otherwise specified in these bylaws, any one or more of the following adverse actions shall constitute grounds to request a hearing:

(a) denial of initial medical staff appointment or requested reappointment to the medical staff, based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;

(b) denial of requested clinical privileges based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;

(c) summary suspension of staff membership or staff privileges for greater than fourteen (14) days;

(d) termination or revocation of medical staff membership or clinical privileges based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;

(e) involuntary reduction or restriction of clinical privileges or membership for thirty (30) days or more in any twelve (12) month period; or

(f) any other disciplinary action or recommendation that must be reported, by law, to the practitioner's California licensing authority under Business and Professions Code Section 805.

7.3 REQUESTS FOR HEARING

7.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the practitioner shall be given prompt written notice of:

(a) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Medical Board of California and/or to the National Practitioner Data Bank, if required;

(b) a brief description of the reasons for the proposed action;

(c) the right to request a hearing pursuant to Section 7.3-3, and that such hearing must be requested in writing within thirty (30) days; and

(d) a summary of the rights granted in the hearing pursuant to the medical staff bylaws.

7.3-2 HEARINGS PROMPTED BY BOARD OF DIRECTORS ACTION

If the hearing is based upon an adverse decision or recommendation of the board of directors, the board of directors or its designee shall fulfill the duties assigned to the medical executive committee or the chief of staff when the medical executive committee is the body whose decision prompted the hearing. This shall include, but not be limited to, preparing the notice of adverse action or recommended action and right to a hearing, scheduling the hearing, providing the notice of hearing and statement of charges, and designating the judicial review committee, presenter and witnesses.

7.3-3 REQUEST FOR HEARING

The practitioner shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the medical executive committee with a copy to the board of directors. Any such request shall include the practitioner's intent with regard to representation. In the event the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

7.3-4 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the medical executive committee has thirty (30) days to schedule a hearing. The medical executive committee will give notice to the practitioner of the time, place and date of the hearing. The date of the commencement of the hearing shall be not be more than sixty (60) days from the date of receipt of the request by the medical executive committee for a hearing, so long as the practitioner has at least thirty (30) days from the date of notice to prepare for the hearing, or both parties mutually agree to an earlier date. When the request is received from a practitioner who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made.

7.3-5 NOTICE OF HEARING AND NOTICE OF REASONS OR CHARGES

Together with the notice stating the place, time and date of the hearing, the chief of staff or designee on behalf of the medical executive committee shall provide the reasons for the recommended action, including the acts or omissions with which the practitioner is charged and a list of the charts in question, where applicable.

7.3-6 JUDICIAL REVIEW COMMITTEE

When a hearing is granted, the medical executive committee shall recommend a judicial review committee. The judicial review committee shall be composed of not less than three (3) members of the active medical staff. The judicial review committee members shall be unbiased, shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, initial decision-makers or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the medical staff from serving as a member of the judicial review committee. In the event that it is not feasible to appoint a judicial review committee from the active medical staff, the medical executive committee may appoint members from other staff categories or practitioners who are not members of the medical staff. Such appointment shall include designation of the chair. The judicial review committee shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the practitioner. All other judicial review committee members shall have MD or DO degrees or equivalent license.

7.3-7 FAILURE TO APPEAR OR PROCEED

Failure without good cause of the practitioner to personally attend and proceed at such a hearing in an efficient and orderly manner shall be grounds for termination of the hearing and shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

7.3-8 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws may be permitted by the officer presiding over the hearing on a showing of good cause, or upon agreement of the parties.

7.4 HEARING PROCEDURE

7.4-1 PREHEARING PROCEDURE

(a) If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, and in no event less than ten (10) days before commencement of the hearing, each party shall furnish to the other a written list of the names of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. Failure to disclose the identity of a witness at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance.

(b) At least thirty (30) days prior to the hearing, the practitioner may receive copies of documents or other evidence relevant to the charges which the medical executive committee possess or controls. The medical executive committee may inspect and copy at least thirty (30) days prior to the hearing, any documents or other evidence relevant to the charges which the practitioner possesses or controls as soon as practicable after receiving the request. The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable practitioners, other than the practitioner under review.

(c) The practitioner and the medical executive committee shall have the right to receive all evidence which will be made available to the judicial review committee. Failure to produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance.

(d) The hearing officer (see Section 7.4-3) shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:

(1) whether the information sought may be introduced to support or defend the charges;

(2) the exculpatory or inculpatory nature of the information sought, if any;

(3) the burden imposed on the party in possession of the information sought, if access is granted; and

(4) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(e) The practitioner shall be entitled to a reasonable opportunity to question and challenge the impartiality of judicial review committee members and the hearing officer. Challenges to the

impartiality of any judicial review committee member shall be ruled on by the hearing officer. Challenges the impartiality of the hearing officer shall be ruled on by the hearing officer.

(f) It shall be the duty of the practitioner and the medical executive committee or its designee to exercise reasonable diligence in notifying the chair of the judicial review committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

7.4-2 REPRESENTATION

The hearings provided for in these bylaws are for the purpose of intraprofessional resolution of matters bearing on professional conduct, professional competency, or character. The parties may be represented by legal counsel.

In all instances, the chief of staff or another physician designated by the medical executive committee shall have the authority to:

(a) be present during all phases of the hearing process;

(b) to make decisions regarding the detailed contents of the notice of reasons or charges;

(c) to make decisions regarding the presentation of testimony and exhibits;

(d) to direct the activities of the medical executive committee's attorney, if any;

(e) to consult with prospective and designated witnesses for the medical executive committee; and

(f) to amend the notice of reasons or charges as he or she seems warranted during the course of the proceedings, subject to the practitioner's procedural rights.

However, the medical executive committee's representative shall not have the authority to modify the nature of the medical executive committee's action or recommendation without the medical executive committee's approval.

7.4-3 THE HEARING OFFICER

The medical executive committee shall recommend a hearing officer to the board of directors to preside at the hearing. The board of directors shall be deemed to approve the selection unless it provides prompt written notice to the medical executive committee stating the reasons for its objections. The hearing officer shall be an attorney-at-law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the district, the medical staff or the involved practitioner or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting

evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances, in accordance with California law. If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

7.4-4 RECORD OF THE HEARING

A court reporter shall be present to make a thorough and accurate record of the hearing proceedings, and the prehearing proceedings, if deemed appropriate by the hearing officer. The cost of attendance of the recorder shall be borne by the district, but the cost of the transcript, if any, shall be borne by the party requesting it. The judicial review committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by a person lawfully authorized to administer such oath.

7.4-5 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The practitioner may be called by the medical executive committee (or its designee) and examined as if under cross-examination.

7.4-6 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The judicial review committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the judicial review committee may request both sides to file written arguments. The hearing process shall be completed within a reasonable time after the notice of the action is received, unless the hearing officer issues a written decision that the practitioner or the medical executive committee failed to provide information in a reasonable time or consented to the delay.

7.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

(a) At the hearing the medical executive committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The practitioner may present evidence in response.

(b) An applicant shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and privileges. An applicant shall not be

permitted to introduce information requested by the medical staff but not produced during the application process or corrective action proceedings, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided above for applicants, throughout the hearing, the medical executive committee shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

7.4-8 ADJOURNMENT AND CONCLUSION

After consultation with the chair of the judicial review committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the medical executive committee and the practitioner may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

7.4-9 BASIS FOR DECISION

The decision of the judicial review committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the judicial review committee shall be subject to such rights of appeal as described in these bylaws.

7.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the judicial review committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the medical executive committee. If the practitioner is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the administrator, the board of directors, and to the practitioner. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. Both the practitioner and the medical executive committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the judicial review committee shall be subject to such rights of appeal or review as described in these bylaws.

7.5 APPEAL

7.5-1 TIME FOR APPEAL

Within ten (10) days after receipt of the decision of the judicial review committee, either the practitioner or the medical executive committee may request an appellate review. A written request for such review shall be delivered to the chief of staff, the administrator, the other party in the hearing, and a copy provided to the board of directors. If a request for appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the medical staff.

7.5-2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

(a) substantial non-compliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice;

(b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5-5; or

(c) the judicial review committee failed to sustain an action or recommendation from the medical executive committee, that, based on the evidence in the hearing record, was reasonable and warranted.

7.5-3 APPEAL BOARD

The board of directors may sit as the appeal board, or it may delegate that function to an appeal board which shall be composed of not less than three (3) individuals designated by the board of directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the board of directors shall be neither the attorney firm that represented either party at the hearing before the judicial review committee nor the attorney who assisted the hearing panel or served as hearing officer.

7.5-4 TIME, PLACE AND NOTICE

The appeal board shall, within thirty (30) days after receipt of request for appellate review, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The appellate review shall commence within sixty (60) days from the date of such request for appellate review, provided however, that when a request for appellate review concerns a practitioner who is under suspension which is then in effect, the appellate review should commence within forty-five (45) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the appeal board for good cause.

7.5-5 APPEAL PROCEDURE

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the judicial review committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the judicial review committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal board may remand the matter to the judicial review committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence

of the appellant and respondent and their representatives. The appeal board shall present to the board of directors its written recommendations as to whether the board of directors should affirm, modify, or reverse the judicial review committee decision consistent with the standard set forth in Section 7.5-6, or remand the matter to the judicial review committee for further review and decision.

7.5-6 DECISION

(a) Except as provided in Section 7.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the board of directors shall render a final decision. The board of directors may affirm, modify, reverse the decision or remand the matter for further review by the judicial review committee or any other body designated by the board of directors for reconsideration stating the purpose for the referral. The board of directors shall give great weight to the judicial review committee findings and shall not act arbitrarily or capriciously. The board of directors may, however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision was reasonable and warranted, and whether any bylaw or policy relied upon by the judicial review committee is unreasonable and unwarranted. The decision shall be in writing, shall specify the reasons for the action taken, and shall provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from those of the judicial review committee. If the board of directors determines that the practitioner was not afforded a fair hearing in compliance with the bylaws, the board of directors shall remand the matter.

(b) If the matter is remanded to the judicial review committee or other body designated by the board of directors for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the board of directors. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the board of directors and the judicial review committee.

(c) The appeal board's decision shall constitute the final decision of the district. Any recommendation affirmed by the appeal board shall become effective immediately. The decision reached shall be forwarded to the chief of staff, the medical executive and credentials committees, the subject of the hearing, and the administrator.

7.5-7 RIGHT TO ONE HEARING

Except in circumstances where a new hearing is ordered by the board of directors or a court because of procedural irregularities or otherwise for reasons not the fault of the practitioner, no practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

7.6 EXCEPTION TO HEARING RIGHTS

7.6-1 AUTOMATIC ACTION BASED UPON ACTIONS TAKEN BY ANOTHER PEER REVIEW BODY

(a) The medical executive committee shall be empowered to:

(1) use as a basis for disqualification from membership and/or privileges, or

(2) automatically impose

any adverse action that has been taken within the preceding thirty-six (36) months by another peer review body (as that term is used in the federal or California laws) after that action is considered final and the action was taken in conformance with California Business & Professions Code section 809 et seq. For purposes of this Section, an action shall be considered final when the practitioner has completed the hearing, appeal and judicial proceedings related to the action.

(b) The practitioner shall not be entitled to any hearing or appeal unless the medical executive committee takes an action that is more restrictive than the final action taken by the original peer review body. Any hearing and appeal that is requested by the practitioner shall not address the merits of the action taken by the original peer review body, which were already reviewed at the original peer review body's hearing, and shall be limited to only the question of whether the automatic action is more restrictive than the original peer review body's action.

(c) Nothing in this Section shall preclude the medical staff or board of directors from taking a more restrictive action than another peer review body based upon the same facts or circumstances.

ARTICLE VIII: ADVANCED PRACTICE PROVIDERS

8.1 QUALIFICATIONS OF ADVANCED PRACTICE PROVIDERS

Advanced Practice Providers (APPs) are non-physician practitioners who are eligible to apply for privileges at Northern Inyo Healthcare District. APPs are not eligible for medical staff membership as described in California state law. They may be granted practice privileges if they hold a license, certificate or other credentials in a category of APPs that the board of directors (after securing medical executive committee recommendation) has identified as eligible to apply for practice privileges, and only if the APPs are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the medical staff bylaws as demonstrated by the medical staff ongoing and focused professional practice evaluation process.

8.2 CATEGORIES

The board of directors may determine, based upon recommendation of the medical executive committee and such other information as it has before it, those categories of APPs that shall be eligible to exercise privileges at Northern Inyo Healthcare District. Such APPs shall be subject to the supervision requirements developed and approved by the interdisciplinary practice committee, the medical executive committee, and the board of directors.

8.3 PRIVILEGES

(a) APPs may exercise only those setting-specific privileges granted to them by the board of directors. The range of privileges for which each APP may apply, and any special limitations or conditions to the exercise of such privileges, shall be based on recommendations of the interdisciplinary practice committee, subject to approval by the credentials committee, the medical executive committee and the board of directors.

(b) An APP must apply and qualify for practice privileges. Applications for initial granting of practice privileges and biennial renewal thereof shall be submitted and processed in a similar manner to that provided for medical staff members, unless otherwise specified in medical staff policies.

(c) Each APP shall be subject to terms and conditions similar to those specified for medical staff members as they may logically be applied to APPs and appropriately tailored to the particular APP.

8.4 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

The prerogatives which may be extended to an APP shall be defined in medical staff and/or district policies. Such prerogatives may include:

(a) Provision of specified patient care services; which services may be provided independently or under the supervision or direction of a medical staff member and consistent with the practice privileges granted to the APP and within the scope of the APP's licensure or certification.

(b) Participation in the open session of general meetings of the medical staff in a non-voting role.

(c) Being a voting participant at departmental committees appropriate to their specialty, which vote shall be limited to the following:

(1) Departmental policies, procedures, or other matters specific to the APP's line of practice; and

(2) Election of department chief.

(d) Attendance at district and medical staff education programs.

Additionally, each APP shall:

(a) Meet those responsibilities required by applicable policies and as specified in the bylaws, Section 2.5, and as they may be logically applied to reflect the scope of practice of the APP.

(b) Retain appropriate responsibility within the APPs area of professional competence for the care and supervision of each patient in the district for whom the APP is providing services.

(c) Participate in peer review of other APPs as appropriate, participate in quality improvement and discharge such other functions as may be required from time to time.

8.5 PROCEDURAL RIGHTS OF ADVANCED PRACTICE PROVIDERS

8.5-1 GRIEVANCE RIGHTS AFTER ADVERSE ACTIONS

Except as otherwise provided in this Section with respect to automatic termination or other matters, an APP shall have the right to utilize the grievance hearing process set forth in this Section in order to challenge any action that, if taken against a medical staff member, would be an adverse action constituting grounds for a procedural rights hearing pursuant to these bylaws. However, nothing contained in these bylaws shall be interpreted to entitle an APP to procedural rights, including, but not limited to, a procedural rights hearing or appellate review to which a medical staff member may be entitled.

An APP may challenge such adverse action by filing a written grievance with the medical executive committee no later than fifteen (15) days after such action. Upon receipt of such a grievance, the medical executive committee or its designee shall conduct an investigation that shall afford the APP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a "hearing" pursuant to the bylaws and shall not be conducted according to the procedural rules applicable to such hearings as set forth in Article VII. Before the interview, the APP shall be informed of the general nature and circumstances giving rise to the action, and the APP may present information relevant thereto at the interview. A record of the interview shall be made. The medical executive committee or its designee shall make a decision and recommendation for final action based on the interview and all other information available to it, and shall submit a written report of its recommendation, decision, and statement of basis for it to the board of directors. After receipt of the medical executive committee report, the board of directors shall take final action on the matter.

8.5-2 EMPLOYMENT BY THE DISTRICT

If the APP is an employee of Northern Inyo Healthcare District, disciplinary actions related to the terms and conditions of employment of the APP shall be governed by applicable human resources policies.

8.5-3 AUTOMATIC TERMINATION

(a) Notwithstanding the provisions of Section 8.5-1, an APP's privileges shall automatically terminate without review if the APP's certification or license expires, is revoked, or is suspended.

(b) Notwithstanding the provisions of Section 8.5-1, an APP's privileges may be subject to termination following review by the interdisciplinary practice committee and medical executive committee if no appropriate supervising practitioner is available because:

(1) The medical staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary and no other member is able or willing to function as the supervising practitioner; or

(2) The supervising practitioner no longer agrees to act as the supervising practitioner for any reason, or the relationship between the APP and the supervising practitioner is otherwise terminated, regardless of the reason thereof and no other member is able or willing to function as the supervising practitioner.

(c) Additionally, APPs are subject to the automatic action provisions of Section 6.4 of these bylaws.

8.5-4 REVIEW OF CATEGORY DECISIONS

The grievance rights afforded by this Section shall not apply to any decision regarding whether a category of APP shall or shall not be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the board of directors, which has the discretion to decline to review the request or to review it using any procedure the board of directors deems appropriate.

ARTICLE IX: OFFICERS

9.1 OFFICERS OF THE MEDICAL STAFF

9.1-1 IDENTIFICATION

The officers of the medical staff shall be the chief of staff, vice chief of staff, immediate past chief of staff, and member-at-large. In addition, the medical staff's department chiefs shall be deemed medical staff officers within the meaning of California law.

9.1-2 QUALIFICATIONS

Officers must be members of the active medical staff at the time of their nomination and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

Additionally, the chief of staff must have previously served on the medical executive committee in some capacity for at least one term.

9.1-3 NOMINATIONS

(a) The medical staff election year shall be every two years.

(b) The medical executive committee shall nominate one or more nominees for the office of chief of staff and may nominate one or more nominees for member-at-large to be filled at the time of elections. The medical executive committee shall give notice of the nominations to members eligible to vote on the officers no later than thirty (30) days prior to the election.

(c) Nominations may also be made by any member entitled to vote by submitting a written nomination to the medical staff office. A member may also nominate him- or herself, provided that he or she qualifies for such office.

(d) All nominees for election shall disclose in writing to the medical staff those current or impending personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the district, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.

9.1-4 ELECTIONS

The chief of staff and member-at-large shall be elected by written ballot sent to eligible members prior to the end of the medical staff year during which an election is held. Whenever feasible, the election shall be held three (3) to six (6) months prior to the end of the medical staff year so as to give the newly elected officer the opportunity to begin transitioning into the role. Voting shall be by written ballot submitted to the medical staff office or via electronic vote. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the medical executive committee

shall decide the election by written ballot at its next meeting or a special meeting called for that purpose.

9.1-5 TERM OF ELECTED OFFICE

The chief of staff shall serve a two (2) year term, commencing on the first day of the medical staff year following the election. The chief of staff shall be eligible to serve consecutive terms.

The vice chief of staff, immediate past chief of staff, and member-at-large shall serve a one (1) year term. The vice chief of staff and member-at-large shall be eligible to serve consecutive terms.

Each officer shall serve until the end of that officer's term, unless that officer resigns or is removed from office.

9.1-6 RECALL OF OFFICERS

Any medical staff officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a medical staff officer may be initiated by the medical executive committee or by a petition signed by at least one-third of the members of the active medical staff presented to the medical executive committee or chief of staff. Recall shall require a majority vote of the medical executive committee. A special meeting may be called for this purpose.

At least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the medical executive committee prior to a vote on removal. This provision does not include actions such as summary suspension where such timeline may not be feasible.

9.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies shall be filled by appointment by the chief of staff with consultation with the medical executive committee until the next regular election, except for the member-at-large, which may remain vacant.

9.2 DUTIES OF OFFICERS

9.2-1 CHIEF OF STAFF

The chief of staff shall serve as the chief officer of the medical staff. With the assistance of the medical executive committee where appropriate, the duties required of the chief of staff (or designee, as allowed by the bylaws) shall include, but not be limited to:

(a) enforcing the medical staff bylaws and policies, implementing sanctions where indicated in consultation with the medical executive committee, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

(b) calling, presiding at, and being responsible for the agenda of all general meetings of the medical staff;

(c) serving as chair of the medical executive committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

(d) in the interim between medical executive committee meetings, performing those responsibilities of the committee that, in the chief of staff's opinion, must be performed prior to the next regular or special meeting of the committee;

(e) serving as an ex-officio member of all other staff committees without vote, unless chief of staff membership in a particular committee is required by these bylaws;

(f) interacting with the administrator and board of directors in all matters of mutual concern within the district;

(g) representing the views and policies of the medical staff to the board of directors, the administrator, and chairing the joint conference committee as indicated in these bylaws;

(h) regularly reporting to the board of directors on the performance of medical staff functions and communicating to the medical staff any concerns expressed by the district board;

(i) being a spokesperson for the medical staff in external professional and public relations;

(j) serving on liaison committees with the board of directors and administration, as well as outside licensing or accreditation agencies;

(k) performing such other functions as may be assigned to the chief of staff by the bylaws, the medical staff, or the medical executive committee.

9.2-2 VICE CHIEF OF STAFF

The vice chief of staff shall serve a one (1) year term and is selected from among the current department chiefs serving on the medical executive committee. The vice chief of staff shall assume all duties and authority of the chief of staff in the absence of the chief of staff and shall perform such other duties as may be assigned. The vice chief of staff will serve as chair of the medical staff quality improvement committee and participate in the district quality improvement committees, as described in the district quality plan.

9.2-3 IMMEDIATE PAST CHIEF OF STAFF

The immediate past chief of staff will remain a member of the medical executive committee for one (1) year, and shall attend at least the first three (3) consecutive months of their term to assure a smooth transition with the change in leadership and longer as deemed necessary. The immediate past chief of staff shall perform such other duties as may be assigned.

9.2-4 MEMBER-AT-LARGE

The member-at-large shall be a member of the medical executive committee and shall perform duties as may be assigned.

ARTICLE X: CLINICAL DEPARTMENTS

10.1 ORGANIZATION OF CLINICAL DEPARTMENTS

The active medical staff shall be organized into clinical departments. Each department shall be organized as a separate component of the medical staff and shall have a chief selected and entrusted with the authority, duties, and responsibilities specified in this Article. When appropriate, or at the recommendation of the departmental committee, the medical executive committee may approve the creation, elimination, modification, or combination of departments.

Department committees, as described in Article XI, may represent a single clinical department or a combination of clinical departments as appropriate.

Additional medical or surgical specialties not currently listed as a department will be assigned to an existing department through the credentialing and privileging process.

10.2 DEPARTMENTS

The clinical departments under these bylaws are:

(a) Anesthesia

(b) Emergency Medicine

(c) Surgery (including Pathology)

(d) Inpatient Medicine

(e) Obstetrics & Gynecology

(f) Orthopedic Surgery (including Podiatry)

(g) Outpatient Medicine

(h) Pediatrics

(i) Radiology

10.3 ASSIGNMENT TO DEPARTMENTS

Each privileged practitioner shall be assigned membership based on specialty or board certification in at least one department, but may also be granted membership and/or clinical privileges in other departments consistent with practice privileges granted.

10.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

(a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department, as per the medical staff's policy on ongoing and focused professional practice evaluation.

(b) Recommending to the medical executive committee guidelines for the granting of clinical privileges and the performance of specified services within the department.

(c) Evaluating and making appropriate recommendations to the credentials committee and the medical executive committee regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department.

(d) Reviewing and evaluating departmental adherence to: (1) medical staff and district policies and procedures, (2) sound principles of clinical practice, and (3) quality improvement.

(e) Coordinating with nursing and ancillary staff in regards to patient care provided by the department's members with nursing and ancillary patient care services.

(f) Reporting to the departmental committee concerning: (1) the activities of the department, and (2) recommendations for maintaining and improving the quality of care provided in the department and the district.

(g) Meeting regularly for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions.

(h) Taking appropriate action when problems in patient care and clinical performance or opportunities to improve care are identified.

(i) Formulating departmental policies/procedures as reasonably necessary for the proper discharge of its responsibilities subject to the approval by the medical executive committee.

10.5 DEPARTMENT CHIEFS

10.5-1 QUALIFICATIONS

Each department shall have a chief who shall be a member of the active staff and shall be qualified by licensure, training, experience and demonstrated ability in at least one of the clinical areas covered by the department. If required by applicable California regulations or other law, the department chief must be certified by an appropriate specialty board or eligible for certification by an appropriate specialty board. Otherwise, the department chief shall possess comparable competence as affirmatively established through the peer review process.

10.5-2 SELECTION

The department chief shall be elected by the voting members of their department. In the event of a tie vote, the chief will be appointed by vote of the medical executive committee. Departments with a single member will automatically have the single member designated as chief. Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt.

The medical director of the department may be eligible to serve as the department chief, if so elected. If after election, the department chief becomes the administratively-appointed medical director of his or her department, a re-election will be held at the next departmental meeting.

10.5-3 TERM OF OFFICE

Each department chief shall serve a one (1) year term which coincides with the medical staff year or until his or her successor is chosen, unless he or she shall sooner resign, be removed from office, or lose his or her medical staff membership or clinical privileges in that department. Department chiefs shall be eligible to serve consecutive terms.

10.5-4 REMOVAL

Removal of department chiefs from office may occur for cause by a two-thirds vote of the department members. The medical executive committee may remove department chiefs in the course of a corrective action proceeding as indicated.

10.5-5 DUTIES

Each chief shall have the following authority, duties and responsibilities, and shall otherwise perform such duties as may be assigned:

(a) oversee the quality of patient care, professional performance and behaviors rendered by practitioners with clinical privileges in the department and designate proctors as necessary;

(b) assign a member of the medical staff to assume responsibility for duties and/or the care of another member's patients in the event the member is unable to fulfill their obligations due to termination of privileges, illness, or similar extenuating circumstances;

(c) enforce the medical staff bylaws and medical staff and district policies within the department;

(d) implement within the department appropriate actions taken by the medical executive committee;

(e) coordinate with district administration, department medical director (if any), and nursing services in matters relevant to the department;

(f) perform such other duties commensurate with the office as may from time to time be reasonably requested by the chief of staff or the medical executive committee.

ARTICLE XI: COMMITTEES

11.1 DESIGNATION

The medical executive committee and the other committees described in these bylaws shall be the standing committees of the medical staff. Special or ad hoc committees may be created by the medical executive committee or the chief of staff to perform specified tasks. Any committee that is carrying out all or any portion of a function or activity required by these bylaws is deemed a duly-appointed and authorized committee of the medical staff.

11.2 GENERAL PROVISIONS

11.2-1 APPOINTMENT OF COMMITTEE MEMBERS AND CHAIRS

The chair and members of committees shall be designated as per the bylaws. If not specified in the bylaws, the chair and members of committees shall be appointed by and may be removed by the chief of staff, subject to consultation with the medical executive committee. Medical staff committees shall be responsible to the medical executive committee. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

The administrator, or his or her designee, shall appoint any non-medical staff committee members who are not otherwise designated by title in the provision or resolution creating the committee.

The removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

11.2-2 COMMITTEE COMPOSITION

Except as otherwise provided in the bylaws, committees established to perform medical staff functions required by these bylaws may include any category of: medical staff members; advanced practice providers; representatives from district services such as administration, nursing services, or medical records; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each active medical staff member and advanced practice provider who serves on a committee participates with vote unless the statement of committee composition provides for designation of the position as non-voting.

11.2-3 REPRESENTATION ON DISTRICT COMMITTEES AND PARTICIPATION IN DELIBERATIONS

The medical staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing medical staff representation on district committees established to perform such functions. The medical executive committee will be responsible for providing a medical staff or APP representative on district committees when requested by the board or administration.

11.2-4 EX-OFFICIO MEMBERS

The chief of staff and the administrator are ex-officio members of all standing and special committees of the medical staff. They and all other persons designated to serve as ex-officio committee members shall serve without vote unless provided otherwise in the provision or resolution creating the committee.

11.2-5 ACTION THROUGH SUBCOMMITTEES

Any medical staff standing committee may establish subcommittees to assist in carrying out its duties, in addition to any such subcommittees established by the medical executive committee or expressly designated in the bylaws. A subcommittee shall be composed of one or more voting members of the standing committee. The medical executive committee shall be informed when a subcommittee is established. The committee chair may also appoint individuals to serve as non-voting subcommittee members, after consulting with, and subject to the approval of, the chief of staff regarding medical staff members, and the administrator regarding district personnel. An ad hoc committee is not considered a subcommittee.

11.2-6 TERM OF COMMITTEE MEMBERS

The term of committee members shall be as designated in the bylaws. If not specified, a committee member shall be appointed for a term of one year, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee.

11.2-7 COMMITTEE VACANCIES

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

11.2-8 LIMITATION OF ATTENDANCE AT COMMITTEE MEETINGS

Unless otherwise specified in the bylaws, any privileged practitioner who is in good standing may be permitted to attend any portion of a medical staff committee's meeting dealing with a matter of importance to that practitioner even though the practitioner is not a member of the committee. However, the committee chair or the chief of staff shall have the discretion to deny entry to the meeting to such practitioner, or to request any nonmember to leave the meeting. Any such nonmember who attends shall abide by all bylaws applicable to that committee.

In addition, during any portion of a committee meeting when the committee is conducting peer review and chart review functions with respect to specific medical staff members, applicants, or other practitioners or advanced practice providers, attendance at the committee's meeting shall be restricted to (a) privileged practitioners who are members of the committee, and (b) any medical staff member or other person whom the committee has invited or requested to attend to assist in the functions (but only for the portion of the meeting designated by the committee or the committee chair).

The committee chair, after consulting with the chief of staff and administrator, may call on outside consultants or other special advisors to assist the committee in fulfilling its duties and allow such special advisors to attend committee meetings related to the assistance they are providing, but such advisors shall not be deemed members of the committee.

Any nonmember who attends a committee meeting shall be deemed to have agreed, by his or her presence at the meeting, to maintain the confidentiality of and to refrain from any unauthorized disclosure to other persons of the committee's records, deliberations, and proceedings.

11.2-9 ACCOUNTABILITY

All medical staff committees shall be accountable to the medical executive committee.

11.3 MEDICAL EXECUTIVE COMMITTEE

11.3-1 COMPOSITION

The medical executive committee shall be composed of the chief of staff, vice chief of staff, immediate past chief of staff, department committee chairs, and a member-at-large, if elected. The chief of staff shall chair and preside over the medical executive committee. The administrator and the chief nursing officer shall be a non-voting ex-officio members.

11.3-2 DUTIES

With the assistance of the chief of staff and/or the use of ad hoc committees as appropriate, the medical executive committee shall:

(a) represent and act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws;

(b) ensure the medical staff fulfills its responsibilities to the district board as per the district bylaws;

(c) monitor, evaluate, and supervise the performance of all medical staff functions, including conducting an annual review of medical staff policies;

(d) review, evaluate, or take other appropriate action for matters related to the competence and other qualifications of privileged practitioners or practitioners applying for privileges;

(e) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all privileged practitioners and when indicated, initiate and/or pursue disciplinary or corrective actions affecting privileged practitioners, as provided in the bylaws;

(f) ensure medical staff's knowledge of and compliance with the medical staff bylaws and policies; the district's bylaws, rules, and policies; state and federal laws and regulations; and other accreditation requirements;

(g) oversee the development of medical staff policies, approve (or disapprove) all such policies, and oversee the dissemination and implementation of all such policies following their approval by the medical staff;

(h) implement, as they relate to the medical staff, the approved policies, procedures, standards, and rules of the district, including, without limitation, the Compliance program (which program relates to Medicare and Medi-Cal fraud and abuse matters); the district confidentiality policies and procedures related to compliance with applicable law, including but not limited to the federal Health Insurance Portability and Accountability Act ("HIPAA")

and the California Medical Information Act; and the district medical error reporting program, including without limitation, applicable disclosure and reporting protocols.

(i) provide liaison between the medical staff, the administrator and the district board by regularly reporting to the district board and to the medical staff;

(j) make recommendations to the district board regarding medical staff structure, membership and privileges requirements, application, disciplinary, and hearing procedures, peer review and quality assessment and improvement activities, and other aspects of medical staff affairs addressed in the medical staff bylaws;

(k) make recommendations to administration in the selection of and assignment of responsibilities to department medical directors or other practitioners contracted by the district to provide administrative services;

(l) review and make recommendations to the administrator regarding quality of care issues related to specified clinical services contract arrangements for professional medical services;

(m) participate and provide information when requested in district proceedings involved with making specified clinical services contracting decisions;

(n) establish, as needed, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the medical executive committee;

(o) appoint committee members for all standing committees, all special medical staff, liaison, or multi-disciplinary committees, and designating the chairs of these committees, except where otherwise provided by these bylaws; and

(p) recommend the amount of annual dues for each medical staff membership category, subject to medical staff approval, and recommend the manner of expenditure of dues funds, subject to the committee's acknowledgment that such expenditures must be consistent with applicable law regarding such expenditures.

11.3-3 MEETINGS

The medical executive committee should be scheduled to meet on a monthly basis and shall meet at least ten (10) times during the medical staff year.

11.4 QUALITY IMPROVEMENT COMMITTEE

11.4-1 COMPOSITION

The quality improvement committee shall consist of the members of the medical executive committee. The administrator and the chief nursing officer shall be ex-officio non-voting members. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity. The chair shall be the vice chief of staff.

11.4-2 DUTIES

The quality improvement committee shall be responsible for overall supervision of patient care services quality monitoring, assessment, and improvement activities and accordingly shall:

(a) in collaboration with the district, oversee the development and implementation of a district-wide quality improvement plan and perform an annual review and recommend revisions as needed;

(b) carry out the duties as described in the district quality improvement plan;

(c) review quality improvement reports from department chiefs, committees, and other medical staff patient care review activities; and

(d) refer problems for assessment and corrective action to appropriate departments or committees.

11.4-3 MEETINGS AND REPORTS

The medical staff quality improvement committee should be scheduled to meet on a monthly basis and shall meet at least ten (10) times during the medical staff year.

11.5 BYLAWS COMMITTEE

11.5-1 COMPOSITION

The bylaws committee shall be composed of at least three (3) active staff members.

11.5-2 DUTIES

The bylaws committee shall make reasonable efforts to assure that the medical staff bylaws and policies adequately and accurately reflect the current structure and practices of the medical staff and comply with applicable legal requirements by:

(a) conducting an annual review of the bylaws;

(b) developing and submitting proposals for bylaws changes to the medical executive committee and to the medical staff in accordance with bylaws procedures;

(c) receiving, evaluating, and making recommendations with respect to bylaws or policies proposals made by the executive committee, department chiefs, member petition or other sources; and

(d) engaging in such other activities as reasonably appropriate for fulfilling these and other functions as specified in the bylaws or policies.

11.5-3 MEETINGS AND REPORTS

The bylaws committee will meet at least annually and otherwise as requested by the bylaws committee chair or chief of staff. The committee shall report its activities and recommendations at least annually to the medical executive committee.

11.6 CREDENTIALS COMMITTEE

11.6-1 COMPOSITION

The credentials committee shall be composed of at least five (5) active staff members, selected on a basis that will ensure insofar as feasible, representation of the clinical departments and the major

clinical specialties which are routinely practiced by privileged practitioners at Northern Inyo Healthcare District.

11.6-2 DUTIES

The credentials committee shall evaluate and make recommendations with respect to the qualifications of all applicants for medical staff appointment, reappointment, privileges, and changes in staff categories, and fulfill other functions as specified in the bylaws or policies.

11.6-3 MEETINGS AND REPORTS

The credentials committee shall meet at least quarterly, or as often as necessary as determined and called by the committee chair, the chief of staff, or the medical staff office. The committee shall report its activities and recommendations with respect to applicants as specified in the bylaws and shall otherwise report the status of pending applications and its activities to the medical executive committee.

11.7 INFECTION CONTROL COMMITTEE

11.7-1 COMPOSITION

The infection control committee shall be composed of at least three (3) privileged practitioners, at least two (2) of which shall be active staff members. Ex-officio members serving without vote shall include the infection prevention nurse, the administrator (or the administrator's designee), and a representative from the clinical laboratory (bacteriology). In addition, representatives from areas such as, but not limited to, the employee health, dietary, respiratory therapy, and environmental service departments may be invited to attend and participate in discussion without vote. The chair of the infection control committee shall be required to complete the necessary infection control training as mandated per state regulations.

11.7-2 DUTIES

The duties of the infection control committee shall include assisting the district in:

(a) developing a hospital-wide infection control program and maintaining surveillance over the program;

(b) developing a system for reporting, identifying and analyzing the incidence and cause of healthcare-associated infections, including assignment of responsibility for the ongoing collection and analytic review of such data;

(c) monitoring implementation of corrective actions for healthcare-associated infections, and making recommendations to eliminate future such infections;

(d) developing and implementing a preventative and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

(e) developing written policies defining special indications for isolation requirements;

(f) coordinating actions on findings from the medical staff's review of the clinical use of antibiotics;

(g) taking such actions as reasonably necessary to assure infection control compliance with regulatory agencies and with established guidelines such as those of the Center for Disease Control and APIC (Association for Professionals in Infection Control and Epidemiology); and

(h) reviewing sensitivities of organisms specific to the facility.

11.7-3 MEETINGS

The infection control committee shall meet at least quarterly. The committee, or a representative of the committee, shall provide to the medical executive committee and the quality improvement regular reports of the committee's activities.

11.8 INTERDISCIPLINARY PRACTICE COMMITTEE

11.8-1 COMPOSITION

The interdisciplinary practice committee (IDPC) shall be composed of:

(a) an equal number of medical staff members who are physicians and nursing staff who are registered nurses;

(b) the lead advanced practice provider;

(c) the chief nursing officer; and

(d) the administrator (or the administrator's designee, who may not be a registered nurse or a physician medical staff member).

The medical executive committee shall appoint the physician members and designate one of them as the chairperson. The chief nursing officer shall appoint the nursing staff members. In addition, representatives in the categories of advanced practice providers granted privileges in the district may serve as consultants on an as-needed basis, and shall participate, when requested and feasible, in the committee proceedings when a member of the same APP category is applying for privileges.

11.8-2 DUTIES

The IDPC functions to establish, implement, monitor, and evaluate policies and procedures for interdisciplinary medical practice pursuant to Title 22, California Code of Regulations, Sections 70706 and 70706.2, other applicable law, and the bylaws. IDPC duties shall include, but not necessarily be limited to, the standardized procedures and credentialing duties as set forth below in this Section.

(a) **STANDARDIZED PROCEDURE DUTIES:**

(1) The IDPC shall develop and review standardized procedures that apply to nurses or APPs, identify functions that are appropriate for standardized procedures, initiate such procedures, and review and approve standardized procedures in accordance with applicable licensure regulations, such as Title 22, California Code of Regulations, Sections 70706 and 70706.2, other applicable law, and the bylaws.

(2) Request for development of standardized procedures may be initiated by the administrator, the chief nursing officer, the medical executive committee, the chief of staff, the appropriate department chiefs, the affected registered nurses or APPs, or supervising practitioners.

(3) Prior to approval of new or amended standardized procedures, the IDPC shall obtain consultation and recommendations from the department chief(s), other appropriate medical staff members, and nonmedical staff members who practice in the clinical field or medical or nursing specialties under review as subject of the proposed standardized procedures.

(4) Standardized procedures shall be reviewed and approved by the IDPC, the medical executive committee, the administrator, and the board of directors in order to become effective.

(5) The IDPC may approve standardized procedures only by affirmative vote of the following IDPC members: the administrator (or the administrator's designee), a majority of the physician members, and a majority of the registered nurse members (including the chief nursing officer).

(6) The IDPC is responsible for assuring that standardized procedures are a collaborative effort among administrators and health professionals, including physicians and nurses. Each standardized procedure shall:

i. Be in writing and show the date or dates of each required approval, including approval by the IDPC;

ii. Specify which standardized procedure functions which registered nurses are authorize to perform and under what circumstances;

iii. State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure;

iv. Specify any experience, training, and/or special education requirements for performance of the standardized procedure functions;

v. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform the standardized procedure functions;

vi. Provide for a method of maintaining a written record of those persons authorized to perform the standardized procedure functions;

vii. Specify the nature and scope of review and/or supervision required for performance of the standardized procedure functions. For example, if the function is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated;

viii. Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition;

ix. State the limitations on settings or departments within the facility where the standardized procedure functions may be performed;

x. Specify any special requirements for procedures relating to patient recordkeeping; and

xi. Provide for a method of periodic review of the standardized procedure.

(b) **CREDENTIALING ADVANCED PRACTICE PROVIDERS DUTIES:**

(1) Upon request by the medical executive committee or the board of directors, or at its own initiative, the IDPC shall make recommendations regarding APP category eligibility, delineation of APP practice privileges, supervision requirements, and other such matters related to APP practice at the district.

(2) The IDPC shall review and evaluate APP applications and requests for privileges and forward its written report and recommendations to the appropriate department chief or credentials committee.

(3) The IDPC shall serve as liaison between APPs and the medical staff.

11.8-3 MEETINGS

The IDPC shall meet as often as needed, but at least annually. The committee shall report its activities and recommendations with respect to applicants as specified in the bylaws to the credentials committee.

11.9 JOINT CONFERENCE COMMITTEE

11.9-1 COMPOSITION

The joint conference committee shall be composed of two (2) members of the board of directors and two (2) members of the medical executive committee, one (1) of which shall be the chief of staff, and the other which shall be appointed by the medical executive committee. The administrator, or designee, shall be a non-voting, ex-officio member. The chair of the committee should alternate yearly between the board of directors and the medical staff; odd-numbered years will be the board of directors, and even-numbered years will be the medical staff.

11.9-2 DUTIES

The function of the joint conference committee is to serve as an official means of liaison between members of the board of directors, the district administration, and the medical staff. The joint conference committee shall act in an advisory function and provide a forum for:

(a) maintenance of effective communications to keep the board, medical staff, and the administrator cognizant of any pertinent actions taken or contemplated;

(b) planning for growth and development of the district and the medical staff;

(c) discussion of matters of district and medical staff policy, practice, and planning not related to peer review; and

(d) interaction between the board of directors and the medical staff on such matters as may be referred by the medical executive committee or the board of directors.

The joint conference committee shall meet on an ad hoc basis to act as a deliberative body as described below for:

(a) the resolution of conflicts or disputes between the medical staff and the board of directors or administration; and

(b) the resolution of any dispute related to the medical staff's rights or self-governance or discharge of medical staff responsibilities.

11.9-3 DISPUTE RESOLUTION PROCESS

All disputes between administration or the board of directors and the medical staff that have not been resolved by prior informal meetings and discussions shall be addressed to and mediated by the joint conference committee.

(a) Following written notice of a dispute needing mediation, the committee shall convene within fourteen (14) days after the next regularly scheduled district board meeting.
(b) The committee shall meet and confer in good faith to formulate a recommendation for mediation of the dispute.
(c) If the committee cannot reach a consensus, the committee may appoint an outside professional mediator as a member of the committee, and the mediator shall serve as the chair of the committee but shall have no vote. The parties shall cooperate to select the mediator from a list of candidates provided by services such as the Judicial Arbitration and Mediation Service or the American Arbitration Association. The cost of the mediator shall be covered by the district.

11.9-4 MEETINGS AND REPORTS

The committee shall meet at least semi-annually, but may also meet as needed on an ad-hoc basis as described above. The chief of staff, or designee, shall report the committee's activities or discussions to the medical executive committee and to the medical staff via email or at the next regularly scheduled meetings, as appropriate for the subject matter. Minutes shall be kept during meetings and a copy maintained at the district office and the medical staff office.

11.10 PHARMACY AND THERAPEUTICS COMMITTEE

11.10-1 COMPOSITION

The pharmacy and therapeutics committee shall be composed of at least three (3) active staff members, the pharmacy director (with vote), and the chief nursing officer or other nurse designated by the chief nursing officer (with vote). Ex-officio members serving without vote shall include the administrator, or

the administrator's designee, and a representative from clinical informatics. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

11.10-2 DUTIES

The duties of the pharmacy and therapeutics committee shall include:

(a) assisting in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage;

(b) advising the medical staff and the pharmaceutical service on matters pertaining to the choice of available drugs;

(c) making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(d) periodically reviewing and maintaining formulary or drug list for use in the hospital;

(e) evaluating clinical data concerning new drugs or preparations requested for use in the hospital;

(f) establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

(g) maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the medical executive committee concerning those activities; and

(h) reviewing untoward drug reactions.

11.10-3 MEETINGS

The pharmacy and therapeutics committee shall meet at least quarterly. The committee shall report a summary of its activities or findings to the medical executive committee and the quality improvement committee on a regular basis.

11.11 PHYSICIAN WELLNESS COMMITTEE

11.11-1 COMPOSITION

The physician wellness committee shall be composed of at least three (3) medical staff members, one (1) of whom should be a psychiatrist whenever feasible. Insofar as feasible, members of this committee shall not actively participate on other peer review, corrective action ad hoc committee, or quality improvement committees while serving on this committee.

11.11-2 DUTIES

The committee shall:

(a) Consider general matters related to the health and well-being of medical staff members and, with the approval of the medical executive committee or chief of staff, develop educational programs or staff events for promoting well-being.

(b) Educate staff on illness and impairment recognition issues specific to physicians.

(c) Review, evaluate, and make recommendations as appropriate or otherwise required by the bylaws:

(1) Voluntary disclosures to the committee by members or other practitioners regarding their health status;

(2) Health status referrals or reports from the chief of staff or other medical staff officer or committee regarding a member; and

(3) Responses from applicants concerning physical or mental disabilities.

(d) Investigate any applicant, member, or other practitioner who has or may have physical or mental disability that may affect the practitioner's capability to exercise the privileges applied for and/or held by the practitioner in a manner that meets the patient care quality standards of the district and the medical staff. An investigation may include any or all of the following steps:

(1) Ascertain the health status of the practitioner through committee interview;

(2) Medical examination by an appropriate healthcare professional to evaluate whether the practitioner has a physical or mental disability or other health problem that may affect patient care;

(3) Evaluate the effects of the health status on the practitioner's capability to exercise privileges applied for or held by the practitioner, and when relevant with respect to a qualified physical or mental disability under applicable law, assess if and how reasonable accommodations can be made;

(4) Provide advice, counseling, or referrals as appropriate.

The activities of the physician wellness committee shall be confidential. However, if the committee receives information that demonstrates that the health or impairment of a practitioner may pose a risk of harm to patients, self or others, that information shall be referred to the chief of staff or the medical executive committee. This committee is not disciplinary in nature and does not preclude other review mechanisms as set forth in these bylaws.

11.11-3 MEETINGS, REPORTING AND MINUTES

The physician wellness committee shall meet as often as necessary, but at least quarterly. It shall maintain only such records of its proceedings as it deems advisable and consistent with confidentiality concerns, and shall routinely report on its activities to the medical executive committee.

11.12 UTILIZATION REVIEW AND MEDICAL RECORDS COMMITTEE

11.12-1 COMPOSITION

The utilization review and medical records committee shall consist of at least three (3) medical staff members. Representatives from quality, utilization review, nursing, billing, medical records, and social services shall be invited as non-voting members.

11.12-2 DUTIES

The utilization review and medical records committee shall perform the following functions:

(a) Delineate the scope of utilization review provided within the district;

(b) Develop critical indicators to be used as screening devices in reviewing the utilization of district services;

(c) After cases have been isolated using the critical indicators, evaluate utilization of services administered and identify areas for improvement, if necessary;

(d) Review patient care services to ascertain if utilization of services within the standards of the district and medical staff are being provided in the most cost-effective manner, address overutilization, underutilization, and inefficient scheduling of care and resources;

(e) Review diagnoses, problems, procedures and the practices of practitioners that appear to have utilization-related problems, and examine relevant quality assurance findings and interface with the practitioners as deemed necessary or appropriate;

(f) Determine appropriate action to be taken with respect to identified utilization and other patient care problems, and report such matters to the medical executive committee and the quality improvement committee;

(g) Refer problems which cannot reasonably be resolved at the committee level to the appropriate committee;

(h) Develop, implement, and maintain such Utilization Review Plan as approved by the medical executive committee and district board; and

(i) Comply with applicable federal and state regulations.

11.12-3 MEETINGS

The utilization review and medical records committee shall meet at least quarterly. The committee shall report a summary of its activities or findings to the medical executive committee on a regular basis. The committee shall also give notification to the medical executive committee promptly after the committee receives notice of any matter for which a practitioner is required to give notice to the medical staff pursuant to these bylaws, if not already reported.

11.13 DEPARTMENTAL COMMITTEES

11.13-1 COMPOSITION

The departmental committees can represent a single clinical department or a combination of clinical departments. The departmental committees shall be composed of at least three (3) practitioners from the represented departments that are designated as core committee members. The majority of core committee members must be physicians. The chair may also be a core committee member.

Core committee members will be designated by the chair of the departmental committee following consultation with the committee members. Core committee members have the duty to attend all meetings of the department, unless excused for good reason by the chair of the committee.

Additional committee members may be assigned as needed to represent all disciplines of the department at regularly scheduled meetings. All practitioners are encouraged to attend their departmental committees, even if not designated as a core member of the committee.

(a) Emergency Services Committee

The emergency services committee shall represent all medical services provided in the emergency department. In addition, the emergency room nurse manager and the administrator (or designee) shall be ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(b) Inpatient Medicine Committee

The inpatient medicine committee represents the adult medical services provided in the medical/surgical and intensive care unit departments. At least one core member of the committee shall be a hospitalist. The medical/surgical nurse manager and the administrator (or designee), as well as representatives from the respiratory therapy, physical therapy, dietary, and pharmacy departments shall be non-voting ex-officio members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(c) Outpatient Medicine Committee

The outpatient medicine committee represents the outpatient services including family medicine, internal medicine, outpatient infusion department, and other outpatient medicine departments not represented by other committees. The clinical nurse manager, a representative from the outpatient infusion department, and the administrator (or designee) shall be non-voting ex-officio members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(d) Perinatal/Pediatrics Committee

The perinatal/pediatrics committee shall represent the pediatric and obstetrical departments. The nurse managers of the perinatal and pediatrics units and the administrator (or designee) shall be ex-officio non-voting members. Other departments may

participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(e) Radiology Services Committee

The radiology committee represents the radiology services. The director of diagnostic services and the administrator (or designee) shall be non-voting ex officio members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(f) Surgery/Tissue/Transfusion/Anesthesia Committee

The surgery, tissue, transfusion and anesthesia (STTA) committee represents all surgical, anesthesia, and pathology services. The director of perioperative nursing and the administrator (or designee) shall serve as ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

11.13-2 DUTIES

The medical staff departmental committees listed in Section 11.13-1 are responsible for overseeing the quality and appropriateness of patient care rendered in the department by, without limitation:

(a) Using critical indicators to conduct concurrent and retrospective peer review of medical records with referral for committee review as indicated;

(b) Monitoring and evaluating clinical performance of all privileged practitioners attending patients or administering care in the department;

(c) Periodically reviewing and evaluating the medical services provided;

(d) Making recommendations concerning matters for which the committee is responsible to the medical executive committee, the quality improvement committee and the administrator;

(e) Reviewing applicants for privileges when requested by the department chief;

(f) Electing annually the departmental committee chair, who presides over the meetings and attends the medical executive committee meetings. This departmental committee chair may or may not be the chief of the department; and

(g) Receiving reports from other committees as appropriate.

11.13-3 MEETINGS AND REPORTS

The medical staff departmental committees shall meet at least quarterly. The committees shall report a summary of their activities or findings to the medical executive committee and quality improvement committee on a regular basis. The committees shall also give notification to the medical executive committee promptly after the committees receive notice of any matter for which a practitioner is required to give notice to the medical staff pursuant to these bylaws, if not already reported.

ARTICLE XII: MEETINGS

12.1 GENERAL MEDICAL STAFF MEETINGS

12.1-1 REGULAR MEETINGS

Regular meetings of the medical staff members shall be held each quarter. The date, place and time of the regular meetings shall be determined by the medical executive committee, and adequate notice shall be given to the members.

12.1-2 AGENDA

The order of business at a meeting of the medical staff shall be determined by the chief of staff and medical executive committee. The agenda shall include, as applicable:

(a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) administrative reports from the chief of staff, departments, and committees, chair of the quality improvement committee, and the administrator;

(c) election of officers when required by these bylaws;

(d) old business; and

(e) new business.

12.1-3 SPECIAL MEETINGS

Special meetings of the medical staff may be called at any time by the chief of staff or the medical executive committee, or shall be called upon the written request of ten percent (10%) of the members of the active medical staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled as soon as reasonably possible, but within thirty (30) days after receipt of such request. Notice shall be given to the members of the staff with as much advance notice as possible, which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.2 COMMITTEE AND DEPARTMENT MEETINGS

12.2-1 REGULAR MEETINGS

Except as otherwise specified in these bylaws, the chairs of medical staff and departmental committees may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

12.2-2 SPECIAL MEETINGS

A special meeting of any medical staff committee or department may be called by the chair thereof, the medical executive committee, or the chief of staff.

12.3 QUORUM

12.3-1 GENERAL MEDICAL STAFF MEETINGS

The presence of fifty percent (50%) of the total members of the active medical staff at any regular or special meeting in person or through written (electronic) ballot shall constitute a quorum for the purpose of the election or removal of medical staff officers, or other special votes as determined by the chief of staff. The presence of twenty-five percent (25%) of members shall constitute a quorum for all other actions.

12.3-2 DEPARTMENT AND COMMITTEE MEETINGS

A quorum of fifty percent (50%) of the voting members shall be required for medical executive and credentials committee meetings. For all other medical staff and department committees, a quorum shall consist of all three core members or substitutes as appointed by the departmental chair (in accordance with Section 11.13-1).

12.4 VOTING AND MANNER OF ACTION

12.4-1 VOTING

Unless otherwise specified in these bylaws, only members of the active medical staff may vote in medical staff general meetings and elections. All members of the medical staff and APP staff are entitled to vote at committee and department meetings appropriate to their specialty as described at time of appointment.

12.4-2 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. A meeting in which a quorum is not initially present may be started, though no action may be taken until a quorum is present. Committee and medical staff action may be conducted by telephone conference or other electronic communication. Votes collected by electronic means require a majority vote to be valid.

12.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters.

12.6 ATTENDANCE REQUIREMENTS

12.6-1 REGULAR ATTENDANCE

Members are expected to attend all meetings of the medical staff and of the department or committee to which assigned. Attendance via telephone conference or other electronic communication shall be accepted. Each member of the consulting or courtesy staff shall be required to attend such meetings as may be determined by the medical executive committee.

12.6-2 ABSENCE FROM MEETINGS

Any member who is compelled to be absent from any medical staff, department, or committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence. Unless excused for good cause by the presiding officer of the department or committee, or the medical staff office for medical staff meetings, failure to attend may be included in the practitioner's ongoing professional practice evaluation, reviewed by the medical executive committee, and may be grounds for removal from such committee or for corrective action.

12.6-3 SPECIAL ATTENDANCE

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting to which notice was given, unless excused by the medical executive committee upon a showing of good cause, shall be a basis for corrective action.

12.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

12.8 EXECUTIVE SESSION

The chairperson of any standing, special, or ad hoc committee of the medical staff, including departments, may call an executive session meeting. Only members of the active medical staff holding voting privileges on the committee shall attend the executive session meeting. The chairperson, at his or her discretion, may request other individuals to attend the meeting in an informational capacity. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

ARTICLE XIII: CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within Northern Inyo Healthcare District, an applicant:

(a) authorizes representatives of the district and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

(b) authorizes persons and organizations to provide information concerning such practitioner to the medical staff;

(c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the medical staff or the district who would be immune from liability under Section 13.3 of this Article; and

(d) acknowledges that the provisions of this Article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at this district.

13.2 CONFIDENTIALITY OF INFORMATION

13.2-1 GENERAL

The minutes, files, records and proceedings of the medical staff and all departments and standing or ad hoc committees, including information regarding any applicant, member or other individual exercising clinical privileges or practice privileges, shall be considered medical staff minutes or records and, to the fullest extent permitted by law, shall be confidential and protected from discovery pursuant to California Evidence Code Section 1157 and any other applicable peer review or other policy or privilege. This information shall become part of the medical staff committee files and shall not become part of any patient files, general district records, or any member's personal or office files.

Dissemination of such information and records shall only be made where expressly required by law, as authorized by these bylaws, or pursuant to officially adopted policies of the medical staff or, where no officially adopted policy exists, only with the express approval of the chief of staff and the administrator.

13.2-2 BREACH OF CONFIDENTIALITY

As effective peer review and consideration of the qualifications of medical staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of medical staff departments or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this medical staff, violates the medical staff bylaws, and will be deemed disruptive to the operations of the district. If it is determined that such a breach has occurred, the medical executive committee may undertake such corrective action as it deems appropriate.

13.2-3 ACCESS TO AND RELEASE OF CONFIDENTIAL INFORMATION

All requests for access to medical staff records, including confidential committee records and credential files, shall be presented to an authorized representative. Authorized representatives include the authorized medical staff office personnel and medical staff officers.

(a) Access for Official Purposes

(1) The following individuals may access medical staff records, including confidential committee records and credentials files, to the extent described:

i. Committee members and their authorized representatives, for the purpose of conducting authorized committee functions.

ii. Medical staff and department officials, and their authorized representatives, for the purpose of fulfilling any authorized function of such official.

iii. The administrator, the board of directors, and their authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities. Information which is disclosed to the board of directors or its appointed representatives shall be maintained as confidential.

iv. Consultants or attorneys engaged by the district may be granted access to credential files that are necessary to enable them to perform their functions, if an authorized medical staff representative agrees.

v. Representatives of licensure agencies, accreditation agencies, or auditors from Medicare or Medicaid, if an authorized representative is with them.

(2) All subpoenas pertaining to medical staff records, including confidential committee records and credentials files, shall be referred to the medical staff office, who shall first consult with the administrator, the chief of staff, and legal counsel regarding appropriate response.

(b) Limits on Access to Practitioner's Credentials File

(1) A practitioner can view the contents of his or her credentials file, as described below, during normal business hours upon reasonable prior request to the chief of staff or medical staff officer. The individual only has the right to review and receive a copy of documents provided by or addressed personally to the individual practitioner. The medical staff has discretion to disclose other documents to a member, but in no case shall copies of confidential letters of reference, hospital verifications or other confidential correspondence be disclosed. An individual practitioner may review the above identified parts of his or her credentials file under the following circumstances:

i. Review of the credentials file is accomplished in the presence of one of the following: authorized medical staff office personnel, officer of the medical staff, a member of the credentials committee, or department chief.

ii. The practitioner understands that he or she may not remove any items from the credentials file.

iii. The practitioner understand that, subject to review by the chief of staff, he or she may add an explanatory note or other document to the file.

iv. The practitioner understands that he or she may not review confidential letters of reference, hospital verifications or other confidential correspondence received by the district or the medical staff.

v. Documents provided by the practitioner for inclusion in the credentials file (e.g., Curriculum Vitae, licenses, insurance policy, continuing medical education) may be photocopied. No other items may be photocopied without the express permission of the credentials chair.

(c) Medical Staff Committee Files and Minutes

(1) Any member shall be allowed access to minutes or other medical staff records which describe meetings or activities of the medical staff committees that they were entitled to attend (e.g. their department committees of which they are members). This does not include minutes or records of meeting or activities from which the practitioner was specifically excluded.

13.3 IMMUNITY FROM LIABILITY

13.3-1 FOR ACTION TAKEN

Each representative of the medical staff and district shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the medical staff or district.

13.3-2 FOR PROVIDING INFORMATION

Each representative of the medical staff and district and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the medical staff or district concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this district.

13.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

(a) application for appointment, reappointment, or clinical privileges;

(b) corrective action;

(c) hearings and appellate reviews;

(d) utilization reviews;

(e) other department, committee or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

(f) queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

13.5 RELEASES

Each applicant or member shall, upon request of the medical staff or district, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

13.6 INDEMNIFICATION

Northern Inyo Healthcare District shall indemnify, defend and hold harmless the medical staff, its individual members, and its appointed representatives (e.g. expert witnesses, lay committee members, hearing officers) from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review, quality assessment, or activities related to establishing standards, policies and/or procedures pursuant to the self-governing medical staff provisions, including, but not limited to:

(a) as a member of or witness for a medical staff department, service, committee or hearing panel;

(b) as a member of or witness for the district board or any district task force, group, or committee, and;

(c) as a person providing information to any medical staff or hospital group, officer, board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a medical staff member or applicant.

The medical staff or member may seek indemnification for such losses and expenses under this bylaws provision, statutory and case law, any available liability insurance or otherwise as the medical staff or member sees fit, and concurrently or in such sequence as the medical staff or member may choose. Payment of any losses or expenses by the medical staff or member is not a condition precedent to the district's indemnification obligations hereunder. In no event will the district indemnify an indemnitee for acts or omissions taken in bad faith or in pursuit of the indemnitee's private economic interests.

ARTICLE XIV: GENERAL PROVISIONS

14.1 DUES OR ASSESSMENTS

The medical executive committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of medical staff membership, subject to the approval of the medical staff, and to determine the manner of expenditure of such funds received.

Failure of a member to pay dues or assessments, without good cause as determined by the medical executive committee, will be included in the member's ongoing professional practice evaluation and may be grounds for corrective action.

14.2 AUTHORITY TO ACT

Any member or members who act in the name of this medical staff without proper authority shall be subject to such disciplinary action as the medical executive committee may deem appropriate.

14.3 DIVISION OF FEES

Any division of fees by members of the medical staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the medical staff.

14.4 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the medical staff or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee
Name of department or committee
[c/o medical staff office, chief of staff]
Hospital name
Street address
City, State, Zip code

Mailed notices to a member, applicant or other party shall be to the addressee at the address as it last appears in the official records of the medical staff or district.

14.5 DISCLOSURE OF INTEREST

All nominees for election or appointment to medical staff offices, department chief, or the medical executive committee shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the medical executive committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff. Further information on conflict of interest may be found in Northern Inyo Healthcare District's compliance program.

14.6 RETALIATION PROHIBITED

Neither the medical staff, its members, committees or department heads, the board of directors, its chief executive officer, or any other employee or agent of the district or medical staff, may engage in any punitive or retaliatory action against any member of the medical staff because that member claims a right or privilege afforded by, or seeks implementation of any provision of, these medical staff bylaws.

ARTICLE XV: ADOPTION AND AMENDMENT OF BYLAWS AND POLICIES

15.1 BYLAWS

15.1-1 PROCEDURE FOR PROPOSALS

Proposals to adopt, amend or repeal the bylaws may be initiated by either of the following methods:

(a) The medical executive committee, with the recommendation of the bylaws committee, or on its own motion, may recommend adoption, amendment or repeal of the bylaws to the voting members of the medical staff as provided in this Article.

(b) The members of the active staff, by a written petition signed by at least twenty percent (20%) of the active staff members, may petition the medical executive committee to initiate a proposal to adopt, amend or repeal the bylaws. Such petition shall identify exact language to be added, changed or deleted. If the medical executive committee agrees with the proposed change, it may recommend the change as provided in subsection (a), above.

15.1-2 APPROVAL BY THE ACTIVE STAFF

If a proposal is initiated as provided above, the chief of staff shall inform the members of the active staff, by mail or by electronic means, of the proposed change. Not less than thirty (30) days and not more than ninety (90) days from the date of such notice, the chief of staff shall either call a special meeting of the medical staff or add it to the agenda of a regular meeting to consider the proposed change.

To be adopted, a proposed change must be approved by a majority of the members of the active staff voting in person or by written ballot. If a written ballot is used, the ballots shall be opened and counted at the meeting and the results shall be announced.

15.1-3 APPROVAL BY THE DISTRICT BOARD

Upon action by the active staff as provided above, the proposed change shall be submitted to the board of directors for approval. The board of board of directors may not unreasonably withhold its approval from the active staff's recommended change. If the board of directors votes to disapprove any part of the recommended change, the board of directors shall give the chief of staff written notice of the reasons for non-approval within ten (10) business days from the board of directors' action. At the request of the medical executive committee, the board of directors' disapproval shall be submitted to the Joint Conference Committee for resolution.

15.2 MEDICAL STAFF POLICIES

15.2-1 PROCEDURE FOR PROPOSALS

Proposals to adopt, amend or repeal the medical staff policies may be initiated by any active medical staff member or medical staff committee.

15.2-2 APPROVAL

(a) Approval by the appropriate medical staff committee(s), as applicable;

(b) Approval by the medical executive committee;

(c) Approval by the active medical staff; and

(d) Submission to the board of directors for approval. If the board of directors disapproves the policy, it will be referred back to the appropriate committee(s).

15.3 TECHNICAL AND EDITORIAL AMENDMENTS

Notwithstanding any other provision of the bylaws to the contrary, the medical executive committee shall have authority on behalf of the medical staff to approve such amendments to the bylaws or policies as the medical executive committee deems to be necessary or appropriate to correct or clarify punctuation, spelling, grammatical or expression errors or ambiguities; cross references; numbering or organization; names or titles of committees, officers, practitioner categories, or other such identifiers. The medical executive committee shall give notice of such amendments to the medical staff members, the administrator, and the district board. Such amendments shall become effective upon approval by the district board.

15.4 DISTRIBUTION OF APPROVED PROPOSALS

Promptly after approval, and if reasonably practical, prior to the proposal's effective date, a copy of an approved proposal for bylaws or policies changes shall be distributed to all members, applicants, and other privileged practitioners and APPs who hold any type of privileges pursuant to the bylaws.

ADOPTED by the medical staff on

_____, 20_____
Date

_____
Chief of Staff

_____
Vice Chief of Staff

APPROVED by the board of directors on

_____, 20_____
Date

_____
President

_____
Secretary

CALL TO ORDER	The meeting was called to order at 5:00 pm by Jean Turner, District Board Chair.
PRESENT	Jean Turner, Chair Robert Sharp, Vice Chair Jody Veenker, Secretary Mary Mae Kilpatrick, Treasurer Topah Spoonhunter, Member-At-Large Kelli Davis MBA, Interim Chief Executive Officer and Chief Operating Officer Tracy Aspel RN, BSN, Chief Nursing Officer William Timbers MD, Interim Chief Medical Officer (*participation via Zoom*) Charlotte Helvie MD, Vice Chief of Staff Keith Collins, General Counsel, Jones and Mayer
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 will be 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 for this meeting. No comments were heard.
ADDITION OF AGENDA ITEMS	Northern Inyo Healthcare District (NIHD) Financial Consultant Vinay Behl requested that two items be added to the agenda for this meeting if the Board determines that there is an immediate need to take action, and due to the fact that both matters came to the attention of NIHD leadership following the posting of the agenda for this meeting. The two proposed agenda items were: - Approval of District Board Resolution 20-08, allowing for the re-financing of the District's 2013 revenue bonds - Approval of a software purchase to be incorporated into the Cerner implementation project, in preparation to meet new Centers for Medicare and Medicaid Services (CMS) transparency requirements going into effect January 1 2021 It was moved by Robert Sharp to declare that an immediate need existed to take action on both items, and to add both items to the agenda for this meeting. The motion was seconded by Topah Spoonhunter, and unanimously passed to approve.
BROWN ACT PRESENTATION	District Legal Counsel Keith Collins provided a presentation on the Ralph M. Brown Act which included the following: - Basic requirements that legislative body meetings and actions be open and public - Identification of who is subject to the Brown Act

- Meeting and agenda guidelines and requirements
- What does and does not constitute a "meeting" of a legislative body
- Recommendation on the handling of public official emails and correspondences

PHYSICIAN RECRUITMENT UPDATE

Interim Chief Medical Officer William Timbers MD provided a physician recruitment update, stating negotiations are in progress or agreements have already been reached with practioners in family medicine; hospitalist practice; plastic surgery; rheumatology; and general surgery with a specialization in breast surgery. Dr. Timbers additionally welcomed Joy Engblade MD back to the NIHD Medical Staff.

INTRODUCTION TO NEW NIHD WEBSITE

NIHD Manager of Marketing, Communications, and Strategy, Barbara Laughon provided an introduction to Northern Inyo Healthcare District's Scorpion website, which was recently brought on line. Sarah Schwald, Director of Healthcare Marketing Strategy with Scorpion provided a walk-through of many of the features of the new website.

DEFINED BENEFIT PENSION PLAN FUNDING OVERVIEW

NIHD Financial Consultant Vinay Behl introduced Rich Wright with Milliman Inc. and Stuart Herskowitz with Hooker and Holcombe, who assisted in providing an overview and history of funding of the District's Defined Benefit Pension Plan. The Plan is currently under-funded as a result of previous financial practices, and in recent years the District has been depositing extra monies into the Plan with the goal of bringing it to 110% funding at a future date. The District Board recently voted to suspend the additional funding payments because of the adverse financial effects of the Covid 19 pandemic. Accrual of the additional funds will continue, however for a period of one year the District will deposit only enough monies into the Plan to cover the 2020/2021 fiscal year expense. The District is also looking into ways to modernize the investment strategy and operation of the Plan in order to realize cost savings and improve interest earnings. It was noted that previous year retirees will not be affected by changes to Plan funding and investments, and that the Plan currently has adequate funds to cover the next 2-3 years of retiring employees. District leadership expects to return to the prior level of contribution beginning with the 2021-2022 fiscal year.

DEFINED BENEFIT PLAN ACTUARIAL REPORT

Mr. Wright called attention to the NIHD Retirement Plan Actuarial Valuation as of January 1 2020, noting that interest rate assumptions have been lowered to reflect a decrease in anticipated investment interest income and returns. The recommended contribution for the 2020/2021 plan year is $645,000 per month.

CERNER IMPLEMENTATION UPDATE

Daryl Duenkel with Wipfli LLP provided an update on the District's Cerner Electronic Health Record (EHR) implementation project, which included the following:

- A Project Charter and Implementation Plan have been developed

for the project
- A Steering Committee and Communication Team have been established, and Subject Matter Experts have been designated
- A kick-off event for the project has been planned for August 26 and 27 2020

LEGAL RELATIONSHIP BETWEEN NIHD AND PIONEER HOME HEALTH (PHH)

General Counsel Keith Collins provided an overview of the legal relationship between NIHD and Pioneer Home Health (PHH), a non-profit public benefit corporation. The overview of NIHD's roles, rights, and responsibilities as the sole general member of PHH included the following:
- The District's role is limited to high-level oversight and voting to approve PHH Directors every year. NIHD can approve, remove, and directly appoint PHH directors.
- The District has the ability to veto changes to PHH's Bylaws
- The District is not precluded from making recommendations to the PHH Board of Directors
- The Board of Directors of PHH is accountable to the public and to government entities
- NIHD and Pioneer Home Health are separate legal entities

It was noted that further research into the details of the relationship between the two organizations (particularly in the areas of compliance and security) will take place, and that the District and PHH fully expect to continue a successful relationship going forward.

POSSIBLE RECORDING OF DISTRICT BOARD MEETINGS

Brief discussion took place on the possibility of recording District Board meetings. It was determined that the Zoom platform and current process for conducting meetings has been working well, and NIHD is seeing increased public participation in monthly Board meetings. The consensus of the District Board was that no changes to the current format for Board of Directors meetings is needed at this time.

PIONEER MEDICAL ASSOCIATES PARTNERSHIP PURCHASE PROPOSAL

Interim Chief Executive Officer Kelli Davis called attention to a proposal to move forward with the possible purchase of a 33.47% interest in the Pioneer Medical Associates (PMA) partnership owned by Drs. Nickoline Hathaway MD and Asao Kamei MD, noting that NIHD already owns 66.54% of that partnership. An appraisal of the PMA medical building (the sole asset of the partnership) has been conducted, and the District hopes to purchase the remaining interest in order to avoid over $200,000 in rent expense every year, and to create an additional long-term asset for the District. Following discussion of this agenda item the Board stated its desire to receive more detailed information on this agenda item prior to taking action. The Board gave consent for NIHD staff to pursue the details of a possible purchase further, with no action being taken at this time.

CLINICS WORKFLOW AND EFFICIENCY PROJECT PROPOSAL

Ms. Davis called attention to a proposal to engage Sonia Singh International, LLC to conduct an efficiency and workflow assessment of

NIHD's medical clinics, at a cost of $125,580. The goal of the efficiency project is to realize improvement in the following areas:

- Increased patient access and patient volume at the NIHD Clinics
- Addition of new service lines
- Increased provider productivity
- Improved reimbursement rates and collections
- Reduced labor costs and supply chain costs
- Overall improvement to the quality of care and patient safety

Ms. Davis additionally noted that District leadership believes the gains realized from the proposed efficiency project will far outweigh its' cost. It was moved by Mr. Sharp, seconded by Mr. Spoonhunter, and unanimously passed to approve the efficiency project proposal with Sonia Singh International, LLC as requested.

ANNUAL REVIEW OF BOARD OF DIRECTORS POLICIES AND PROCEDURES

Ms. Turner called attention to annual review of the Board of Directors Policies and Procedures, stating that the only changes being proposed at this time are the following:

- Change of the terms *Board President* and *Board Vice President*, to be *Board Chair* and *Board Vice Chair*
- The deletion of lengthy sample interview questions from the policy titled *Suggested Guidance to Fill a Board Vacancy by Appointment*

It was moved by Mr. Sharp, seconded by Mary Mae Kilpatrick, and unanimously passed to approve the NIHD Board of Directors Policies and Procedures as presented, including the revisions noted.

BOARD OF DIRECTORS ANNUAL OPERATING BUDGET

NIHD Controller Genifer Owens reviewed the annual Operating Budget for the District Board of Directors, which consists of:

- $7,400 in professional fees expense, including Board Packet software and Strategic Planning sessions
- $7,100 for standard Board meeting stipends, plus a $900 allowance to attend the Association of California Healthcare Districts (ACHD) annual conference

Ms. Turner indicated that because of financial constraints the Board does not plan to attend the ACHD conference this year, and she additionally noted that she will attend the conference herself at her own cost, and not at the District's expense.

DISTRICT BOARD RESOLUTION 20-09

Ms. Owens also called attention to proposed District Board Resolution 20-09, which will update the designation of officers who may operate NIHD's financial accounts and sign for District financial transactions. The authorized officers will include individuals holding the following positions: Chief Executive Officer; Chief Operating Officer; Chief Nursing Officer; Revenue Cycle Director; and Director of the Rural Health Clinic and Northern Inyo Associates Clinics. It was moved by Ms. Kilpatrick, seconded by Jody Veenker, and unanimously passed to approve District Board Resolution 20-09 as presented.

FINANCIAL UPDATE AS OF JUNE 30, 2020

NIHD Financial Consultant Vinay Behl provided a financial update as of June 30 2020, reporting the following:

- Due to the Covid 19 pandemic, the District experienced a huge reduction in patient revenue from March 2020 through June 2020
- Volume experienced an uptick in the month of June, coming in better than expected
- The projected bottom line deficit for the 2019/2020 fiscal year is a negative 5.3 million
- Cash on hand has increased, primarily due to relief programs and government loans

Mr. Behl additionally reported that the District has begun preparations for its annual audit with Eide Bailey LLP.

CONFLICT OF INTEREST CODE

District Legal Counsel Keith Collins called attention to possible changes to the District's Conflict of Interest Code, which would create steeper penalties for anti-nepotism violations. Mr. Collins noted that he was asked to look into possibly strengthening the anti-nepotism wording in the District's Code; however he does not necessarily recommend that the existing Code be changed. Noting that the District's existing Conflict of Interest Code and Policies already in place are more than adequate to create an anti-nepotism culture within the District, a motion was made by Ms. Kilpatrick, seconded by Ms. Veenker, and unanimously passed to accept only the additional language proposed in Section 8 of the revised Code, and to eliminate the additional wording included in Section 7.

REVISION OF INTERIM CHIEF EXECUTIVE OFFICER CONTRACT

Mr. Collins also called attention to proposed changes to the *Agreement For Employment of Interim Chief Executive Officer* Kelli Davis, to better clarify her continuing responsibilities as Chief Operating Officer. He additionally stated that if the Board is comfortable with the terms of the revised agreement, the topic of Ms. Davis's compensation will be placed on the agenda for the September regular meeting. It was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve the proposed changes to the *Agreement For Employment of Interim Chief Executive Officer* as presented.

RENEWAL OF JONES & MAYER LEGAL SERVICES AGREEMENT

Mr. Collins recused himself from the meeting and exited the room at this time, in order to allow for discussion of a proposed renewal of the *Agreement for the Provision of Legal Services* with Jones and Mayer. Ms. Davis called attention to a recommendation for renewal of the existing agreement with Jones and Mayer scheduled to expire on October 1 2020. The Board requested that additional language be added to the agreement to ensure that NIHD staff does not engage legal counsel without the approval of the Chief Executive Officer, in an effort to better control legal expenses. It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and unanimously passed to approve renewing the *Agreement for the Provision of Legal Services* with Jones and Mayer for an additional term of 1 year, including language being added to specify that the Interim CEO

must authorize requests to engage legal counsel services. Mr. Collins re-entered the meeting at that time.

MEDICAL, DENTAL, AND VISION BROKER PROPOSAL (VERUS INSURANCE)

Mr. Behl called attention to a Medical, Dental, and Vision (MDV) broker proposal submitted by Verus Insurance. Scott Kelly with Verus provided a presentation on what Verus can do to help NIHD better manage its existing MDV plan, while reducing costs and at the same time not compromising benefits. At the conclusion of the presentation, Mr. Behl stated that Verus will bring a detailed timeline of their proposal back to the Board of Directors at the September regular meeting, and that no action on this matter is being requested at this time.

AD HOC COMMITTEE FORMATION, BOARD & MEDICAL STAFF RELATIONSHIP BUILDING

Ms. Turner requested that the District Board Chair and Vice Chair be authorized to establish a Board of Directors Ad Hoc Committee for the purpose of building stronger NIHD Board of Directors and Medical Staff relations. It was moved by Ms. Veenker, seconded by Mr. Sharp, and unanimously passed to authorize the Board Chair and Vice Chair to establish a Board of Directors Ad Hoc Committee for this purpose.

EASTERN SIERRA EMERGENCY PHYSICIANS QUARTERLY REPORT

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

- The physician group has put a great deal of time and effort into Covid 19 preparedness
- ESEP is working closely with the NIHD Hospitalist program, which will be led by Joy Engblade MD and Monika Mehrens DO. Dr. Mehrens will join the NIHD Medical Staff on a full-time basis in the near future.
- A new ED physician, Gregory Gaskin MD has joined the ESEP physician group. The ESEP group will soon be staffed solely by local providers, without the need for locums' coverage.

RETURN ON INVESTMENT (ROI) COMMITTEE REPOT

Mr. Behl provided an update on the efforts of the NIHD Return on Investment (ROI) Committee, noting the following:

- The Committee continues its financial assessment of Pioneer Home Health operations, which have shown significant improvement in recent months
- An ROI assessment and analysis of the possible purchase of the Pioneer Medical Associates partnership percentage continues
- Provider compensation is currently under review, and a new value-based compensation model is being considered
- The Clinics efficiency project proposed at this meeting has the recommendation of the ROI Committee
- The ROI Committee supports re-funding of the District's revenue bonds, in an effort to positively benefit cash flow

DISTRICT BOARD RESOLUTION 20-08, REVENUE BOND RE-FUNDING

Mr. Behl called attention to proposed District Board Resolution 20-08, which would allow for the re-funding of the District's 2013 revenue bonds. It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and

unanimously passed to approve District Board Resolution 20-08 as presented.

TRANSPARENCY TOOL FOR CERNER IMPLEMENTATION

Mr. Behl also called attention to the purchase of transparency software for the Cerner implementation project, one of the two agenda items added at the start of this meeting. The transparency tool will assist with Managed Medicare reporting, and it is believed that the return on investment for the software will be significant. The annual cost for the product is still under negotiation, but it has been negotiated down from $94,992 to annual payments of approximately $71,000. Following discussion of the need for this purchase it was moved by Ms. Veenker, seconded by Mr. Sharp, and unanimously passed to approve the purchase of the transparency tool for the Cerner implementation project as requested.

OUTSOURCE INC. COLLECTIONS UPDATE

Mr. Behl also provided an update on progress made by Outsource Inc. on processing of the District's backlog of Athena medical claims. He reported that $24,000,000 in healthcare claims were unbilled at the time Outsource was retained, and of those claims $18,500,000 have been addressed to date. The District is still on track to realize $9,000,000 in income as a result of the Outsource Inc. collections project.

CHIEF OF STAFF REPORT

Vice Chief of Staff Charlotte Helvie, MD stated following careful review and consideration the Medical Executive Committee recommends approval of the following Medical Staff appointments:

MEDICAL STAFF APPOINTMENTS

1. Adam Jesionek, MD (*family medicine/hospitalist*) – Provisional Active Staff
2. Danish Atwal, MD (*Renown Cardiology*) – Telemedicine Staff
3. Htet Khine, MD (*Renown Cardiology*) – Telemedicine Staff

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

POLICY AND PROCEDURE APPROVALS

Dr. Helvie additionally stated 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. *Biosafety Plan*
2. *Blood Bank – Emergency Requests for Blood Components*
3. *Death in the Operating Room*
4. *Draping for Surgical Procedures*
5. *Electrosurgical Cautery*
6. *Fire Safety in Surgery*
7. *Immediate Use Sterilization Procedure*
8. *Implantation of Medical Devices*
9. *Medical Device Tracking*
10. *Medical Students in the OR*
11. *NPO Guidelines*
12. *Sterile Processing Scope of Service*

13. Sterile Processing Standards of Practice
14. Surgeries Requiring an Assistant
15. Clorox Total 360 System Electrostatic Sprayer
16. Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program
17. NIHD Workforce Exposed to Communicable Illness
18. Scope of Service – Infection Prevention
19. Toy Cleaning

It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve Policies and Procedures 1 through 19 as requested.

ANNUAL APPROVAL

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

1. *Standardized Protocol – Physician Assistant in the Operating Room*

It was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve the *Standardized Protocol – Physician Assistant in the Operating Room* annual approval as requested.

CONSENT AGENDA

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

- *Approval of minutes of the July 19 2020 regular meeting*

It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve the Consent Agenda item as presented.

BOARD MEMBER REPORTS

Ms. Turner asked if any members of the Board of Directors wished to comment on any items of interest. She then stated that she currently serves as a member of the ACHD Advocacy Committee, and that she would be happy to share information on current legislation with anyone who is interested. No other reports were given.

ADJOURNMENT TO CLOSED SESSION

At 11:04 pm Ms. Turner announced the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. Conference with Legal Counsel, existing litigation (*pursuant to Paragraph (1) of subdivision (d) of Government Code Section 54956.9*), name of case: Inyo County LAFCO and NIHD v. SMHD, Case No. 34-2015-8002247-CY-WM-GDS-Sacramento County.
B. Conference with Labor Negotiators, Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
C. Perform a Public Employee Performance Evaluation (*pursuant to Government Code Section 54957(b)*), title: Interim Chief Executive Officer.

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 12:25 am the meeting returned to Open Session. Ms. Turner reported the Board took no reportable action.

ADJOURNMENT The meeting was adjourned at 12:25 am.

_____
Jean Turner, Chair

Attest: _____
Jody Veenker, Secretary

NORTHERN INYO HEALTHCARE DISTRICT

Improving our communities, one life at a time.
One Team, One Goal, Your Health!

150 Pioneer Lane
Bishop, California 93514

(760) 873-5811

DATE: September 16, 2020

TO: Board of Director's
Northern Inyo Healthcare District

FROM: Kelli Davis, Interim Chief Executive Officer (CEO)

RE: Bi-Monthly CEO – Northern Inyo Healthcare District

REPORT DETAIL

Leadership

In October, we bid a fond farewell to our Chief Nursing Officer (CNO), Tracy Aspel, and we welcome our new CNO, Allison Partridge, to her new role within the District and to the Executive Team. We wish Tracy a wonderful retirement and new path in life and sincerely hope she finds much peace, happiness, new memories and joy along the way. Simultaneously, we welcome Allison, with the outreach of a supportive and united hand, as she takes on this important role as the leader of our nursing and other clinical teams. We are very excited for the new days, weeks, months and beyond with this new addition to the Executive Team family!

Workforce

As the pandemic continues to unfold, the NIHD team members continue to manage change positively and proudly. While some work environments and personal lives are on pause, the lives of healthcare workers face increased strains and new challenges. Our team members are part of the essential workforce on the front lines of COVID-19, so they know what it means to worry about risk, navigate countless hours of work, and to adapt their personal lives to meet the needs of their professional lives. Still, it is not easy.

Recognition of the challenges being faced daily through notes and words of positive encouragement, support and tokens of appreciation have been many and they really do make a difference! The letter of support recently sent to the NIHD team, from our Board of Director's, was appreciated, and the responses were many, both to the Executive Team and to the Board.

Strategic Planning

"The best way to predict the future, is to create it" – Abraham Lincoln

While 2020 has been more complex than previous years, the healthcare industry norm is one of complexity and uncertainty, in general. Planning the success of NIHD is more important now

than ever. A strong strategic plan for NIHD will better prepare us for the known and the unknown challenges ahead.

Strategic Planning for NIHD

The strategic planning process involves the creation of objectives and goal setting focused on where we see NIHD in the long term. Through these objectives and goals, we can create our plan to achieve them.

Role of Leadership and the Board in Strategic Planning

Both District leadership and members of the Board of Director's are essential in the strategic planning process. A clear understanding of governance and how NIHD operates is key in the creation of an effective strategic plan designed for the entire District to succeed. Additionally, the Board members provide leadership, governance and motivation for strategic success.

Why is Strategic Planning Important?

Where is NIHD headed and what will it take to get there? NIHD is comprised of many departments with varying contributions to the healthcare cycle. This can make it easy for department team members to become confused about what is going on. Ensuring that our District has a long lasting future is a priority for all team members, our Board of Director's, leadership and other stakeholders. Providing clarity and clear, transparent communication through a strategic plan that addresses key issues/challenges/concerns, our vision and goals, and the steps we will take to get there, helps to align our team. A strong strategic plan will increase confidence, trust and faith throughout our organization and ultimately, our community. Additionally, by updating our strategic plan, we are more likely to see:

- Increased employee engagement and motivation
- Increased team member contributions and collaboration
- Shared visioning
- Clarity and confidence to make sound financial decisions
- Transformational leadership and employee satisfaction

Next Steps

While leadership and the Board have had some workshops over the last couple of years, the current NIHD strategic plan was developed in 2016. Conversations with David Sandberg have been underway over the last several weeks. He has been updated on the dynamics of leadership, workforce, medical staff and the Board to allow for background review and the development of as much pre-work prior to any sessions for strategic planning. Taking a conscientious approach to cost savings, time, resources and the current CV19 affects, is a top priority for NIHD leadership.

Department Reports

Please find the reports from the department leaders I support in the next pages. You are sure to see much work underway, some challenges and of course, some celebration of the amazing work and service provision taking place at NIHD.

Closing

The support and guidance by the NIHD Board of Director's is greatly appreciated. As always, please do not hesitate to contact me with any questions or to share any concerns you may have.

Respectfully submitted,
Kelli Davis - Interim CEO

DATE: September 2020

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Barbara Laughon, Manager of Marketing, Communications & Strategy

RE: Department Update

REPORT DETAIL

NEW BUSINESS:
The District has added a Digital Marketing Specialist to its Marketing Team. Caroline Casey comes to us from Mammoth Lakes Tourism and is looking forward to engaging with TeamNIHD on digital marketing projects. Please welcome Caroline when you have the opportunity.

The District has developed a Strategic Marketing Committee to better understand the District's opportunities to communicate with our community. It will also allow us to better monitor marketing strategy effectiveness and make adjustments required to maintain or increase success. Our initial project will be developing a catalog of videos introducing our physicians' philosophy of care and elaborating on the passions that drive them serve others.

Strategic Communications is collaborating with other team members on the upcoming Annual Report. Under the leadership of Vinay Behl, we will help communicate the collective strengths and the value the District brings to its community.

On a personal note, Strategic Communications wishes to thank CNO Tracy Aspel for her endless dedication to the District. We are grateful for her support of our department and wish her well on her upcoming retirement. We will miss you, Tracy!

OLD BUSINESS:
Strategic Communications continues to produce weekly COVID-19 Incident Command Briefings for District staff featuring information generated from the District and gathered from Inyo County and the Eastern Sierra region.

With the assistance of Scorpion Healthcare, the District secured access to its Facebook page. We have tentatively dipped our collective toe into the social media waters with internal posts and general educational posts crafted by Scorpion Healthcare.

DATE: September 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Neil Lynch, Purchasing

RE: Department Update

REPORT DETAIL

NEW BUSINESS:
Purchasing continues to work on Cerner preparation and began data extraction from our legacy systems. We continue to have numerous activities centered on the supply chain as it relates to Covid supply shortages.

OLD BUSINESS:
Purchasing is beginning work on the materials management item master. Specifically, we hope to determine what items will be included in the Cerner build and what items should sunset with our legacy systems. This activity is a big undertaking but necessary for successful role out of the district's new systems.

DATE: September 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Bryan Harper, Director of ITS

RE: Department Update

REPORT DETAIL

NEW BUSINESS:

ITS is currently working on replacing the current wireless network in preparation for Cerner. The current wireless network is over 10 years old, has limited range, and uses older technology as well has a higher cost of ownership. This upgrade will increase our wireless speed, harden our security including the guest wireless along with saving the district thousands of dollars per year.

ITS continues to work on computer upgrades for the district. This is a long and difficult process but, will pay dividends when we move to Cerner next year.

OLD BUSINESS:

The ITS and Clinical Engineering (CE) team just completed the rollout and configuration of the Bbraun smart pumps.

ITS just completed the wireless survey assessment from Cerner, and, based on discussions with the team that did the walk through with Cerner, they were impressed with our overall network operations center and current setup.

Guest wireless segmentation complete. All Guest internet traffic is now separate from hospital traffic.

DATE: September 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Lynda Vance, Project Management Specialist

RE: Department Update

REPORT DETAIL

NEW BUSINESS:

Annual Report

I have been working on gathering data and material for my part of the annual report. I have not partaken in this activity before, but I am excited to be able to participate.

Project Management Professional

I have completed my 60 continuing education units required to renew my PMP in September. This is good for 3 years.

Projects *(this is a summary of the high-level work, not a complete list)*

Discovery – 3 (Logisticare Transport; ADP to Replace Kronos Time areas; Bronco Clinic Restart; Shifthound expansion for new MOU; HEDIS (deficiency in Insurance Reporting))
Kick Offs – 5 (Scorpion Social Media, Omnicell Cabinets, Cerner Connected projects outside Wipfli, Sonia Singh Clinic Workflow, SAP Concur, Contract assistant)
Actively Working – 5 (Amion Schedule Software (Med Staff); Door Access Badge standard workflow; Nuance Powershare (Share DI portal); Cerner (EHR) Estimated Go Live May 2021; PPM Navex)
Go Live – 1 (People Element (Workforce Intelligence Solutions and Analytics) Go Live Sept 2020)
Post Go Live – 6 (Bbraun Smart IV Pumps (Hosp); Scorpion Website; TEE -Trans Esophageal Electrocardiography; HealthFinch; Graphiumhealth Anesthesia EHR; Tele-psychiatry with Regroup)
Closing – 3 (VendorMate Credentialing Software; Interpreter Intelligence; Confidential charting in Clinics workflow; Urgent need to build out beds)
Moves Completed - 9 (Coding, Ortho Clinic, Business office, Charge Capture, House Supervisor, PACU office, Informatics, CEO office, CMO office)

DATE: September 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Rich Miears, Manager of Environmental Services & Laundry

RE: Department Update

REPORT DETAIL

ENVIRONMENTAL SERVICES:
The Environmental Services (ES) team operates Monday –Sunday 400am to 1230am. Our staff cleans areas from Birch Street, to the Joseph House to our OR's and PACU. We currently have 23 fulltime employees in ES with two vacant spots to fill. We just picked up a new chemical from Ecolab that we are going to add to our dispensing system. This chemical will cut the kill time almost in half of Covid, MRSA and other diseases verses what we are currently using. This chemical can also be used to clean windows and deodorize as well. This chemical is the most multi-functional product that I have ever seen. It's called K54 peroxide disinfectant.

Our Clorox 360 system is a new static cleaning technology that the NIHD Foundation has purchased for us. This technology has cut some of our room turn-over times by half.

Recently, we have been dealing with an ES employee shortage because of possible Covid exposure due to staff not taking precautions during their lunch time. This has put our ES staffing levels at a skeleton crew. A lot of the ES staff have stepped up and picked up extra work during this time, and have done an amazing job getting the work done. ES staffing levels should be back to normal by next week.

A couple of weeks ago, I had a meeting with an Unger Supplies sales person. She had some new styles of mop handles that were very ergonomically friendly for housekeepers. I have ordered a few to try out.

LAUNDRY:
The Laundry team operates Monday –Friday from 500am to 1630pm. We currently have 5 employees with staggered start times throughout the day. Our chemical line has been safe so far, but it has been hard to get certain linens stocked in the hospital.

The Laundry team is still washing washable PPE coats and washable masks, which has saved NIHD in our disposable ordering shortage during Covid. We are currently trying to up our levels of washable PPE coats for the next possible Covid surge. The last time we had a surge of Covid, I felt that our nursing staff was using them so fast we couldn't wash them fast enough. So it's time to increase our supply of PPE Coats.

These PPE washable coats are very hard to come by. I have had to purchase a lot on EBay, and also order PPE Coats from Encompass, a linen company, which takes about 2 months to get.

Our equipment has been working great, until a support building boiler pump went out this week. Not getting an adequate hot water supply to our washers has a big impact. We are only operating with 2 of 3 washers right now. The boiler problem should be fixed very soon.

OTHER INFORMATION:
Talent Pool- Currently at 9 employees and we just moved one into a fulltime spot into ES. So far, the applicants in ADP for Talent Pool are still trickling in slowly.

Shredding- Jim Ramirez from Laundry has stepped into filling the gap until we find a replacement for the shredding position, and he has been doing a great job. Jim spends about 6 hours doing laundry and the other 2 hours shredding for the hospital daily.

Screeners- We hired 4 temporary screeners from Sierra Employment to cover Radiology for 5 days per week, Main and the ED entrance 7 days per week: Maureen Barrett, Christy Morton, Cheryl Jackson and Ty Tucker. They are doing a great job, and they are really friendly, too.

DATE: September 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Thad Harlow, Director of Rehabilitative Services

RE: Department Update

REPORT DETAIL

PHYSICAL THERAPY:
We have completed the final phase of the Adult Outpatient Clinic remodel. This project gave us more room in the therapy gym for patient care, as well as 2 additional private treatment rooms and expanded front office space.

We continue with our Limited Operations and COVID precautions for all 3 disciplines. We are also able to offer telehealth therapy services for those community members whose health related conditions put them at higher risk from COVID, and for those who are reluctant to come to campus for their therapy.

We have begun meetings involving the Cerner project with several of my therapists, my front office assistant manager, and myself involved in various roles.

OCCUPATIONAL THERAPY:
At this time we have decided not to fill the OT Pediatric position, and revisit the need for this therapist once volumes return to normal levels. The Pediatric OT and ST clinic is in the process of moving clinic locations, and is in the final phase of planning with the start of the move expected in the near future. This will open up additional space for providers in the PMA building.

Our Pediatric OT is heavily involved in treating local students, and we have implemented a telehealth model for these students which is working quite well.

SPEECH THERAPY:
The ST team is moving forward with our new graduate ST and supporting her in her onboarding and Clinical Fellowship training. The ST team is looking at options to expand our Pediatric services to the community.

DATE: September 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Scott Hooker, Director of Facilities

RE: Department Update

REPORT DETAIL

MAINTENANCE/FACILITIES

New Business:

Facilities and Maintenance are working with Pharmacy, Project Management and others to help coordinate the install of the new Omni cell drug dispensers. This will be an OSHPD project as the seismic anchorage needs to be approved and inspected by OSHPD. Unfortunately, the new drug dispensers will not fit into the existing seismic anchorage brackets. We have Colombo Construction and their vendors helping us with this project.

Old Business:

Our chiller plant will be upgraded in the months to come. As part of this, we have brought in a temporary chiller to supplement, as our current chillers are failing. We will also be updating the building maintenance program. This is the program that gives us control of all our buildings' utilities so that they do not run at 100% capacity at all times. This upgraded system will not only give us better control, but should help us save some money on utility bills. RHP mechanical has ordered all of the parts that will attach to the points where we will be getting data from. We hope that the install will start in several weeks. The building separation project continues to inch along. OSHPD is now questioning part of the wall that has already been approved installed and inspected. We may have to go back and add some fire life safety detail to this wall. Pharmacy project plans are ready to submit. We had to move Infusion out of the area in order to work on the building separation project. OSHPD is requiring this area to be brought up to their codes and regulations prior to us moving Infusion back in. This will be costly and complicated. We have Colombo Construction and Ping and Associates Architectural working on a rough order of magnitude for us.

SECURITY

New Business:

We seem to be providing more security standbys multiple times per day and in many different locations. Many of these are related to the COVID requirements; wearing masks, screening, etc. The public seems to be frustrated and tired. Security Officers are helping out with the new COVID screening process during their shifts.

Old Business:

Security is currently operating with 6 officers, one less than we are used to. Security is onsite Sunday – Thursday 600p-330a Friday and Saturday noon-400a.

DATE: September 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Mary Ellen Tillemans, Revenue Cycle Director

RE: Department Update

REPORT DETAIL

NEW BUSINESS:
Admission Services**:** Assisting with temp screening of incoming employees & patients/public

Charge Capture/Revenue Cycle**:** Cerner implementation prep, Charge Master review/correlation & updates of codes and description unification

Provider/payor credentialing software acquired. Manage, streamline/automate, alerts & eporting

OLD BUSINESS:
Admission Services: Registration Teams continue to work to assure COVID patient safety practices

Revenue Cycle: Continued AR focus, back-log AR follow-up & reimbursement efficiency, policy and procedures development

Charge Capture: CMS Price Transparency Rule Preparation Project (01/01/2021), policy and procedures development

DATE: September 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Larry Weber, Director of Diagnostic Services

RE: Department Update

REPORT DETAIL

NEW BUSINESS

Cardiopulmonary:

Over the last two months, Cardiopulmonary is seeing about 85% of Pre-Covid patient volumes. Terry Tye is working on IAC (Intersocietal Accreditation Commission) accreditation for the Echo lab. David Kim (Sonographer) recently received his Echo Certification. Proposal with Cerner for add on module to add Cerner Power Chart EKG to Cerner implementation. This will allow the EKGs to electronically upload into the electronic health record. The new Pneumotrac Spirometer, at the Pediatric clinic, is setup and Morgan Nutting and Austin Archer; our Pulmonary Function Technicians will do training with the clinic staff. The Qualitative Fit test Kit arrived, training and competencies have been done with cardiopulmonary staff. The Cardiopulmonary Department will be fit testing NIHD staff for the 1870 mask. NIHD has received more Powered Air Purifying Respirators the Respiratory care department has insured proper function of all the new units and distributed them to departments throughout the hospital.

Diagnostic Imaging:

Over the last two months in limited operations, DI is performing at about 82% of Pre-Pandemic volumes. This is up from a low of 40% of pre pandemic patient volume in April. Ashley Weatherford, R.T. (R) has successfully completed her Mammography training classes and is awaiting the state to allow her to sit for her state Mammography licensure. DI is currently recruiting for a Sonographer and a Radiologic Technologist.

Laboratory Services:

Laboratory Services continues to trend to pre-pandemic normalcy relative to patient volume, now having volumes that are only 4% below Pre-pandemic volumes. Relative to staffing, NIHD has hired Sandy DeGiovanni as our laboratory Manager. Sandy comes to us with 7 years' experience as a Clinical Lab Scientist and has extensive experience and passion around education and recruiting in a rural setting. Sandy is currently recruiting for both a Microbiology Coordinator and a Blood Bank Coordinator. The latter vacancy is a result of Catherine Baldwin, SDB, notifying NIHD of her intended retirement after 25 years of service to our district and our community. Catherine has served as our Blood Bank Coordinator since 2008. We wish Catherine well in her retirement but recognize that Catherine's contributions will be difficult to replace.

OLD BUSINESS

Cardiopulmonary:

Our Echo sonographer continues to promote the Trans esophageal echocardiography (TEE) program. We have completed four TEE procedures since it went live in April of this year. We are seeing our volume of stress tests, EKGs and ambulatory cardiac monitoring trending back to pre-Covid 19 levels. All exercise stress tests are prescreened for Covid prior to procedure. The Department continue to prescreen all patients for Covid prior to PFT procedure. The Respiratory therapists continue to prepare for a surge related to Covid. We have intubation kits prepared, adequate supplies and equipment ready

Diagnostic Imaging:

Imaging Staffing has normalized since our last report with all staff returning to work from quarantined status. Volumes continue to increase as listed in new business. Drive through service continues to operate.

Laboratory Services:

Laboratory Services continues to struggle with supply chain reliability for SARS CoV 2 testing supplies. Drive through Collections continue to provide about 30% of total lab OP services. Over the last 2 months, our community has continued to improve in compliance with the request to schedule lab appointments. We are now seeing less than 10% of our patients come to the hospital for lab collection services without an appointment.

DATE: September 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Greg Bissonette, Foundation Executive Director/Grant Writer

RE: Department Update

REPORT DETAIL

FOUNDATION:
July and August saw board meetings each month and work on projects concerning the Healing Garden and the recent AED purchase for the Joseph House. For the press release on the AED, the Foundation took a group photo with the device at the Joseph House and Barbara Laughon is working on the press release. The Foundation also facilitated a grant from Metabolic Studio/Annenberg Foundation which gave the District $5,000 for personal protection equipment (PPE). The Foundation served as a pass through while the Districts awaits its official ruling from the IRS on its ability to accept grants as a governmental entity.

GRANT WRITING:
On the Grant Writing side, the District received two grant awards. The California Harm Reduction Initiative awarded the District $303,750, over three years, to fund a Harm Reduction Specialist staff position to work on the opioid addiction treatment services at the RHC. The California Department of Health Care Services also funded the District $100,000 for continued funding on our substance use navigator position and to hire an additional behavioral health counselor to service the Emergency Department in working with patients with Opioid Use Disorder (OUD).

DATE: September 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report

Denice Hynd, Director of Nutritional Services

RE: Department Update

REPORT DETAIL

NEW BUSINESS:
The dietary department has been successful in requesting all dietary vendors adhere to NIHD's temperature screening process, vendors remain compliant and willing to do so. The kitchen has made requests for Preferred Disposal to switch out dumpsters to ensure a clean product is offered to NIHD's campus. Staff has been covering each other's shifts due to staff illness; staff continue to abide by infection control and public health mandates. The dietary team prepared and assembled 100 individually packaged pastry boxes for the staff at the Bishop Care Center – the BCC employees we're extremely grateful for this act of kindness. Additionally, Jack in the Box gifted 100 breakfast sandwiches/hash browns to NIHD staff as a token of appreciation during these challenging times.

Total Meals Served June through 3rd week in August:

Patient Meals Served: 3,035

Staff Meals Served: 9,365

Gifted Pastries Served: 100

Inyo County Shelter Meals Served: 128 (since April)

Clinically, the dietitians have been attending subject matter expert meetings with Cerner to ensure dietary workflows are taken into consideration during the new implementation process. Communications between the dietitians and the Chief of Staff have begun to streamline our bedside and outpatient diabetic nutrition education. Lastly, the dietitians have begun to brainstorm on new Healthy Lifestyle Topics and platforms.

OLD BUSINESS:
Day to day operations for the dietary department continues to include:

- Feeding staff during lunch and dinner
- Coordinating with special event committees to organize and provide food during opportunities of celebration and acknowledgment
- Providing nuclear medicine meals
- Providing inpatient meals
- Maintaining survey readiness through environment of care observations and actions
- Enforcing social distancing recommendations while waiting and dining in the cafeteria

September 16th 2020 Interim Chief Medical Officer Report to the Board of Directors

COVID-19 Update

The past few weeks have been challenging and sorrowful. Inyo county and NIHD saw a spike in COVID-19 cases as well as deaths due to the virus. A significant portion of these cases and deaths are related to the recent outbreak at the Bishop Care Center and affected both residents and staff. There has also been community spread unrelated to this specific outbreak. At the time of this writing on September 5th we have seen 183 positive cases in the county with 13 deaths. Fortunately the numbers of new cases appears to be down trending but the risk for a recurrent spike remains real especially in the wake of the Labor Day holiday weekend and travel into Inyo county. NIHD continues to take precautions to help prevent COVID-19 spread and to help protect patients and staff. We continue to screen all patients and staff coming onto campus and mandate appropriate PPE. We continue to use telehealth and social distancing and are following the action plan as outlined in the 'NIHD Covid-19 Operations Action Plan'. As of 9/5 we remain in limited operations.

COVID-19 Testing

Access to molecular tests such as PCR for in-house testing continues to be a challenge due to high demand and limited supply. We currently have a small stockpile of tests that rely on this test for screening admissions, surgeries, and other high risk patients (we have 113 tests at of 9/5). With this shortage we have been continuing to utilize send out molecular testing for scheduled surgeries and outpatient testing and other less urgent indications but this has inherent limitations due to turn around time. Current TAT are decreased however to around 1-3 days (average 1.37 as of 9/5). We also continue to provide IgG and IgM antibody serum testing to evaluate for exposure to COVID-19. We have evaluated the possibility of serum antigen testing as an additional testing strategy but at this time these tests are unavailable.

Weekly Press Briefings

Dr. Stacey Brown, Tracy Aspel, Kelli Davis and I continue to participate in weekly or bi-weekly press briefing on Fridays at noon to discuss COVID-19 with local media. This has been well received and provides us a venue for supplying the community with accurate information regarding the disease and updates on NIHD's operations and services.

Contract Negotiations

Urology Contract

Dr. Ercolani's group, "Elite Robotic Surgical Consultants" And their new contract took effect 9/1/20. This will result in 120,000$ of savings and we will also see more days of on-site coverage from ERSC.

Physician Contact Revision Update

I continue working to revise the base physician contracts to include a more significant emphasis of productivity and quality. This has been a arduous process that has required significant input from Vinay Behl and the rest of the executive team to craft. The RHC physician contracts have been extended through 12/31/20 where applicable to allow more time to revise the contract model and to ensure everyone starts the revised contract at the same time. This model will eventually apply to all providers at NIHD.

Dr. David Plank

Dr. David Plank, a plastic surgeon and hand surgeon, has signed a contract effective 9/1/20 although due to delays in obtaining his California medical license he will not start clinically until later this fall.

Dr. Nels Dahlgren

Dr. Dahlgren is a Anesthesia pain management specialists who has signed a contract effective 9/1/20 although he will not start clinical shifts until later this fall.

Dr. Rich Meredick

Dr. Meredick has signed a year long contract effective 9/1/20.

Dr. Engblade

Dr. Engblade has signed a cardio-pulmonary contract to review stress tests, EKG's and other related cardio-pulmonary tests.

Recruitment and Staffing

1. Dr. Mellisa Butts is the significant other of Dr. Ma and is in the process of applying for telehealth rheumatology privliges at NIHD.
2. Dr. Engblade returned to NIHD full time in august and has assumed the role of hospitalist director.
3. Dr. Jesionek began working in August as a hospitalist and has been well received.
4. Dr. Ricci will be joining pediatrics in October.
5. Dr. O'Neal, a general surgeon and breast surgeon began working in September.

6. Dr. Pearson-Souders is a urologist who is finishing a fellowship and she is very interested in relocating to Bishop next year and providing full time local urology services. Dr. Ercolani and ERSC are aware of this and support this transition.
7. Dr. Clayton Davis is also a urology resident interested in the area he still has 2.5 years left in his training however. We will keep in touch with him as our needs change and he approaches the completion of his training.
8. There have been several general surgeons including Drs. Cheryl Olson (who also does breast surgery), Nadia Guardado, and Lynn Bryan who have all expressed interest in the area. At this time we do not have need for their services but we will continue to keep in touch as our needs change.
9. Dr. Slotnick has resigned.

Bronco Clinic

I have been working with WIFPLI to enroll the bronco clinic as a licensure exempt clinic (1206b) which would allow us to bill for services including mediCal, family PACT, and commercial insurance. This project continues to move forward and will hopefully be completed in the near future.

Provider Based Clinic Evaluation

Currently the NIA clinics are not licensed through the hospital and therefore the hospital is unable to collect a facility fee for services. WIPFLI gave a initial rough estimate that this could be a loss of revenue amounting to 1-2 million per year. The largest barrier to changing this designation is that the clinics need to be OSHPD level 3 compliant. Colombo construction has been asked to provide the district with a proposal for evaluating the NIA clinics for OSHPD level 3 compliance at which point a ROI will be completed to determine the cost effectiveness of transitioning to provider based hospital licensed clinics. This project is on hold at the moment pending the sale of the pioneer medical associates building and a formal analysis of the potential ROI.

Marriage Family Therapist

MFT's contracted through Toiyable continue to see patients. We will renegotiate our medi-cal rate at the end of the fiscal year.

Medical Staff Office Update

Amanda Holland in the the medical staff office has resigned leaving Dianne Picken as the sole MSO employee. We will plan to hire a replacement for Amanda. We are also evaluating the possibility of automated credentialing software which is becoming industry standard. Additionally we are discussing moving provider enrollment under the MSO.

Quality

Quality is now under the CMO and I have been working with the quality team to identify new projects and ensure we are meeting goals for current projects. Two of the most pressing are the PRIME grant and HEDIS reporting. The PRIME grant is funding that is tied to meeting quality metrics like antibiotic meaningful use for example. We have in the past not met the needed metrics and have left significant grant funding on the table. PRIME will transition to QIP next year. HEDIS reporting is required by certain payers such as blue cross to ensure we are meeting specific care metrics. Meeting these metrics is tied to compensation and continued contracting with these payers. We have previously been approximately six months behind on HEDIS reporting. We are working on catching up on this back log and ensuring a system is in place for timely and accurate reporting. Under quality I will also be involved in CMQCC, OSHPD MIRCAL, as well as UOR's and chairing the quality council. The quality council is a multi-disciplinary committee that looks at quality initiatives to improve care or systems at the district. We are currently working on a sepsis protocol and ACE's initiative.

Pharmacy

Pharmacy is now under the CMO and I have been working with Frank and Jeff and the rest of the pharmacy team. The BBraun roll out was very successful and was implemented without any notable issues. We have approved a 340B position for pharmacy which will bring on a part time individual with 340B program training to help ensure we are maximizing the benefits of this program at NIHD. Briefly 340B is a federal program that provides discounted drugs to qualifying institutions like critical access hos-

pitals. We have also been discussing the multipliers used for drug administration charges and ensuring that this is in-line with standard practice.

Cerner Implementation

I have stepped into the role of "sponsor" for this project band have been participating is steering meetings as well as change readiness meetings with Cerner and WIPFLI to lay the framework for ramped up implementation in the coming months.

RHC Efficiency Study

I will be working with Sonia Singh and Mohamed Saleh and RHC leadership as well as the rest of the executive team to facilitate this study and create an action plan based on the recommendations. LEAN process training occurred on 9/1/20.

Respectfully,

Will Timbers, MD

September 2020 CNO Board of Directors Report

CNO General Information-Tracy Aspel, BSN-RN:

- Allison Partridge, MSN, RN began orientation to the Chief Nurse Officer role on 9/14/2020.
- Tracy Aspel, BSN, RN will retire on 10/2/2020.
- Incident Command for COVID continues to meet weekly. Tasks completed total 257 issues. Currently 6 task items remain open/in progress. The District remains fully operational for limited services. Decisions to remain at this level are centered around availability of staff, supplies, bed space and number of COVID patients requiring hospitalization. Focus remains on prevention of spread. August 3, 2020 the District began screening for symptoms of COVID for all persons entering the facilities. Staff and patients have adapted well to the screening process.
- Testing for COVID infections has been standardized in the way samples are collected and the decision to test based upon history of exposure and symptoms. Workflows are mapped for staff utilization.
- LabCorp test result turn-around-times have significantly improved over the past month to 1.37 days from time the sample is picked up from NIHD to delivery of results.
- Surge plans have been formalized and approved at the incident command. Great collaboration occurred under the leadership of Allison Partridge, MSN, RN.

Case Management & Hospital Social Work: Melanie Fox, BSN-RN & Heather Edwall, LCSW:

- We are still surviving Coronavirus without patient overflow. YEAH TEAM!!!!! 😊 😊 😊
- Due to a major outbreak at Bishop Care Center there was some trouble discharging patients to SNF-level care in August, but the infections seem to have been contained and BCC is able to accept patients again now. RNCM continues to keep a close watch on this facility and works closely with her colleagues there to stay abreast of changes.

PATIENT CARE:

- SW conducted 199 total patient tasks: 48 contacts were made for mental health reasons; 55 for substance abuse; and 27 (combined) CPS/APS issues. All numbers are up from the previous reporting period, although this may have to do with the way SW is entering data as we get a system figured out.
- SW utilized our in-house interpreter for the first time during this reporting period; language line usage was also up this month and is working well.
- 2 couplets have been referred to the new Home Visiting program through Inyo County First 5.
- Discussions continue regarding how best to staff the New Moms' Group formerly run by the now-closed NEST. For the next month the SW is going to co-facilitate the group with Julie Tillemans via Zoom, and we will see how many moms participate and how many questions come up regarding maternal mental health vs. breastfeeding before we decide how to move forward.
- A UOR was filed by a patient seen by the SW in the Women's Clinic.
- RNCM estimates that 10-12 patients have been swung during this timeframe. Physical therapy continues to drive many of these referrals.

RESOURCE DATABASE:

- We are still working on getting internal contacts entered.
- SW attended a House Supe staff meeting to introduce the online resource list. SW has been training new staff on this tool during orientation.

Next Steps: Watch for an official rollout email and training on search features, hopefully in the next 2 months and/or when we have about 400 entries. Staff will be asked for their suggestions via email

to resources@nih.org, and can continue to notify list admins about changes, etc. by emailing this address in the future.

TRAINING:

- SW completed Level II of AAP's online Trauma & Resilience Zoom training with members of the RHC Pediatrics team.
- SW attended CASA of the Eastern Sierra's 4-hour Zoom symposium on Resilience on July 30.

COMMUNITY INVOLVEMENT:

- RNCM continues to monitor the COVID situation at Bishop Care Center and its sister facility in Redlands, as well as any changes at Pioneer Home Health that have been caused by the recent uptick in cases.
- SW is working with informatics and Michelle Garcia to collect data on domestic violence for the community's next DV Council meeting in November. SW is also attempting to get numbers from Inyo County Health & Human Services however they are claiming the state will not let them release much aggregate data due to HIPAA concerns in a very small community.

ADMINISTRATIVE:

- SW & RNCM both attended House Supervisor staff meetings in the past two months. Discussions included the online resource database and discharge info needed by Pioneer Home Health.
- We are trying to relocate the brochure racks purchased for the social services office, as far fewer visitors are in the hospital now and nursing staff have not been coming to take what they need since COVID started. The plan is to move one rack to the ED lobby, one rack to the main hospital lobby, and the third to the triage room in OB. The managers of these departments are excited about the possibility of being to offer more info to patients easily, and the SW is happy to keep each location stocked with the info that is likely to be most relevant to that department's patients.
- SW still needs to get approved as a "Billable Provider " in case of future furloughs/increased need between hospital and RHC -- could be a good opportunity to recoup some money and to be more flexible in providing services where needed. A meeting was held 7/14 and SW sent some personal info to Whitney Jacobsen and Lisa Harmon but so far no info has come back. Tracy found out that LCSW's are covered under the regular hospital policy; no additional coverage needs to be added for either Linda Christensen or Heather Edwall.

Emergency Department & Disaster Management: Allison Partridge-DON, MSN-RN, Gina Riesche-Manager, BSN-RN and Jenny Bates-Assistant Nurse Manager, MNE-RN:

- Jenny Bates, MSN, RN, has been a key leader in the Sepsis program development. This collaborative effort will help nursing teams with early recognition and rapid interventions to support best outcomes for patients who present with sepsis in the emergency department or develop sepsis during inpatient stays at NIHD. Education for staff will be provided. Physician order sets have been developed, along with check lists that will standardize the care of the sepsis patients.

Acute/Subacute & Intensive Care Unit: Allison Partridge-DON, MSN-RN, Justin Nott-Manager, BSN-RN & Brooklyn Burley-Assistant Nurse Manager, RN:

- Early Mobilization of patients continues to be developed with specific guidelines for trauma patients in our ICU. This project is being led by Brooklyn Burley, BSN, RN.
  Work continues on Early Mobilization of the post-operative total joint replacement patients in collaboration with the NIHD Rehab Department and NIHD's Orthopedic Surgeons.
  The benefits to the patient of Early Mobilization include reduction in post-operative complications such as blood clots and pneumonia. Recovery is enhanced and patients are able to get back to the activities of daily living sooner.

Perinatal Services: Allison Partridge-DON, MSN-RN, Julie Tillemans-Manager, BSN-RN:

- We have identified goals to run monthly crash-cesarean drills, quarterly neonatal resuscitation drills, and frequent drills with a focus of early recognition for maternal hemorrhage and pre-eclampsia/eclampsia. We take pride in meeting the Standard of Care of delivery within 30 minutes after recognition of maternal and or fetal distress. Running monthly drills has been a pro-active way to assure high quality, effective, and safe patient care.
- Our Team places a focus on enhanced recovery after cesarean sections. Our hospital recognizes the importance of providing evidence-based, patient-centered care by incorporating a standardized, multidisciplinary approach aimed to optimize recovery from cesarean delivery and improve maternal and newborn outcomes.
- Since April, our Team has worked diligently alongside other departments and we saw this preparedness come to fruition when our Team assisted in the delivery of a 26-week gestational infant via emergency cesarean this summer. This infant was transferred to a higher level of care on his first day of life and continues to amaze his parents and his healthcare team with his growth and development! While our team gained invaluable experience with this delivery, our overall preparedness provided a foundation upon which we were able to achieve a positive outcome for the mother and baby.

Pre-operative, Post Anesthesia Care Unit (PACU) and Infusion: Ann Wagoner-DON, BSN-RN & Nicole Eddy-Manager, BSN-RN:

- Tammy Andersen, BSN, RN has begun orientation to the Nurse Manager position for PACU/Outpatient Nursing role. She has management experience and is excited to grow in nursing leadership responsibilities.
- Space remains a challenge for the treatment of patient with wound. This program is under review for Return on Investment currently. Work is in process to look for a better way to provide this service within the community.
- Infusions continue to be provided within the PACU during the wait for the infusion center to re-open. Staff remains focused on spacing patients for safety during COVID within the PACU setting.

Operative and Sterile Processing Units: Ann Wagoner-DON, BSN-RN & Julie Allen-Manager, RN:

- The NIHD surgical team is training Nicole Eddy, BSN, RN, into the role of surgical nurse. This is a long process in this very specialized area of nursing care. Nicole is reported to being learning quickly and bringing expertise on use of the electronic health record to this team.
- The surgical team has been supporting increasing numbers of urology surgeries. They are excited to utilize their skills to support Drs. Su and Ercolani.

Quality, Clinical Informatics and Survey Readiness Team: Robin Christensen-DON & Ali Feinberg-Manager RN:

- Ali Feinberg, BSN, RN, has hit the ground running in her new role of Manager in this evolving department. She led an informatics project to develop Respiratory Care Unit (RCU) Beds within the electronic health record; allowing for documentation to occur on patients admitted into this service line during COVID. Integrated testing involved key stakeholder from around the district to assure data and orders flowed between key service lines.
- Antibiotic Stewardship project team is tied to the sepsis project and other medical conditions that require the use of antibiotics. In order to make this project successful, data must drive decisions. This team is working to mine the data needed. This quality project is essential to the district for the health of our community. It is also tied to fiscal initiatives that incentivize the completion of the project.

Infection Prevention and Employee Health: Robin Christensen – DON, Jennifer Yednock, Infection Prevention & Marcia Male, Employee Health Specialist:

- Influenza vaccination is more important than ever during the COVID-19 pandemic. Marcia Male, MSN, RN, began providing flu shots September 3rd for all staff, volunteers, contracted workers (including medical staff) and Board Members.
- Martha Reynolds, RN, has cross trained to support the employee health services.
- Jennifer Yednock, RN, has joined the NIHD Team and is training to the role of Infection Preventionist. Robin Christensen, our current IP, will assure Jennifer is supported during this on-boarding. The role of the IP is important to all healthcare facilities under normal circumstance; during the pandemic, this role has played an essential role in decisions that have kept the district staff, patients and visitors safe.

Language Services: Jose Garcia-Manager:

- The Spanish Call Center re-opened on August 31. It had been closed due to a leave of absence.
- Interpreter Intelligence application is up and running to schedule interpreter for face-to-face language services for our Spanish speaking (Limited English Proficiency) patients.
- Additional video interpreter units have been provided for use at NIHD by Blue Cross Insurance. NIHD doesn't own these, but are able to utilize these for interpreter services. This will allow for rapid access to use a video unit for our patients who need interpreting in American Sign Language or many languages.

Clinics: Jannalyn Lawrence –DON, Dan David – Care Coordination Manager & Jessica Nichols – Telehealth Manager:

- Efficiency Project is underway in the RHC. Executive Leadership training in LEAN process took place on September 1. Assessment via direct observation and interview of staff occurred during the week of August 31st. This 90-day project will continue on beyond the time period supported by Sonia Singh and Mohamed Saleh, the consultants hired by the Board or Directors.
- The week of August 29 will include a Kaizen event with participants from various roles within the clinic and key stakeholders that interface from outside district departments. This will occur over a week with identification of items that can improve processes at the RHC. Look for more to come in the next CNO report.

Respectfully Submitted,

Tracy Aspel, CNO

Northern Inyo Healthcare District
Preliminary Statement of Revenues, Expenses, and Changes in Net Position

	Month To Date 03/31/2020	Month To Date 04/30/2020	Month To Date 05/31/2020	Month To Date 06/30/2020	Month To Date 07/31/2020	Month To Date 08/31/2020
	Actual	Actual	Actual	Actual	Actual	Actual
Total Net Patient Revenue	6,433,336	5,860,325	7,035,896	10,209,116	8,009,574	8,107,835
Cost of Services						
Salaries & Wages	2,306,957	1,999,126	2,082,140	2,131,310	2,244,425	2,257,499
Benefits	1,354,501	1,510,414	1,425,243	1,534,685	1,285,813	1,130,757
Professional Fees	1,780,735	1,345,196	1,022,558	1,993,984	1,617,924	1,815,000
Pharmacy	307,021	97,521	(92,043)	277,996	176,452	195,000
Medical Supplies	363,525	225,429	236,510	518,908	373,322	250,000
Hospice Operations	0	(205,000)	0	0	0	0
Other Direct Costs	509,948	356,243	373,844	571,281	608,603	595,000
Bad Debt	146,593	416,771	380,084	1,166,413	(43,085)	0
Total Cost of Services	6,769,280	6,155,700	5,428,336	8,194,577	6,263,454	6,243,256
General and Administrative Overhead						
Salaries & Wages	367,916	383,970	699,368	333,484	341,944	326,215
Benefits	270,688	337,172	258,528	267,213	280,576	265,000
Professional Fees	206,042	(35,279)	161,631	461,022	239,896	450,000
Depreciation and Amortization	347,920	348,193	348,359	357,427	348,949	350,000
Other Administrative Costs	145,028	399,073	(181,879)	486,975	122,302	190,000
Total General and Administrative Overhead	1,337,594	1,433,129	1,286,007	1,906,121	1,333,667	1,581,215
Financing Expense	284,392	293,024	308,433	82,068	7,548	(2,062)
Financing Income	209,722	209,723	209,723	515,079	0	0
Investment Income	34,548	99,268	(8,295)	43,759	(28,259)	2,850
Miscellaneous Income	77,260	2,890,894	(2,829,840)	121,511	128,856	47,399
Change in Net Position	(1,636,400)	1,178,357	(2,607,413)	698,699	505,502	331,551
Cash	5,269,679.30	29,794,230.48	35,395,220.31	37,429,842.48	13,484,693.24	14,875,557.63

LAIF	8,595,686.82	8,654,046.81	22,913,504.16	22,350,008.12	45,432,271.17	45,432,353.12
CARES Act		1,724,442.81	4,996,327.97			
PPP			8,927,627.95			
Medicare Advance		14,594,153.77				
IGT		7,338,015.60				
Cash without Subsidy	**13,865,366.12**	**14,791,665.11**	**20,728,156.37**	**22,199,282.50**	**21,336,396.31**	**22,727,342.65**

NORTHERN INYO HEALTHCARE DISTRICT
SUBMISSION TO THE BOARD OF DIRECTORS
FOR APPROVAL

Date: September 7, 2020

Title: **COMPLIANCE DEPARTMENT QUARTERLY REPORT**

Presenter(s): Patty Dickson
Compliance Officer

Synopsis: The Compliance Department Quarterly Report updates the Board on the work of the Compliance Department. It provides information on audits, breaches, contract work, and projects. All information in the report is summarized, however, any additional details will be provided to the Board of Directors upon request.

Prepared by: __Patty Dickson
Compliance Officer

Reviewed by: Kelly Davis
Name
Title INTERIM CEO

Approved by: Kelly Davis
Name
Title INTERIM CEO

FOR EXECUTIVE TEAM USE ONLY:

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

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Compliance Report
September 2020

1. **Comprehensive Compliance Program review** – no update since previous quarterly report
2. **Breaches**
    a. The Compliance Department has investigated 16 alleged breaches since June 1, 2020.
        i. Investigations closed with no reporting required – 11
        ii. Investigations still active – 2
        iii. Reported to CDPH/OCR – 3
            1. No determinations received from CDPH
3. **Issues and Inquiries** - no update since previous quarterly report
4. **Audits**
    a. Employee Access Audits - The Compliance Department Analyst manually completes audits for access of patient information systems to ensure 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. Audits are also conducted when requested or "for cause"
        iv. Compliance performs between 250-800 audits monthly.
            1. Each audit ranges from hundreds of lines of data to thousands of lines of data.
            2. A "flag" is created when any access appears unusual.
            3. Flags are reviewed and resolved by comparison audits, workflow review, discussions with workforce, and discussions with leadership.
    b. Business Associates Agreements (BAA) audit
        i. We currently have approximately 160 Business Associates Agreements.

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   ii. 2 BAAs are currently in negotiations
   iii. We have executed 9 BAAs since June 1, 2020
c. Vendor Contract reviews
   i. 4 contracts currently in review with vendor and/or legal counsel
   ii. 29 contracts reviewed in conjunction with legal counsel since June 1, 2020
   iii. Reviewing all Athena and Partners contracts for notification of cancellation or renegotiation timelines – roughly 19 contracts in review
d. PACS (Picture Archival and Communication System) User Access Agreements - No update since previous quarterly report
e. HIMS scanning audit – Scheduled for Q4 CY 2020
f. Language Access Services Audit – no update since previous quarterly report
g. 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. Due again in Nov 2020
   ii. NIHD is now using 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.
      1. We have 70 Vendor Companies registered.
      2. We have 127 Representatives registered.
h. 340B audit – completed and demonstrated compliance.
i. An audit of NIHD Board of Directors Agendas, Minutes, and Resolutions is in progress.

5. **CPRA (California Public Records Act) Requests**
   a. The Compliance office either has responded or is responding to 43 CPRA requests so far in 2020.
      i. Thousands of documents have already been released in response
      ii. Tens of thousands of documents have been reviewed to determine responsiveness and status of disclosure
6. **Compliance Workplan** - – no update since previous quarterly report
7. **Unusual Occurrence Reports** (UOR) - Transitioned to Quality Department

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a. UORs now addressed by Michelle Garcia with support from Ali Feinberg, Robin Christensen, and assistance from the Compliance Department as needed. Reporting on UORs will no longer accompany the Compliance Quarterly Report.

8. **CDPH Licensing Survey Response Monitoring** – no update since previous quarterly report
9. **The Joint Commission Survey Response** – no update since previous quarterly report
10. **Compliance and Business Ethics Committee**
    a. Has not met in 2020. Plans to meet Q4.
    b. Need to reassess team members and meeting dates
11. **California Division of Occupational Safety and Health (CAL DOSH) Complaint**
    a. No further communication from CAL DOSH at this time (09/04/2020).
12. **Optimization, update, and audit of Policy Management software**
    a. Proper policies and policy management is a large component of an effective Compliance Program.
    b. A small team comprised of nursing, operations, compliance, and ITS representatives have been completing work on the policy management software optimization.
    c. Clean up work is on-going. Development of optimal processes to assign policies will assure that policies are only assigned to readers that must review the policies.
    d. Will reduce employer costs by allowing for better use of employee time by reducing policy assignments to those necessary and required.
    e. Anticipated go-live before end of CY 2020
13. **Optimization, update, and audit of Contract Management software**
    a. Update to most current version of software will occur in September 2020
    b. Training for licensed users to occur in September 2020
    c. Will allow for monitoring metrics (Joint Commission standard)
    d. Will allow for filtering and easier access by users
    e. Can now be configured to send notifications when contracts are due to be reviewed or renegotiated
    f. Will reduce visible contracts from almost 1800 to the 200 currently active contracts
    g. All historic contracts in the system will still be available for review.

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

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

Narrative:
We have successfully completed the Planning Phase for the project. All associated planning phase tasks were completed on time and there are no significant issues or concerns to report to the Board of Directors. We have entered the Data Gathering phase. During this phase, we will begin to collect data that will populate the Cerner databases. Data examples include the Charge Master, Item Master, Formulary, and Lab Tests. In addition, we will gather current department workflows. Cerner will review these workflows and recommend changes to apply standardization or conform with industry best practices when appropriate.

NIHD and Cerner continue to monitor the latest developments of the COVID-19 pandemic. There are approximately ten Cerner events that are typically conducted either at our facility or in Kansas City. Based on CDC guidelines, we currently have travel restrictions in place. For example, the formal Cerner kick-off event was originally scheduled to occur in Kansas City. NIHD opted to conduct this event virtually. The next two Cerner Events: Workflow and Integration scheduled for November 3 – 5, 2020, and Train the Trainer scheduled for December 15 – 17, 2020 will be conducted virtually instead of having Cerner consultants travel to our facility. Planning for these events is underway and we expect to meet the goals and objectives of these events with this modified approach.

Top Five Accomplishments for this Reporting Period

1. All tasks associated with the Planning Phase were successfully completed on time.
2. The Cerner formal kick-off meetings were held on August 26 and 27, 2020.
3. The NIHD project team has been fully assembled with the last step of identifying our Super Users now completed.
4. We have a project Name: Sierra Cerner Project. We have started to create a project logo and brand.
5. The communication team continues to develop and distribute timely and targeted communication.

Issues or Concerns the Board of Directors Should Be Aware Of

1. None

Upcoming Events or Milestones

1. Learning and Adoption Workshop
2. Completion of our Risk Mitigation Plan
3. Begin weekly department calls with Cerner consultants. The first few weeks will focus on data gathering information that will be used to configure the Cerner systems (e.g., item master, charge master, formulary).

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

Reviewed by: _____
Name
Title of Chief who reviewed

Approved by: _____
Name
Title of Chief who approved

FOR EXECUTIVE TEAM USE ONLY:

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