# September 15 2021 Regular Meeting

## September 15 2021 Regular Meeting

# *AGENDA*

## NORTHERN INYO HEALTHCARE DISTRICT
## BOARD OF DIRECTORS REGULAR MEETING
## September 15, 2021 at 5:30 p.m.

***Beginning July 1, 2021, the Board will again meet in person at 2957 Birch Street Bishop, CA 93514 at 5:30 pm. Members of the public will be allowed to attend in person or via zoom. Public comments can be made in person or via zoom:***

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

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

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. Adjournment to Closed Session to/for:
   A. CONFERENCE WITH LABOR NEGOTIATORS pursuant to Government Code Section 54957.6.
   B. CONFERENCE WITH LEGAL COUNSEL- ANTICIAPTED LITIGATION
      Significant exposure to litigation (pursuant to paragraph (2) of subdivision (d) of Government Code Section 54956.9: (two cases)
   C. CONFERENCE WITH LEGAL COUNSEL- ANTICIPATED LITIGATION

Significant exposure to litigation pursuant to paragraph (2) or (3) of subdivision (d) of Government Code section 54956.9: (one case)

D. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
Title: District Legal Counsel, Gov. Code. 54957(b) (1).

E. PUBLIC EMPLOYEE APPOINTMENT pursuant to Government Code 54957
Title: Chief Executive Officer

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

5. New Business

A. Jones and Mayer Contract Review (*Board will consider the approval of this contract)*
B. Pioneer Home Health Care Component Presentation by Noel Caughman with BBK Law Firm (*Board will receive this presentation)*
C. Approval of the Pharmacy and Infusion Project Preliminary Budget $3,000,000.00 *(Board will consider the approval of this budget)*
D. Compliance and Business Ethics Committee *(Board will consider the appointment of a representative)*
E. Chief Executive Officer Search Update (*Board will receive an update)*

6. Chief of Staff Report, Sierra Bourne MD:

A. Medical Staff Resignations (*Board will consider the approval of these Medical Staff Resignations*)
1. Arrash Fard, MD (*cardiology*) – telemedicine staff; Adventist Health – effective 8/31/2021

B. Policies and Procedures (*Board will consider the approval of these Policies and Procedures*)
*1. Safe Patient Handling – Minimal Lift Program*
*2. Packing Blood Products in Transport Containers*
*3. Safe-T-Vue 10 Non-reversible Temperature Indicators - Direction for Use*
*4. Returning Dispensed Blood Products to Inventory*
*5. ABO/Rh Confirmation Testing - Patients*
*6. ABO/Rh Testing for Adults*
*7. "Crash Pack" Emergency Dispense of Uncrossmatched Blood - Preparation and Reconciliation*
*8. Dispensing Blood Products - Non-emergent*
*9. Transfusion Criteria*
*10. Cerebrospinal Fluid Cultures*
*11. Principles Of Asepsis In The Operating Room*
12. *Warming Cabinet For Blankets/Solutions*
*13. Credentialing – da Vinci Robotic Surgery*

C. Biennial Review of Medical Staff Policies (*Board will consider the approval of these Medical Staff Policies*)
1. *Standardized Protocol - General Policy for the Physician Assistant*
*2. Standardized Procedure - Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife*
*3. Standardized Procedure - Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife*

4. *Standardized Protocol - Laboratory and Diagnostic Testing Policy for the Physician Assistant*
5. *Standardized Protocol - Medication/Device Policy for the Physician Assistant*
6. *Standardized Protocol - Minor Surgical Policy for the Physician Assistant*
7. *Standardized Procedure - Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife*
8. *Standardized Procedure - Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife*

D. Medical Executive Committee Meeting Report (*Board will receive this report*)

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***Consent Agenda***

7. Interim Chief Executive Officer Report *(Board will receive this report)*
8. Chief Medical Officer Report *(Board will receive this report)*
9. Policies and Procedure approval *(Board will consider the approval of these Policies and Procedures)*

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10. Reports from Board members *(information item)*
11. Adjournment

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

**NORTHERN INYO HEALTHCARE DISTRICT**
**SUBMISSION TO THE BOARD OF DIRECTORS**
**FOR CONSIDERATION**

Date: August 24, 2021

Title: **Jones & Mayer contract for Board Counsel**

Presenter(s): Patty Dickson
Compliance Officer

Synopsis: The contract for NIHD Board counsel with the law firm Jones & Mayer expires October 1, 2021. The Compliance Department respectfully submits an updated contract for consideration by the Board of Directors. I have attached the previous 1 year agreement, and a new 3 year proposed contract from Jones and Mayer. Each agreement also includes a Business Associates Agreement that the Compliance Department finds acceptable.

**The Compliance Department has no recommendation.**

Prepared by: Patty Dickson
Compliance Officer

Reviewed by: Kelli Davis
Name
Title INTERIM CEO

Approved by: Kelli Davis
Name
Title INTERIM CEO

**FOR EXECUTIVE TEAM USE ONLY:**

Date of Executive Team Approval: 9-1-2021 Submitted by: Kelli Davis
Chief Officer

**AGREEMENT BETWEEN NORTHERN INYO HEALTHCARE DISTRICT AND JONES & MAYER FOR THE PROVISION OF LEGAL SERVICES**

## INTRODUCTION

WHEREAS, Northern Inyo Healthcare District (hereinafter referred to as "NIHD" or "District") may have the need for the legal services of the Jones & Mayer law firm hereinafter referred to as "Contractor"), and in consideration of the mutual promises, covenants, terms, and conditions hereinafter contained, the parties hereby agree as follows:

## TERMS AND CONDITIONS

### 1. SCOPE OF WORK.

The Contractor shall serve as General Counsel for NIHD, and furnish to NIHD, upon its request, those services and work set forth in Attachment A, attached hereto and by reference incorporated herein. Requests by the District to the Contractor to perform under this Agreement will be made by the CEO for the District or his/her designee. Requests to the Contractor for work or services to be performed under this Agreement will be based upon NIHD's need for such services. The District makes no guarantee or warranty, of any nature, that any minimum level or amount of services or work will be requested of the Contractor by the District under this Agreement. NIHD by this Agreement incurs no obligation or requirement to request from Contractor the performance of any services or work at all, even if District should have some need for such services or work during the term of this Agreement.

Services and work provided by the Contractor at the District's request under this Agreement will be performed in a manner consistent with the requirements and standards established by applicable federal, state, county, and District laws, ordinances, regulations, and resolutions. Such laws, ordinances, regulations, and resolutions include, but are not limited to, those which are referred to in this Agreement.

### 2. TERM.

The term of this Agreement shall be from **October 1, 2020** to **October 1, 2021,** unless sooner terminated as provided below.

### 3. CONSIDERATION.

A. Compensation. NIHD shall pay to Contractor in accordance with the Schedule of Fees (set forth as Attachment **B**) for the services and work described in Attachment **A** which are performed by Contractor at the County's request.

B. Travel and per diem. District shall reimburse Contractor for travel expenses and per diem which Contractor incurs in providing services and work requested by District under this Agreement. Contractor shall request approval by the District prior to incurring any travel or per diem expenses. Requests by Contractor for approval to incur travel and per diem expenses shall be submitted to the Administration Office of NIHD. Travel and per diem expenses will be reimbursed in accordance with the rates set forth in the Schedule of Travel and Per Diem Payment (Attachment **C**). District reserves the right to deny reimbursement to Contractor for travel or per diem expenses which are either in excess of the amounts that may be paid to under the rates set forth in Attachment **C**, or which are incurred by the Contractor without the prior approval of the District.

C. Incidental Expenses. District shall reimburse Contractor in accordance with the Schedule of Fees (Attachment **B**) for those Incidental Expenses which are specifically identified in the Schedule of Fees and which are necessarily incurred by the Contractor in providing the services and work requested by District under this Agreement. Reimbursement by NIHD for such Incidental Expenses will be limited to Contractor's actual cost without regard to any administrative or overhead expenses incurred by Contractor in obtaining or utilizing such incidental services or supplies. Reimbursement for actual costs will not exceed the amounts set forth in the Schedule of Fees.

D. No additional consideration. Except as expressly provided in this Agreement, Contractor shall not be entitled to, nor receive, from District, any additional consideration, compensation, salary, wages, or other type of remuneration for services rendered under this Agreement. Specifically, Contractor shall not be entitled, by virtue of this Agreement, to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays, or other paid leaves of absence of any type or kind whatsoever.

E. Billing and payment. The billing and payment arrangement is set forth in Attachment B.

G. Federal and State taxes.

(1) Except as provided in subparagraph (2) below, District will not withhold any federal or state income taxes or social security from any payments made by District to Contractor under the terms and conditions of this Agreement.

(2) District will withhold California State income taxes from payments made under this Agreement to non-California resident independent contractors when it is anticipated that total annual payments to Contractor under this Agreement will exceed one thousand four hundred ninety nine dollars ($1,499.00).

(3) Except as set forth above, District has no obligation to withhold any taxes or payments from sums paid by District to Contractor under this Agreement. Payment of all taxes and other assessments on such sums is the sole responsibility of Contractor. NIHD has no responsibility or liability for payment of Contractor's taxes or assessments.

(4) The total amounts paid by District to Contractor, and taxes withheld from payments to non-California residents, if any, will be reported annually to the Internal Revenue Service and the California State Franchise Tax Board. To facilitate this reporting, Contractor shall complete and submit to the District an Internal Revenue Service (IRS) Form W-9 upon executing this Agreement.

**4. WORK SCHEDULE.**

Contractor's obligation is to perform, in a timely manner, those services and work identified in Attachment A which are requested by the District. It is understood by Contractor that the performance of these services and work will require a varied schedule. Contractor will arrange his/her own schedule, but will coordinate with District to ensure that all services and work requested by District under this Agreement will be performed within the time frame set forth by District.

**5. REQUIRED LICENSES, CERTIFICATES, AND PERMITS.**

A. Any licenses, certificates, or permits required by the federal, state, county, municipal governments, for contractor to provide the services and work described in Attachment A must be procured by Contractor and be valid at the time Contractor enters into this Agreement or as otherwise may be required. Further, during the term of this Agreement, Contractor must maintain such licenses, certificates, and permits in full force and effect. Licenses, certificates, and permits may include, but are not limited to, driver's licenses, professional licenses or certificates, and business licenses. Such licenses, certificates, and permits will be procured and maintained in force by Contractor at no expense to the District. Contractor will provide District, upon execution of this Agreement, with evidence of current and valid licenses, certificates and permits which are required to perform the services identified in Attachment **A**. Where there is a dispute between Contractor and District as to what licenses, certificates, and permits are required to perform the services identified in Attachment **A**, District reserves the right to make such determinations for purposes of this Agreement.

B. Contractor warrants that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in covered transactions by any federal department or agency. Contractor also warrants that it is not suspended or debarred from receiving federal funds as listed in the List of Parties Excluded from Federal Procurement or Non-procurement Programs issued by the General Services Administration available at: http://www.epls.gov.

**6. OFFICE SPACE, SUPPLIES, EQUIPMENT, ETC.**

Contractor shall provide such office space, supplies, equipment, vehicles, reference materials, and telephone service as is necessary for Contractor to provide the services identified in Attachment A to this Agreement. Except for those incidental expenses specifically identified in the Schedule of Fees (Attachment), District is not obligated to reimburse or pay Contractor, for any expense or cost incurred by Contractor in procuring or maintaining such items. Responsibility for the costs and expenses incurred by Contractor in providing and maintaining items not specifically set forth in the Schedule of Fees (Attachment **B**), is the sole responsibility and obligation of Contractor.

## 7. COUNTY PROPERTY.

A. Personal Property of County. Any personal property such as, but not limited to, protective or safety devices, badges, identification cards, keys, etc. provided to Contractor by District pursuant to this Agreement are, and at the termination of this Agreement remain, the sole and exclusive property of District. Contractor will use reasonable care to protect, safeguard and maintain such items while they are in Contractor's possession. Contractor will be financially responsible for any loss or damage to such items, partial or total, which is the result of Contractor's negligence.

B. Products of Contractor's Work and Services. Any and all compositions, publications, plans, designs, specifications, blueprints, maps, formulas, processes, photographs, slides, video tapes, computer programs, computer disks, computer tapes, memory chips, soundtracks, audio recordings, films, audio-visual presentations, exhibits, reports, studies, works of art, inventions, patents, trademarks, copyrights, or intellectual properties of any kind which are created, produced, assembled, compiled by, or are the result, product, or manifestation of, Contractor's services or work under this Agreement are, and at the termination of this Agreement remain, the sole and exclusive property of the District. At the termination of the Agreement, Contractor will convey possession and title to all such properties to District.

## 8. WORKERS' COMPENSATION.

Contractor shall provide Statutory California Worker's Compensation coverage and Employer's Liability coverage for not less than $1,000,000 per occurrence for all employees engaged in services or operations under this Agreement. The District, its agents, officers and employees shall be named as additional insured or a waiver of subrogation shall be provided.

## 9. INSURANCE REQUIREMENTS FOR PROFESSIONAL SERVICES.

Contractor shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Consultant, its agents, representatives, or employees.

A. Minimum Scope and Limit of Insurance. Coverage shall be at least as broad as:

1. Commercial General Liability (CGL): Insurance Services Office Form CG 00 01 covering CGL on an "occurrence" basis for bodily injury and property damage, including products-completed operations, personal injury and advertising injury, with limits no less than **$1,000,000.00** per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location or the general aggregate limit shall be twice the required occurrence limit.

2. Automobile Liability: Insurance Services Office Form Number CA 0001 covering, Code 1 (any auto), or if Contractor has no owned autos, Code 8 (hired) and 9 (non-owned), with limit no less than **$500,000.00** per accident for bodily injury and property damage.

3. Workers' Compensation insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than **$** ___ per accident for bodily injury or disease.
*(Not required if Contractor provides written verification it has no employees)*

4. Professional Liability (Errors and Omissions) Insurance appropriates to the Contractor's profession, with limit no less than **$1,000,000.00** per occurrence or claim.

If the Contractor maintains higher limits than the minimums shown above, the District requires and shall be entitled to coverage for the higher limits maintained by the contractor.

B. Other Insurance Provisions. The insurance policies are to contain, or be endorsed to contain, the following provisions:

1. Additional Insured Status.

The District, its officers, officials, employees, and volunteers are to be covered as insureds on the auto policy with respect to liability arising out of automobiles owned, leased, hired or borrowed by or on behalf of the Contractor; and on the CGL policy with respect to liability arising out of work or operations performed by or on behalf of the Contractor including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to the Contractor's insurance (at least as broad as ISO Form CG 20 10, 11 85 or both CG 20 10 and CG 23 37 forms if later revisions used).

2. Primary Coverage.

For any claims related to this contract, the Contractor's insurance coverage shall be primary insurance as respects the District, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by the District, its officers, officials, employees, or volunteers shall be excess of the Contractor's insurance and shall not contribute with it.

3. Notice of Cancellation.

Each insurance policy required above shall state that coverage shall not be canceled, except after thirty (30) days' prior written notice (10 days for non-payment) has been given to the District.

4. Waiver of Subrogation.

Contractor hereby grants to District a waiver of any right to subrogation which any insurer of said Contractor may acquire against the District by virtue of the payment of any loss under such insurance. Contractor agrees to obtain any endorsement that may be necessary to effect this waiver of subrogation, but this provision applies regardless of whether or not the District has received a waiver of subrogation endorsement from the insurer.

C. Deductibles and Self-Insured Retentions. Any deductibles or self-insured retentions must be declared to and approved by the District. The District may require the Contractor to provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention.

D. Acceptability of Insurers. Insurance is to be placed with insurers with a current A.M. Best's rating of no less than A:VII, unless otherwise acceptable to the District.

E. Claims Made Policies. If any of the required policies provide coverage on a claims-made basis:

1. The Retroactive Date must be shown and must be before the date of the contract or the beginning of contract work.

2. Insurance must be maintained and evidence of insurance must be provided for at least five (5) years after completion of the contract of work.

3. If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a Retroactive Date prior to the contract effective date, the Contractor must purchase "extended reporting" coverage for a minimum of five (5) years after completion of contract work.

F. Verification of Coverage. Contractor shall furnish the District with original certificates and amendatory endorsements or copies of the applicable policy language effecting coverage required by this clause. All certificates and endorsements are to be received and approved by the District before work commences. However, failure to obtain the required documents prior to the work beginning shall not waive the Contractor's obligation to provide them. The District reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

G. Subcontractors. Contractor shall require and verify that all subcontractors maintain insurance meeting all the requirements stated herein.

H. Special Risks or Circumstances. District reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

**10. STATUS OF CONTRACTOR.**

All acts of Contractor, its agents, officers, and employees, relating to the performance of this Agreement, shall be performed as independent contractors, and no agent, officer, or employee of Contractor is to be considered an employee of District. Contractor, by virtue of this Agreement, has no authority to bind or incur any obligation on behalf of District. Except as expressly provided in Attachment **A**, Contractor has no authority or responsibility to exercise any rights or power vested in the District. It is understood by both Contractor and District that this Agreement shall not under any circumstances be construed or considered to create an employer-employee relationship or a joint venture. As an independent contractor:

A. Contractor shall determine the method, details, and means of performing the work and services to be provided by Contractor under this Agreement.

B. Contractor shall be responsible to District only for the requirements and results specified in this Agreement, and except as expressly provided in this Agreement, shall not be subjected to District's control with respect to the physical action or activities of Contractor in fulfillment of this Agreement.

C. Contractor, its agents, officers, and employees are, and at all times during the term of this Agreement shall, represent and conduct themselves as independent contractors, and not as employees of District.

**11. DEFENSE AND INDEMNIFICATION.**

Contractor shall defend, indemnify, and hold harmless District, its agents, officers, and employees from and against all claims, damages, losses, judgments, liabilities, expenses, and other costs, including litigation costs and attorney's fees, arising out of, resulting from, or in connection with, the performance of this Agreement by Contractor, or Contractor's agents, officers, or employees. Contractor's obligation to defend, indemnify, and hold the District, its agents, officers, and employees harmless applies to any actual or alleged personal injury, death, or damage or destruction to tangible or intangible property, including the loss of use. Contractor's obligation under this paragraph extends to any claim, damage, loss, liability, expense, or other costs which is caused in whole or in part by any act or omission of the Contractor, its agents, employees, supplier, or any one directly or indirectly employed by any of them, or anyone for whose acts or omissions any of them may be liable.

Contractor's obligation to defend, indemnify, and hold the District, its agents, officers, and employees harmless under the provisions of this paragraph is not limited to, or restricted by, any requirement in this Agreement for Contractor to procure and maintain a policy of insurance.

To the extent permitted by law, District shall defend, indemnify, and hold harmless Contractor, its agents, officers, and employees from and against all claims, damages, losses, judgments, liabilities, expenses, and other costs, including litigation costs and attorney's fees, arising out of, or resulting from, the active negligence, or wrongful acts of District, its officers, or employees.

**12. RECORDS AND AUDIT.**

A. Records. Contractor shall prepare and maintain all records required by the various provisions of this Agreement, federal, state, county, municipal, ordinances, regulations, and directions. Contractor shall maintain these records for a minimum of four (4) years from the termination or completion of this Agreement. Contractor may fulfill its obligation to maintain records as required by this paragraph by substitute photographs, microphotographs, or other authentic reproduction of such records.

B. Inspections and Audits. Any authorized representative of District shall have access to any books, documents, papers, records, including, but not limited to, financial records of Contractor, which District determines to be pertinent to this Agreement, for the purposes of making audit, evaluation, examination, excerpts, and transcripts during the period such records are to be maintained by Contractor. Further, District has the right, at all reasonable times, to audit, inspect, or otherwise evaluate the work performed or being performed under this Agreement.

## 13. NONDISCRIMINATION.

During the performance of this Agreement, Contractor, its agents, officers, and employees shall not unlawfully discriminate in violation of any federal, state, or local law, against any employee, or applicant for employment, or person receiving services under this Agreement, because of race, religion, color, national origin, ancestry, physical handicap, medical condition, marital status, age, or sex. Contractor and its agents, officers, and employees shall comply with the provisions of the Fair Employment and Housing Act (Government Code section 12900, et seq.), and the applicable regulations promulgated thereunder in the California Code of Regulations. Contractor shall also abide by the Federal Civil Rights Act of 1964 (P.L. 88-352) and all amendments thereto, and all administrative rules and regulations issued pursuant to said act.

## 14. CANCELLATION.

This Agreement may be canceled by District without cause, and at will, for any reason by giving to Contractor thirty (30) days written notice of such intent to cancel. Contractor may cancel this Agreement without cause, and at will, for any reason whatsoever by giving thirty (30) days written notice of such intent to cancel to District.

## 15. ASSIGNMENT.

This is an agreement for the services of Contractor. District has relied upon the skills, knowledge, experience, and training of Contractor as an inducement to enter into this Agreement. Contractor shall not assign or subcontract this Agreement, or any part of it, without the express written consent of District. Further, Contractor shall not assign any monies due or to become due under this Agreement without the prior written consent of District.

## 16. DEFAULT.

If the Contractor abandons the work, or fails to proceed with the work and services requested by District in a timely manner, or fails in any way as required to conduct the work and services as required by District, NIHD may declare the Contractor in default and terminate this Agreement upon five (5) days written notice to Contractor. Upon such termination by default, District will pay to Contractor all amounts owing to Contractor for services and work satisfactorily performed to the date of termination.

## 17. WAIVER OF DEFAULT.

Waiver of any default by either party to this Agreement shall not be deemed to be waiver of any subsequent default. Waiver or breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach, and shall not be construed to be a modification of the terms of this Agreement unless this Agreement is modified as provided in paragraph twenty-three (23) below.

## 18. CONFIDENTIALITY.

Contractor agrees to comply with the various provisions of the federal, state, and county laws, regulations, and ordinances providing that information and records kept, maintained, or accessible by Contractor in the course of providing services and work under this Agreement, shall be privileged, restricted, or confidential. Contractor agrees to keep confidential all such information and records. Disclosure of such confidential, privileged, or protected information shall be made by Contractor only with the express written consent of the District. Any disclosure of confidential information by Contractor without the District's written consent is solely and exclusively the legal responsibility of Contractor in all respects.

## 19. CONFLICTS.

Contractor agrees that it has no interest, and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of the work and services under this Agreement.

**20. POST AGREEMENT COVENANT.**

Contractor agrees not to use any confidential, protected, or privileged information which is gained from the District in the course of providing services and work under this Agreement, for any personal benefit, gain, or enhancement. Further, Contractor agrees for a period of two years after the termination of this Agreement, not to seek or accept any employment with any entity, association, corporation, or person who, during the term of this Agreement, has had an adverse or conflicting interest with the District, or who has been an adverse party in litigation with the District, and concerning such, Contractor by virtue of this Agreement has gained access to the District's confidential, privileged, protected, or proprietary information.

**21. SEVERABILITY.**

If any portion of this Agreement or application thereof to any person or circumstance shall be declared invalid by a court of competent jurisdiction, or if it is found in contravention of any federal, state, or county statute, ordinance, or regulation, the remaining provisions of this Agreement, or the application thereof, shall not be invalidated thereby, and shall remain in full force and effect to the extent that the provisions of this Agreement are severable.

**22. FUNDING LIMITATION.**

The ability of District to enter this Agreement is based upon available funding from various sources. In the event that such funding fails, is reduced, or is modified, from one or more sources, District has the option to cancel, reduce, or modify this Agreement, or any of its terms within ten (10) days of its notifying Contractor of the cancellation, reduction, or modification of available funding. Any reduction or modification of this Agreement made pursuant to this provision must comply with the requirements of paragraph twenty-four (24) (Amendment).

**23. AMENDMENT.**

This Agreement may be modified, amended, changed, added to, or subtracted from, by the mutual consent of the parties hereto, if such amendment or change is in written form and executed with the same formalities as this Agreement, and attached to the original Agreement to maintain continuity.

**24. NOTICE.**

Any notice, communication, amendments, additions, or deletions to this Agreement, including change of address of either party during the terms of this Agreement, which Contractor or District shall be required, or may desire, to make, shall be in writing and may be personally served, or sent by prepaid first class mail to, the respective parties as follows:

**NORTHERN INYO HEALTHCARE DISTRICT:**
Administration
150 Pioneer Lane
Bishop, CA 93514

**CONTRACTOR:**

Ryan Jones, Partner
Jones & Mayer
6349 Auburn Blvd
Citrus Heights, CA

**25. ENTIRE AGREEMENT.**

This Agreement contains the entire agreement of the parties, and no representations, inducements, promises, or agreements otherwise between the parties not embodied herein or incorporated herein by reference, shall be of any force or effect. Further, no term or provision hereof may be changed, waived, discharged, or terminated, unless the same be in writing executed by the parties hereto.

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**AGREEMENT BETWEEN NORTHERN INYO HEALTHCARE DISTRICT AND JONES & MAYER FOR THE PROVISION OF LEGAL SERVICES**

IN WITNESS THEREOF, THE PARTIES HERETO HAVE SET THEIR HANDS AND SEALS THIS 2nd DAY OF

**NORTHERN INYO HEALTHCARE DISTRICT**

By: Kelli Davis

Dated: 8-25-2020

**CONTRACTOR**

By: _____
Signature

_____
Ryan Jones, Partner

Dated: _____

APPROVED AS TO FORM AND LEGALITY:

_____
District Counsel

APPROVED AS TO ACCOUNTING FORM:

_____
Chief Financial Officer

APPROVED AS TO PERSONNEL REQUIREMENTS:

_____
Personnel Services

APPROVED AS TO INSURANCE REQUIREMENTS:

_____
Risk Manager

**ATTACHMENT A**

**AGREEMENT BETWEEN NORTHERN INYO HEALTHCARE DISTRICT AND JONES & MAYER FOR THE PROVISION OF LEGAL SERVICES**

**TERM:**

**FROM:** October 1, 2020 **TO:** October 1, 2021

**SCOPE OF WORK:**

Contractor shall provide General Counsel legal services for the District. That type of work includes, but is not limited to, the items listed in the Scope of Services section of the RFP for General Counsel Legal Services (released February 29, 2020) at pages 4-5.

**ATTACHMENT A-1**

**AGREEMENT BETWEEN NORTHERN INYO HEALTHCARE DISTRICT AND JONES & MAYER FOR THE PROVISION OF LEGAL SERVICES**

**TERM:**

**FROM: October 1, 2020 TO: October 1, 2021**

NORTHERN INYO HEALTHCARE DISTRICT
**HIPAA BUSINESS ASSOCIATE AGREEMENT**

This Business Associate Agreement ("Agreement") is made by and between the Northern Inyo Healthcare District, referred to herein as Covered Entity ("CE"), and of JONES & MAYER referred to herein as Business Associate ("BA"). This Agreement is effective as of October 1, 2020, (the "Agreement Effective Date").

***RECITALS***

As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require JONES & MAYER to enter into a contract containing specific requirements with BA prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("C.F.R.") and contained in this Agreement.

In consideration of the mutual promises below and the exchange of information pursuant to this Agreement, the parties agree as follows:

**1. Definitions**

a. **Breach** shall have the meaning given to such term under the HITECH Act [42 U.S.C. Section 17921].

b. **Business Associate** shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.

c. **Covered Entity** shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

d. **Data Aggregation** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

e. **Designated Record Set** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

f. **Electronic Protected Health Information** means Protected Health Information that is maintained in or transmitted by electronic media.

g. **Electronic Health Record** shall have the meaning given to such term in the HITECT Act, including, but not limited to, 42 U.S.C. Section 17921.

h. **Health Care Operations** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

i. **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

j. **Protected Health Information or PHI** means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501. Protected Health Information includes Electronic Protected Health Information [45 C.F.R. Sections 160.103, 164.501].

k. **Protected Information** shall mean PHI provided by CE to BA or created or received by BA on CE's behalf.

l. **Security Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

m. **Unsecured PHI** shall have the meaning given to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to, 42 U.S.C. Section 17932(h).

2. **Obligations of Business Associate**

a. **Permitted Uses.** BA shall not use Protected Information except for the purpose of performing BA's obligations under the Contract and as permitted under the Contract and Agreement. Further, BA shall not use Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by CE. However, BA may use Protected Information (i) for the proper management and administration of BA, (ii) to carry out the legal responsibilities of BA, or (iii) for Data Aggregation purposes for the Health Care Operations of CE [45 C.F.R. Sections 164.504(e)(2)(ii)(A) and 164.504(e)(4)(i)].

b. **Permitted Disclosures.** BA shall not disclose Protected Information except for the purpose of performing BA's obligations under the Contract and as permitted under the Contract and Agreement. BA shall not disclose Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so disclosed by CE. However, BA may disclose Protected Information (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; or (iv) for Data Aggregation purposes for the Health Care Operations of CE. If BA discloses Protected Information to a third party, BA must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this Agreement and only disclosed as required by law or for the purposes for which was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify BA of any breaches of confidentiality of the Protected Information, to the extent it has obtained knowledge of

such breach [42 U.S.C. Section 17932; 45 C.F.R. Sections 164.504(e)(2)(i), 164.504(e)(2)(i)(B), 164.504(e)(2)(ii)(A) and 164.504(e)(4)(ii)].

c. **Prohibited Uses and Disclosures.** BA shall not use or disclose Protected Information for fundraising or marketing purposes. BA shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates [42 U.S.C. Section 17935(a)]. BA shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. section 17935(d)(2); however, this prohibition shall not affect payment by CIMH to BA for services provided pursuant to the Contract.

d. **Appropriate Safeguards.** BA shall implement appropriate safeguards as are necessary to prevent the use or disclosure of Protected Information otherwise than as permitted by the Contract that reasonably and appropriately protect the confidentiality, integrity and availability of the Protected Information, in accordance with 45 C.F.R. Sections 164.308, 164.310, and 164.312. [45 C.F.R. Section 164.504(e)(2)(ii)(B); 45 C.F.R. Section 164.308(b)]. BA shall comply with the policies and procedures and documentation requirements of the HIPAA Security Rule, including, but not limited to, 45 C.F.R. Section 164.316. [42 U.S.C. Section 17931].

e. **Reporting of Improper Access, Use or Disclosure.** BA shall report to CE in writing of any access, use or disclosure of Protected Information not permitted by the Contract and Agreement, and any Breach of Unsecured PHI of which it becomes aware without unreasonable delay and in no case later than ten (10) calendar days after discovery [42 U.S.C. Section 17921; 45 C.F.R. Section 164.504(e)(2)(ii)(C); 45 C.F.R. Section 164.308(b)].

f. **Business Associate's Agents.** BA shall ensure that any agents, including subcontractors, to whom it provides Protected Information, agree in writing to the same restrictions and conditions that apply to BA with respect to such PHI and implement the safeguards required by paragraph c above with respect to Electronic PHI [45 C.F.R. Section 164.504(e)(2)(ii)(D); 45 C.F.R. Section 164.308(b)]. BA shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation (see 45 C.F.R. Sections 164.530(f) and 164.530(e)(1)).

g. **Access to Protected Information.** BA shall make Protected Information maintained by BA or its agents or subcontractors in Designated Record Sets available to CE for inspection and copying within ten (10) days of a request by CE to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.524 [45 CF.R. Section 164.504(e)(2)(ii)(E)]. If BA maintains an Electronic Health Record, BA shall provide such information in electronic format to enable CE to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. Section 17935(e).

h. **Amendment of PHI.** Within ten (10) days of receipt of a request from CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA or its agents or subcontractors shall make such Protected Information available to CE for amendment and incorporate any such amendment to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.526. If any individual requests an amendment of Protected Information directly from BA or its agents or subcontractors, BA must notify CE in writing within five (5) days of the request. Any approval or denial of amendment of Protected Information maintained by BA or its agents or subcontractors shall be the responsibility of CE [45 C.F.R. Section 164.504(e)(2)(ii)(F)].

i. **Accounting Rights.** Within ten (10) days of notice by CE of a request for an accounting of disclosures of Protected Information, BA and its agents or subcontractors shall make available to

CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.528, and the HITECH Act, including but not limited to 42 U.S.C. Section 17935(c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an electronic health record and is subject to this requirement. At a minimum, the information collected and maintained shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individuals' authorization, or a copy of the written request for disclosure. In the event that the request for an accounting is delivered directly to BA or its agents or subcontractors, BA shall within five (5) days of a request forward it to CE in writing. It shall be CE's responsibility to prepare and deliver any such accounting requested. BA shall not disclose any Protected Information except as set forth in Sections 2.b. of this Agreement [45 C.F.R. Sections 164.504(e)(2)(ii)(G) and 165.528].

j. **Governmental Access to Records.** BA shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to CE and to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining BA's compliance with the Privacy Rule [45 C.F.R. Section 164.504(e)(2)(ii)(H)]. BA shall provide to CE a copy of any Protected Information that BA provides to the Secretary concurrently with providing such Protected Information to the Secretary.

k. **Minimum Necessary.** BA (and its agents or subcontractors) shall request, use and disclose only the minimum amount of Protected Information necessary to accomplish the purpose of the request, use, or disclosure. [42 U.S.C. Section 17935(b); 45 C.F.R. Section 164.514(d)(3)] BA understands and agrees that the definition of "minimum necessary" is in flux and shall keep itself informed of guidance issued by the Secretary with respect to what constitutes "minimum necessary."

l. **Data Ownership.** BA acknowledges that BA has no ownership rights with respect to the Protected Information.

m. **Notification of Breach.** During the term of the Contract, BA shall notify CE within twenty-four (24) hours of any suspected or actual breach of security, intrusion or unauthorized use or disclosure of PHI of which BA becomes aware and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. BA shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

n. **Breach Pattern or Practice by Covered Entity.** Pursuant to 42 U.S.C. Section 17934(b), if the BA knows of a pattern of activity or practice of the CE that constitutes a material breach or violation of the CE's obligations under the Contract or Agreement or other arrangement, the BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the BA must terminate the Contract or other arrangement if feasible, or if termination is not feasible, report the problem to the Secretary of DHHS. BA shall provide written notice to CE of any pattern of activity or practice of the CE that BA believes constitutes a material breach or violation of the CE's obligations under the Contract or Agreement or other arrangement within five (5) days of discovery and shall meet with CE to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

o. **Audits, Inspection and Enforcement.** Within ten (10) days of a written request by CE, BA and its agents or subcontractors shall allow CE to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of Protected Information pursuant to this Agreement for the purpose of determining whether BA has complied with this Agreement; provided, however, that (i) BA and CE shall mutually agree in advance upon the scope, timing and location of such an inspection, and (ii) CE shall protect the confidentiality of all confidential and proprietary information of BA to which CE has access during the course of such inspection. The fact that CE inspects, or fails to inspect, or has the right to inspect, BA's facilities, systems, books, records, agreements, policies and procedures does not relieve BA of its responsibility to comply with this Agreement, nor does CE's (i) failure to detect or (ii) detection, but failure to notify BA or require BA's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of CE's enforcement rights under the Contract or Agreement. BA shall notify CE within ten (10) days of learning that BA has become the subject of an audit, compliance review, or complaint investigation by the Office for Civil Rights.

3. **Termination**

a. **Material Breach**. A breach by BA of any provision of this Agreement, as determined by CE, shall constitute a material breach of the Contract and shall provide grounds for immediate termination of the Contract, any provision in the Contract to the contrary notwithstanding. [45 C.F.R. Section 164.504(e)(2)(iii)].

b. **Judicial or Administrative Proceedings.** CE may terminate the Contract, effective immediately, if (i) BA is named as a defendant in a criminal proceeding for a violation of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws or (ii) a finding or stipulation that the BA has violated any standard or requirement of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

*c.* **Effect of Termination.** Upon termination of the Contract for any reason, BA shall, at the option of CE, return or destroy all Protected Information that BA or its agents or subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If return or destruction is not feasible, as determined by CE, BA shall continue to extend the protections of Section 2 of this Agreement to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. [45 C.F.R. Section 164.504(e)(ii)(2(I)]. If CE elects destruction of the PHI, BA shall certify in writing to CE that such PHI has been destroyed.

4. **Disclaimer**

CE makes no warranty or representation that compliance by BA with this Agreement, HIPAA, the HITECH Act, or the HIPAA Regulations will be adequate or satisfactory for BA's own purposes. BA is solely responsible for all decisions made by BA regarding the safeguarding of PHI.

5. **Amendment**

The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the Contract of Agreement may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule, and other applicable laws relating to the security or confidentiality of PHI. The parties

understand ad agree that CE must receive satisfactory written assurance from BA that BA will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Agreement embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule or other applicable laws. CE may terminate the Contract upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the Contract or Agreement when requested by CE pursuant to this Section or (ii) BA does not enter not enter into an amendment to the Contract or Agreement providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

6. **Assistance in Litigation of Administrative Proceedings**

BA shall make itself, and any subcontractors, employees or agents assisting BA in the performance of its obligations under the Contract or Agreement, available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its directors, officers or employees based upon a claimed violation of HIPAA by the BA, the HITECH Act, the Privacy Rule, the Security Rule, or other laws relating to security and privacy, except where BA or its subcontractor, employee or agent is named adverse party.

7. **No Third-Party Beneficiaries**

Nothing express or implied in the Contract or Agreement is intended to confer, nor shall anything herein confer, upon any person other than CE, BA and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

8. **Effect on Contract**

Except as specifically required to implement the purposes of this Agreement, or to the extent inconsistent with this Agreement, all other terms of the Contract shall remain in full force and effect.

9. **Interpretation**

The provisions of this Agreement shall prevail over any provisions in the Contract that may conflict or appear inconsistent with any provision in this Agreement. This Agreement and the Contract shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the Agreement Effective Date.

| COVERED ENTITY | BUSINESS ASSOCIATE |
|---|---|
| Northern Inyo Healthcare District | |
| By: Kelli Davis | By:_____ |
| Print Name: KELLI DAVIS | RYAN JONES_____ |
| Title: INTERIM CEO | Title: Partner, Jones & Mayer |
| Date: 8-25-2020 | Date: _____ |

**ATTACHMENT B**

**AGREEMENT BETWEEN NORTHERN INYO HEALTHCARE DISTRICT AND JONES & MAYER FOR THE PROVISION OF LEGAL SERVICES**

**TERM:**

**FROM: October 1, 2020 TO: October 1, 2021**

**SCHEDULE OF FEES:**

Monthly retainer: Contractor will provide general legal services for $7,600 per month. That monthly fee is capped at 40 hours per month. For general legal service above 40 hours per month, District will pay an hourly rate of $200 for all attorneys. General legal services are those services which involve regular, recurring legal and factual issues. General legal services include: Attendance at District meetings, work with District staff on all agenda items for Board meetings, drafting, review and revision of District agendas, agreements, contracts, instruments, basic ordinances, reports, resolutions, and other documents as requested by District. The parties agree to assess the rate and proposed hours after 6 months and determine whether the rates are appropriate for both sides.

Litigation and special legal services include those matters which present unique legal and/or factual issues and are billed at a rate of $225 per hour for attorney services and $125 per hour for paralegal services. As with general legal services, all attorneys in our office would bill at this same hourly rate for litigation and special legal services. Special legal services differ from general legal services in that they are of an irregular non-recurring basis. Examples include all litigation, or a complex employment investigation.

The General Counsel may not unilaterally designate any matter as a special project. For any "special" matter, we will first need approval from the CEO or Board of Directors, and we will provide a proposed budget for said work before it is approved. It is our goal to keep as much work as possible under general legal services. While it may seem contrary for a law firm to want to reduce its billings, we have found that in order to maintain a healthy and long-term relationship with our municipal clients, keeping the billing reasonable is essential. If you ask our current clients, you will find that our billing practices are sensible because of our long-term approach to client relationships. Moreover, we appreciate that the money spent on our firm are precious tax dollars that could be used for other important municipal services. Local governments in California have limited resources and must spend their revenues judiciously.

Rate Guarantee. We propose freezing our rates for a period of two years, with rates to vary thereafter based upon the Consumer Price Index increase for the prior year utilizing the standard as established by the Bureau of Labor Statistics of the U.S. Department of Labor for consumers in the Inyo County area, or another mutually agreed upon index.

Expense Reimbursement/Mileage. For all general legal services, we will bill three hours of travel time each way from to Bishop. We generally do not bill fax, word processing, or small reproduction

matters (under 100 pages). The firm will charge the client for actual necessary costs incurred for all of the following including but not limited to: court filing fees, attorney services (includes service of process fees, arbitrators, and mediators), messenger services, Lexis-Nexis research, overnight or express delivery services, mileage, parking fees, travel expenses, if applicable, including hotel, air travel and car rentals, actual costs for large reproduction projects if performed by an outside service, or $0.10 per page (b/w) and $0.20 per page (color) if performed in house, and any other expense not listed above which becomes necessary to the successful resolution of a client matter. In addition to the above, we would charge travel time for litigation and special services.

Method of Payment/Payment terms. A monthly invoice is sent to the client by the 15th of each month. Payment in full is due within 45 days of receipt. Our current practice with our clients is to bill by 1/10th of an hour every month on the first of the month for the prior months' services and costs. Jones & Mayer uses the Timeslips billing system to track attorney fees and expenses. Attorneys are responsible for entering their time directly into the system. Costs are paid by Accounting through the QuickBooks system, then entered separately into Timeslips for billing to the client. The time entries and costs appear on the bill in line item form, enabling the client to easily review and approve individual entries. The invoices will include an itemized statement which indicates work completed and hours of service rendered. Individualized billing entries are made for both retainer and non-retainer services to allow tracking and evaluation of services rendered. We also prepare annual audit responses on behalf of our clients for all pending litigation matters as required by insurance carriers, accounting auditors or joint powers authorities, as applicable.

**ATTACHMENT C**

**AGREEMENT BETWEEN NORTHERN INYO HEALTHCARE DISTRICT AND JONES & MAYER FOR THE PROVISION OF LEGAL SERVICES**

**TERM:**

**FROM: October 1, 2020 TO: October 1, 2021**

**SCHEDULE OF TRAVEL AND PER DIEM PAYMENT**

Travel shall be at the county's request and will be billed at cost.

Per diem travel from portal to portal will be at the current IRS rate.

understand ad agree that CE must receive satisfactory written assurance from BA that BA will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Agreement embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule or other applicable laws. CE may terminate the Contract upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the Contract or Agreement when requested by CE pursuant to this Section or (ii) BA does not enter not enter into an amendment to the Contract or Agreement providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

6. **Assistance in Litigation of Administrative Proceedings**

BA shall make itself, and any subcontractors, employees or agents assisting BA in the performance of its obligations under the Contract or Agreement, available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its directors, officers or employees based upon a claimed violation of HIPAA by the BA, the HITECH Act, the Privacy Rule, the Security Rule, or other laws relating to security and privacy, except where BA or its subcontractor, employee or agent is named adverse party.

7. **No Third-Party Beneficiaries**

Nothing express or implied in the Contract or Agreement is intended to confer, nor shall anything herein confer, upon any person other than CE, BA and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

8. **Effect on Contract**

Except as specifically required to implement the purposes of this Agreement, or to the extent inconsistent with this Agreement, all other terms of the Contract shall remain in full force and effect.

9. **Interpretation**

The provisions of this Agreement shall prevail over any provisions in the Contract that may conflict or appear inconsistent with any provision in this Agreement. This Agreement and the Contract shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the Agreement Effective Date.

COVERED ENTITY

Northern Inyo Healthcare District
By: Jean Turner

Print Name: Jean Turner

Title: District Board Chair

Date: _____

BUSINESS ASSOCIATE

By: _____

RYAN JONES

Title: Partner, Jones & Mayer

Date: 4/7/2020

**AGREEMENT BETWEEN NORTHERN INYO HEALTHCARE DISTRICT AND JONES & MAYER FOR THE PROVISION OF LEGAL SERVICES**

IN WITNESS THEREOF, THE PARTIES HERETO HAVE SET THEIR HANDS AND SEALS THIS 2nd DAY OF APRIL, 2020

**NORTHERN INYO HEALTHCARE DISTRICT**

By:_____
Jean Turner, District Board Chair

Dated:_____

**CONTRACTOR**

By:_____
Ryan Jones, Partner

Dated: 4/7/2020

**APPROVED AS TO FORM AND LEGALITY:**

_____
District Counsel

APPROVED AS TO ACCOUNTING FORM:

_____
Chief Financial Officer

**AGREEMENT BETWEEN NORTHERN INYO HEALTHCARE DISTRICT AND JONES & MAYER FOR THE PROVISION OF LEGAL SERVICES**

## INTRODUCTION

WHEREAS, Northern Inyo Healthcare District (hereinafter referred to as "NIHD" or "District") may have the need for the legal services of the Jones & Mayer law firm hereinafter referred to as "Contractor"), and in consideration of the mutual promises, covenants, terms, and conditions hereinafter contained, the parties hereby agree as follows:

## TERMS AND CONDITIONS

### 1. SCOPE OF WORK.

The Contractor shall serve as General Counsel for NIHD, and furnish to NIHD, upon its request, those services and work set forth in Attachment A, attached hereto and by reference incorporated herein. Requests by the District to the Contractor to perform under this Agreement will be made by the CEO for the District or his/her designee. Requests to the Contractor for work or services to be performed under this Agreement will be based upon NIHD's need for such services. The District makes no guarantee or warranty, of any nature, that any minimum level or amount of services or work will be requested of the Contractor by the District under this Agreement. NIHD by this Agreement incurs no obligation or requirement to request from Contractor the performance of any services or work at all, even if District should have some need for such services or work during the term of this Agreement.

Services and work provided by the Contractor at the District's request under this Agreement will be performed in a manner consistent with the requirements and standards established by applicable federal, state, county, and District laws, ordinances, regulations, and resolutions. Such laws, ordinances, regulations, and resolutions include, but are not limited to, those which are referred to in this Agreement.

### 2. TERM.

The term of this Agreement shall be from **October 1, 2020** to **October 1, 2021,** unless sooner terminated as provided below.

### 3. CONSIDERATION.

A. Compensation. NIHD shall pay to Contractor in accordance with the Schedule of Fees (set forth as Attachment **B**) for the services and work described in Attachment **A** which are performed by Contractor at the County's request.

B. Travel and per diem. District shall reimburse Contractor for travel expenses and per diem which Contractor incurs in providing services and work requested by District under this Agreement. Contractor shall request approval by the District prior to incurring any travel or per diem expenses. Requests by Contractor for approval to incur travel and per diem expenses shall be submitted to the Administration Office of NIHD. Travel and per diem expenses will be reimbursed in accordance with the rates set forth in the Schedule of Travel and Per Diem Payment (Attachment **C**). District reserves the right to deny reimbursement to Contractor for travel or per diem expenses which are either in excess of the amounts that may be paid to under the rates set forth in Attachment **C**, or which are incurred by the Contractor without the prior approval of the District.

C. Incidental Expenses. District shall reimburse Contractor in accordance with the Schedule of Fees (Attachment **B**) for those Incidental Expenses which are specifically identified in the Schedule of Fees and which are necessarily incurred by the Contractor in providing the services and work requested by District under this Agreement. Reimbursement by NIHD for such Incidental Expenses will be limited to Contractor's actual cost without regard to any administrative or overhead expenses incurred by Contractor in obtaining or utilizing such incidental services or supplies. Reimbursement for actual costs will not exceed the amounts set forth in the Schedule of Fees.

D. No additional consideration. Except as expressly provided in this Agreement, Contractor shall not be entitled to, nor receive, from District, any additional consideration, compensation, salary, wages, or other type of remuneration for services rendered under this Agreement. Specifically, Contractor shall not be entitled, by virtue of this Agreement, to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays, or other paid leaves of absence of any type or kind whatsoever.

E. Billing and payment. The billing and payment arrangement is set forth in Attachment B.

G. Federal and State taxes.

(1) Except as provided in subparagraph (2) below, District will not withhold any federal or state income taxes or social security from any payments made by District to Contractor under the terms and conditions of this Agreement.

(2) District will withhold California State income taxes from payments made under this Agreement to non-California resident independent contractors when it is anticipated that total annual payments to Contractor under this Agreement will exceed one thousand four hundred ninety nine dollars ($1,499.00).

(3) Except as set forth above, District has no obligation to withhold any taxes or payments from sums paid by District to Contractor under this Agreement. Payment of all taxes and other assessments on such sums is the sole responsibility of Contractor. NIHD has no responsibility or liability for payment of Contractor's taxes or assessments.

(4) The total amounts paid by District to Contractor, and taxes withheld from payments to non-California residents, if any, will be reported annually to the Internal Revenue Service and the California State Franchise Tax Board. To facilitate this reporting, Contractor shall complete and submit to the District an Internal Revenue Service (IRS) Form W-9 upon executing this Agreement.

**4. WORK SCHEDULE.**

Contractor's obligation is to perform, in a timely manner, those services and work identified in Attachment A which are requested by the District. It is understood by Contractor that the performance of these services and work will require a varied schedule. Contractor will arrange his/her own schedule, but will coordinate with District to ensure that all services and work requested by District under this Agreement will be performed within the time frame set forth by District.

**5. REQUIRED LICENSES, CERTIFICATES, AND PERMITS.**

A. Any licenses, certificates, or permits required by the federal, state, county, municipal governments, for contractor to provide the services and work described in Attachment A must be procured by Contractor and be valid at the time Contractor enters into this Agreement or as otherwise may be required. Further, during the term of this Agreement, Contractor must maintain such licenses, certificates, and permits in full force and effect. Licenses, certificates, and permits may include, but are not limited to, driver's licenses, professional licenses or certificates, and business licenses. Such licenses, certificates, and permits will be procured and maintained in force by Contractor at no expense to the District. Contractor will provide District, upon execution of this Agreement, with evidence of current and valid licenses, certificates and permits which are required to perform the services identified in Attachment **A**. Where there is a dispute between Contractor and District as to what licenses, certificates, and permits are required to perform the services identified in Attachment **A**, District reserves the right to make such determinations for purposes of this Agreement.

B. Contractor warrants that it is not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in covered transactions by any federal department or agency. Contractor also warrants that it is not suspended or debarred from receiving federal funds as listed in the List of Parties Excluded from Federal Procurement or Non-procurement Programs issued by the General Services Administration available at: http://www.epls.gov.

**6. OFFICE SPACE, SUPPLIES, EQUIPMENT, ETC.**

Contractor shall provide such office space, supplies, equipment, vehicles, reference materials, and telephone service as is necessary for Contractor to provide the services identified in Attachment A to this Agreement. Except for those incidental expenses specifically identified in the Schedule of Fees (Attachment), District is not obligated to reimburse or pay Contractor, for any expense or cost incurred by Contractor in procuring or maintaining such items. Responsibility for the costs and expenses incurred by Contractor in providing and maintaining items not specifically set forth in the Schedule of Fees (Attachment **B**), is the sole responsibility and obligation of Contractor.

**7. COUNTY PROPERTY.**

A. Personal Property of County. Any personal property such as, but not limited to, protective or safety devices, badges, identification cards, keys, etc. provided to Contractor by District pursuant to this Agreement are, and at the termination of this Agreement remain, the sole and exclusive property of District. Contractor will use reasonable care to protect, safeguard and maintain such items while they are in Contractor's possession. Contractor will be financially responsible for any loss or damage to such items, partial or total, which is the result of Contractor's negligence.

B. Products of Contractor's Work and Services. Any and all compositions, publications, plans, designs, specifications, blueprints, maps, formulas, processes, photographs, slides, video tapes, computer programs, computer disks, computer tapes, memory chips, soundtracks, audio recordings, films, audio-visual presentations, exhibits, reports, studies, works of art, inventions, patents, trademarks, copyrights, or intellectual properties of any kind which are created, produced, assembled, compiled by, or are the result, product, or manifestation of, Contractor's services or work under this Agreement are, and at the termination of this Agreement remain, the sole and exclusive property of the District. At the termination of the Agreement, Contractor will convey possession and title to all such properties to District.

**8. WORKERS' COMPENSATION.**

Contractor shall provide Statutory California Worker's Compensation coverage and Employer's Liability coverage for not less than $1,000,000 per occurrence for all employees engaged in services or operations under this Agreement. The District, its agents, officers and employees shall be named as additional insured or a waiver of subrogation shall be provided.

**9. INSURANCE REQUIREMENTS FOR PROFESSIONAL SERVICES.**

Contractor shall procure and maintain for the duration of the contract insurance against claims for injuries to persons or damages to property which may arise from or in connection with the performance of the work hereunder by the Consultant, its agents, representatives, or employees.

A. Minimum Scope and Limit of Insurance. Coverage shall be at least as broad as:

1. Commercial General Liability (CGL): Insurance Services Office Form CG 00 01 covering CGL on an "occurrence" basis for bodily injury and property damage, including products-completed operations, personal injury and advertising injury, with limits no less than **$1,000,000.00** per occurrence. If a general aggregate limit applies, either the general aggregate limit shall apply separately to this project/location or the general aggregate limit shall be twice the required occurrence limit.

2. Automobile Liability: Insurance Services Office Form Number CA 0001 covering, Code 1 (any auto), or if Contractor has no owned autos, Code 8 (hired) and 9 (non-owned), with limit no less than **$500,000.00** per accident for bodily injury and property damage.

3. Workers' Compensation insurance as required by the State of California, with Statutory Limits, and Employer's Liability Insurance with limit of no less than **$** ___ per accident for bodily injury or disease.
*(Not required if Contractor provides written verification it has no employees)*

4. Professional Liability (Errors and Omissions) Insurance appropriates to the Contractor's profession, with limit no less than **$1,000,000.00** per occurrence or claim.

If the Contractor maintains higher limits than the minimums shown above, the District requires and shall be entitled to coverage for the higher limits maintained by the contractor.

B. Other Insurance Provisions. The insurance policies are to contain, or be endorsed to contain, the following provisions:

1. Additional Insured Status.

The District, its officers, officials, employees, and volunteers are to be covered as insureds on the auto policy with respect to liability arising out of automobiles owned, leased, hired or borrowed by or on behalf of the Contractor; and on the CGL policy with respect to liability arising out of work or operations performed by or on behalf of the Contractor including materials, parts, or equipment furnished in connection with such work or operations. General liability coverage can be provided in the form of an endorsement to the Contractor's insurance (at least as broad as ISO Form CG 20 10, 11 85 or both CG 20 10 and CG 23 37 forms if later revisions used).

2. Primary Coverage.

For any claims related to this contract, the Contractor's insurance coverage shall be primary insurance as respects the District, its officers, officials, employees, and volunteers. Any insurance or self-insurance maintained by the District, its officers, officials, employees, or volunteers shall be excess of the Contractor's insurance and shall not contribute with it.

3. Notice of Cancellation.

Each insurance policy required above shall state that coverage shall not be canceled, except after thirty (30) days' prior written notice (10 days for non-payment) has been given to the District.

4. Waiver of Subrogation.

Contractor hereby grants to District a waiver of any right to subrogation which any insurer of said Contractor may acquire against the District by virtue of the payment of any loss under such insurance. Contractor agrees to obtain any endorsement that may be necessary to effect this waiver of subrogation, but this provision applies regardless of whether or not the District has received a waiver of subrogation endorsement from the insurer.

C. Deductibles and Self-Insured Retentions. Any deductibles or self-insured retentions must be declared to and approved by the District. The District may require the Contractor to provide proof of ability to pay losses and related investigations, claim administration, and defense expenses within the retention.

D. Acceptability of Insurers. Insurance is to be placed with insurers with a current A.M. Best's rating of no less than A:VII, unless otherwise acceptable to the District.

E. Claims Made Policies. If any of the required policies provide coverage on a claims-made basis:

1. The Retroactive Date must be shown and must be before the date of the contract or the beginning of contract work.

2. Insurance must be maintained and evidence of insurance must be provided for at least five (5) years after completion of the contract of work.

3. If coverage is canceled or non-renewed, and not replaced with another claims-made policy form with a Retroactive Date prior to the contract effective date, the Contractor must purchase "extended reporting" coverage for a minimum of five (5) years after completion of contract work.

F. Verification of Coverage. Contractor shall furnish the District with original certificates and amendatory endorsements or copies of the applicable policy language effecting coverage required by this clause. All certificates and endorsements are to be received and approved by the District before work commences. However, failure to obtain the required documents prior to the work beginning shall not waive the Contractor's obligation to provide them. The District reserves the right to require complete, certified copies of all required insurance policies, including endorsements required by these specifications, at any time.

G. Subcontractors. Contractor shall require and verify that all subcontractors maintain insurance meeting all the requirements stated herein.

H. Special Risks or Circumstances. District reserves the right to modify these requirements, including limits, based on the nature of the risk, prior experience, insurer, coverage, or other special circumstances.

**10. STATUS OF CONTRACTOR.**

All acts of Contractor, its agents, officers, and employees, relating to the performance of this Agreement, shall be performed as independent contractors, and no agent, officer, or employee of Contractor is to be considered an employee of District. Contractor, by virtue of this Agreement, has no authority to bind or incur any obligation on behalf of District. Except as expressly provided in Attachment **A**, Contractor has no authority or responsibility to exercise any rights or power vested in the District. It is understood by both Contractor and District that this Agreement shall not under any circumstances be construed or considered to create an employer-employee relationship or a joint venture. As an independent contractor:

A. Contractor shall determine the method, details, and means of performing the work and services to be provided by Contractor under this Agreement.

B. Contractor shall be responsible to District only for the requirements and results specified in this Agreement, and except as expressly provided in this Agreement, shall not be subjected to District's control with respect to the physical action or activities of Contractor in fulfillment of this Agreement.

C. Contractor, its agents, officers, and employees are, and at all times during the term of this Agreement shall, represent and conduct themselves as independent contractors, and not as employees of District.

**11. DEFENSE AND INDEMNIFICATION.**

Contractor shall defend, indemnify, and hold harmless District, its agents, officers, and employees from and against all claims, damages, losses, judgments, liabilities, expenses, and other costs, including litigation costs and attorney's fees, arising out of, resulting from, or in connection with, the performance of this Agreement by Contractor, or Contractor's agents, officers, or employees. Contractor's obligation to defend, indemnify, and hold the District, its agents, officers, and employees harmless applies to any actual or alleged personal injury, death, or damage or destruction to tangible or intangible property, including the loss of use. Contractor's obligation under this paragraph extends to any claim, damage, loss, liability, expense, or other costs which is caused in whole or in part by any act or omission of the Contractor, its agents, employees, supplier, or any one directly or indirectly employed by any of them, or anyone for whose acts or omissions any of them may be liable.

Contractor's obligation to defend, indemnify, and hold the District, its agents, officers, and employees harmless under the provisions of this paragraph is not limited to, or restricted by, any requirement in this Agreement for Contractor to procure and maintain a policy of insurance.

To the extent permitted by law, District shall defend, indemnify, and hold harmless Contractor, its agents, officers, and employees from and against all claims, damages, losses, judgments, liabilities, expenses, and other costs, including litigation costs and attorney's fees, arising out of, or resulting from, the active negligence, or wrongful acts of District, its officers, or employees.

**12. RECORDS AND AUDIT.**

A. Records. Contractor shall prepare and maintain all records required by the various provisions of this Agreement, federal, state, county, municipal, ordinances, regulations, and directions. Contractor shall maintain these records for a minimum of four (4) years from the termination or completion of this Agreement. Contractor may fulfill its obligation to maintain records as required by this paragraph by substitute photographs, microphotographs, or other authentic reproduction of such records.

B. Inspections and Audits. Any authorized representative of District shall have access to any books, documents, papers, records, including, but not limited to, financial records of Contractor, which District determines to be pertinent to this Agreement, for the purposes of making audit, evaluation, examination, excerpts, and transcripts during the period such records are to be maintained by Contractor. Further, District has the right, at all reasonable times, to audit, inspect, or otherwise evaluate the work performed or being performed under this Agreement.

**13. NONDISCRIMINATION.**

During the performance of this Agreement, Contractor, its agents, officers, and employees shall not unlawfully discriminate in violation of any federal, state, or local law, against any employee, or applicant for employment, or person receiving services under this Agreement, because of race, religion, color, national origin, ancestry, physical handicap, medical condition, marital status, age, or sex. Contractor and its agents, officers, and employees shall comply with the provisions of the Fair Employment and Housing Act (Government Code section 12900, et seq.), and the applicable regulations promulgated thereunder in the California Code of Regulations. Contractor shall also abide by the Federal Civil Rights Act of 1964 (P.L. 88-352) and all amendments thereto, and all administrative rules and regulations issued pursuant to said act.

**14. CANCELLATION.**

This Agreement may be canceled by District without cause, and at will, for any reason by giving to Contractor thirty (30) days written notice of such intent to cancel. Contractor may cancel this Agreement without cause, and at will, for any reason whatsoever by giving thirty (30) days written notice of such intent to cancel to District.

**15. ASSIGNMENT.**

This is an agreement for the services of Contractor. District has relied upon the skills, knowledge, experience, and training of Contractor as an inducement to enter into this Agreement. Contractor shall not assign or subcontract this Agreement, or any part of it, without the express written consent of District. Further, Contractor shall not assign any monies due or to become due under this Agreement without the prior written consent of District.

**16. DEFAULT.**

If the Contractor abandons the work, or fails to proceed with the work and services requested by District in a timely manner, or fails in any way as required to conduct the work and services as required by District, NIHD may declare the Contractor in default and terminate this Agreement upon five (5) days written notice to Contractor. Upon such termination by default, District will pay to Contractor all amounts owing to Contractor for services and work satisfactorily performed to the date of termination.

**17. WAIVER OF DEFAULT.**

Waiver of any default by either party to this Agreement shall not be deemed to be waiver of any subsequent default. Waiver or breach of any provision of this Agreement shall not be deemed to be a waiver of any other or subsequent breach, and shall not be construed to be a modification of the terms of this Agreement unless this Agreement is modified as provided in paragraph twenty-three (23) below.

**18. CONFIDENTIALITY.**

Contractor agrees to comply with the various provisions of the federal, state, and county laws, regulations, and ordinances providing that information and records kept, maintained, or accessible by Contractor in the course of providing services and work under this Agreement, shall be privileged, restricted, or confidential. Contractor agrees to keep confidential all such information and records. Disclosure of such confidential, privileged, or protected information shall be made by Contractor only with the express written consent of the District. Any disclosure of confidential information by Contractor without the District's written consent is solely and exclusively the legal responsibility of Contractor in all respects.

**19. CONFLICTS.**

Contractor agrees that it has no interest, and shall not acquire any interest, direct or indirect, which would conflict in any manner or degree with the performance of the work and services under this Agreement.

**20. POST AGREEMENT COVENANT.**

Contractor agrees not to use any confidential, protected, or privileged information which is gained from the District in the course of providing services and work under this Agreement, for any personal benefit, gain, or enhancement. Further, Contractor agrees for a period of two years after the termination of this Agreement, not to seek or accept any employment with any entity, association, corporation, or person who, during the term of this Agreement, has had an adverse or conflicting interest with the District, or who has been an adverse party in litigation with the District, and concerning such, Contractor by virtue of this Agreement has gained access to the District's confidential, privileged, protected, or proprietary information.

**21. SEVERABILITY.**

If any portion of this Agreement or application thereof to any person or circumstance shall be declared invalid by a court of competent jurisdiction, or if it is found in contravention of any federal, state, or county statute, ordinance, or regulation, the remaining provisions of this Agreement, or the application thereof, shall not be invalidated thereby, and shall remain in full force and effect to the extent that the provisions of this Agreement are severable.

**22. FUNDING LIMITATION.**

The ability of District to enter this Agreement is based upon available funding from various sources. In the event that such funding fails, is reduced, or is modified, from one or more sources, District has the option to cancel, reduce, or modify this Agreement, or any of its terms within ten (10) days of its notifying Contractor of the cancellation, reduction, or modification of available funding. Any reduction or modification of this Agreement made pursuant to this provision must comply with the requirements of paragraph twenty-four (24) (Amendment).

**23. AMENDMENT.**

This Agreement may be modified, amended, changed, added to, or subtracted from, by the mutual consent of the parties hereto, if such amendment or change is in written form and executed with the same formalities as this Agreement, and attached to the original Agreement to maintain continuity.

**24. NOTICE.**

Any notice, communication, amendments, additions, or deletions to this Agreement, including change of address of either party during the terms of this Agreement, which Contractor or District shall be required, or may desire, to make, shall be in writing and may be personally served, or sent by prepaid first class mail to, the respective parties as follows:

**NORTHERN INYO HEALTHCARE DISTRICT:**
Administration
150 Pioneer Lane
Bishop, CA 93514

**CONTRACTOR:**

Ryan Jones, Partner
Jones & Mayer
6349 Auburn Blvd
Citrus Heights, CA

**25. ENTIRE AGREEMENT.**

This Agreement contains the entire agreement of the parties, and no representations, inducements, promises, or agreements otherwise between the parties not embodied herein or incorporated herein by reference, shall be of any force or effect. Further, no term or provision hereof may be changed, waived, discharged, or terminated, unless the same be in writing executed by the parties hereto.

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**AGREEMENT BETWEEN NORTHERN INYO HEALTHCARE DISTRICT AND JONES & MAYER FOR THE PROVISION OF LEGAL SERVICES**

IN WITNESS THEREOF, THE PARTIES HERETO HAVE SET THEIR HANDS AND SEALS THIS 2nd DAY OF

**NORTHERN INYO HEALTHCARE DISTRICT** **CONTRACTOR**

By:_____ By:_____
Signature

Dated:_____ _____
Ryan Jones, Partner

Dated:_____

APPROVED AS TO FORM AND
LEGALITY:

_____
District Counsel

APPROVED AS TO ACCOUNTING FORM:

_____
Chief Financial Officer

APPROVED AS TO PERSONNEL REQUIREMENTS:

_____
Personnel Services

APPROVED AS TO INSURANCE REQUIREMENTS:

_____
Risk Manager

**ATTACHMENT A**

**AGREEMENT BETWEEN NORTHERN INYO HEALTHCARE DISTRICT AND JONES & MAYER FOR THE PROVISION OF LEGAL SERVICES**

**TERM:**

**FROM: October 1, 2020 TO: October 1, 2021**

**SCOPE OF WORK**:

Contractor shall provide General Counsel legal services for the District. That type of work includes, but is not limited to, the items listed in the Scope of Services section of the RFP for General Counsel Legal Services (released February 29, 2020) at pages 4-5.

**ATTACHMENT A-1**

**AGREEMENT BETWEEN NORTHERN INYO HEALTHCARE DISTRICT AND JONES & MAYER FOR THE PROVISION OF LEGAL SERVICES**

**TERM:**

**FROM: October 1, 2020 TO: October 1, 2021**

NORTHERN INYO HEALTHCARE DISTRICT
**HIPAA BUSINESS ASSOCIATE AGREEMENT**

This Business Associate Agreement ("Agreement") is made by and between the Northern Inyo Healthcare District, referred to herein as Covered Entity ("CE"), and of JONES & MAYER referred to herein as Business Associate ("BA"). This Agreement is effective as of October 1, 2020, (the "Agreement Effective Date").

***RECITALS***

As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require JONES & MAYER to enter into a contract containing specific requirements with BA prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("C.F.R.") and contained in this Agreement.

In consideration of the mutual promises below and the exchange of information pursuant to this Agreement, the parties agree as follows:

**1. Definitions**

a. **Breach** shall have the meaning given to such term under the HITECH Act [42 U.S.C. Section 17921].

b. **Business Associate** shall have the meaning given to such term under the Privacy Rule, the Security Rule, and the HITECH Act, including but not limited to, 42 U.S.C. Section 17938 and 45 C.F.R. Section 160.103.

c. **Covered Entity** shall have the meaning given to such term under the Privacy Rule and the Security Rule, including, but not limited to, 45 C.F.R. Section 160.103.

d. **Data Aggregation** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

e. **Designated Record Set** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

f. **Electronic Protected Health Information** means Protected Health Information that is maintained in or transmitted by electronic media.

g. **Electronic Health Record** shall have the meaning given to such term in the HITECT Act, including, but not limited to, 42 U.S.C. Section 17921.

h. **Health Care Operations** shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501.

i. **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and E.

j. **Protected Health Information or PHI** means any information, whether oral or recorded in any form or medium: (i) that relates to the past, present or future physical or mental condition of an individual; the provision of health care to an individual; or the past, present or future payment for the provision of health care to an individual; and (ii) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual, and shall have the meaning given to such term under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.501. Protected Health Information includes Electronic Protected Health Information [45 C.F.R. Sections 160.103, 164.501].

k. **Protected Information** shall mean PHI provided by CE to BA or created or received by BA on CE's behalf.

l. **Security Rule** shall mean the HIPAA Regulation that is codified at 45 C.F.R. Parts 160 and 164, Subparts A and C.

m. **Unsecured PHI** shall have the meaning given to such term under the HITECH Act and any guidance issued pursuant to such Act including, but not limited to, 42 U.S.C. Section 17932(h).

2. **Obligations of Business Associate**

a. **Permitted Uses.** BA shall not use Protected Information except for the purpose of performing BA's obligations under the Contract and as permitted under the Contract and Agreement. Further, BA shall not use Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so used by CE. However, BA may use Protected Information (i) for the proper management and administration of BA, (ii) to carry out the legal responsibilities of BA, or (iii) for Data Aggregation purposes for the Health Care Operations of CE [45 C.F.R. Sections 164.504(e)(2)(ii)(A) and 164.504(e)(4)(i)].

b. **Permitted Disclosures.** BA shall not disclose Protected Information except for the purpose of performing BA's obligations under the Contract and as permitted under the Contract and Agreement. BA shall not disclose Protected Information in any manner that would constitute a violation of the Privacy Rule or the HITECH Act if so disclosed by CE. However, BA may disclose Protected Information (i) for the proper management and administration of BA; (ii) to carry out the legal responsibilities of BA; (iii) as required by law; or (iv) for Data Aggregation purposes for the Health Care Operations of CE. If BA discloses Protected Information to a third party, BA must obtain, prior to making any such disclosure, (i) reasonable written assurances from such third party that such Protected Information will be held confidential as provided pursuant to this Agreement and only disclosed as required by law or for the purposes for which was disclosed to such third party, and (ii) a written agreement from such third party to immediately notify BA of any breaches of confidentiality of the Protected Information, to the extent it has obtained knowledge of

such breach [42 U.S.C. Section 17932; 45 C.F.R. Sections 164.504(e)(2)(i), 164.504(e)(2)(i)(B), 164.504(e)(2)(ii)(A) and 164.504(e)(4)(ii)].

c. **Prohibited Uses and Disclosures.** BA shall not use or disclose Protected Information for fundraising or marketing purposes. BA shall not disclose Protected Information to a health plan for payment or health care operations purposes if the patient has requested this special restriction, and has paid out of pocket in full for the health care item or service to which the PHI solely relates [42 U.S.C. Section 17935(a)]. BA shall not directly or indirectly receive remuneration in exchange for Protected Information, except with the prior written consent of CE and as permitted by the HITECH Act, 42 U.S.C. section 17935(d)(2); however, this prohibition shall not affect payment by CIMH to BA for services provided pursuant to the Contract.

d. **Appropriate Safeguards.** BA shall implement appropriate safeguards as are necessary to prevent the use or disclosure of Protected Information otherwise than as permitted by the Contract that reasonably and appropriately protect the confidentiality, integrity and availability of the Protected Information, in accordance with 45 C.F.R. Sections 164.308, 164.310, and 164.312. [45 C.F.R. Section 164.504(e)(2)(ii)(B); 45 C.F.R. Section 164.308(b)]. BA shall comply with the policies and procedures and documentation requirements of the HIPAA Security Rule, including, but not limited to, 45 C.F.R. Section 164.316. [42 U.S.C. Section 17931].

e. **Reporting of Improper Access, Use or Disclosure.** BA shall report to CE in writing of any access, use or disclosure of Protected Information not permitted by the Contract and Agreement, and any Breach of Unsecured PHI of which it becomes aware without unreasonable delay and in no case later than ten (10) calendar days after discovery [42 U.S.C. Section 17921; 45 C.F.R. Section 164.504(e)(2)(ii)(C); 45 C.F.R. Section 164.308(b)].

f. **Business Associate's Agents.** BA shall ensure that any agents, including subcontractors, to whom it provides Protected Information, agree in writing to the same restrictions and conditions that apply to BA with respect to such PHI and implement the safeguards required by paragraph c above with respect to Electronic PHI [45 C.F.R. Section 164.504(e)(2)(ii)(D); 45 C.F.R. Section 164.308(b)]. BA shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation (see 45 C.F.R. Sections 164.530(f) and 164.530(e)(1)).

g. **Access to Protected Information.** BA shall make Protected Information maintained by BA or its agents or subcontractors in Designated Record Sets available to CE for inspection and copying within ten (10) days of a request by CE to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.524 [45 CF.R. Section 164.504(e)(2)(ii)(E)]. If BA maintains an Electronic Health Record, BA shall provide such information in electronic format to enable CE to fulfill its obligations under the HITECH Act, including, but not limited to, 42 U.S.C. Section 17935(e).

h. **Amendment of PHI.** Within ten (10) days of receipt of a request from CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA or its agents or subcontractors shall make such Protected Information available to CE for amendment and incorporate any such amendment to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.526. If any individual requests an amendment of Protected Information directly from BA or its agents or subcontractors, BA must notify CE in writing within five (5) days of the request. Any approval or denial of amendment of Protected Information maintained by BA or its agents or subcontractors shall be the responsibility of CE [45 C.F.R. Section 164.504(e)(2)(ii)(F)].

i. **Accounting Rights.** Within ten (10) days of notice by CE of a request for an accounting of disclosures of Protected Information, BA and its agents or subcontractors shall make available to

CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 C.F.R. Section 164.528, and the HITECH Act, including but not limited to 42 U.S.C. Section 17935(c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an electronic health record and is subject to this requirement. At a minimum, the information collected and maintained shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individuals' authorization, or a copy of the written request for disclosure. In the event that the request for an accounting is delivered directly to BA or its agents or subcontractors, BA shall within five (5) days of a request forward it to CE in writing. It shall be CE's responsibility to prepare and deliver any such accounting requested. BA shall not disclose any Protected Information except as set forth in Sections 2.b. of this Agreement [45 C.F.R. Sections 164.504(e)(2)(ii)(G) and 165.528].

j. **Governmental Access to Records.** BA shall make its internal practices, books and records relating to the use and disclosure of Protected Information available to CE and to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining BA's compliance with the Privacy Rule [45 C.F.R. Section 164.504(e)(2)(ii)(H)]. BA shall provide to CE a copy of any Protected Information that BA provides to the Secretary concurrently with providing such Protected Information to the Secretary.

k. **Minimum Necessary.** BA (and its agents or subcontractors) shall request, use and disclose only the minimum amount of Protected Information necessary to accomplish the purpose of the request, use, or disclosure. [42 U.S.C. Section 17935(b); 45 C.F.R. Section 164.514(d)(3)] BA understands and agrees that the definition of "minimum necessary" is in flux and shall keep itself informed of guidance issued by the Secretary with respect to what constitutes "minimum necessary."

l. **Data Ownership.** BA acknowledges that BA has no ownership rights with respect to the Protected Information.

m. **Notification of Breach.** During the term of the Contract, BA shall notify CE within twenty-four (24) hours of any suspected or actual breach of security, intrusion or unauthorized use or disclosure of PHI of which BA becomes aware and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. BA shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and state laws and regulations.

n. **Breach Pattern or Practice by Covered Entity.** Pursuant to 42 U.S.C. Section 17934(b), if the BA knows of a pattern of activity or practice of the CE that constitutes a material breach or violation of the CE's obligations under the Contract or Agreement or other arrangement, the BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the BA must terminate the Contract or other arrangement if feasible, or if termination is not feasible, report the problem to the Secretary of DHHS. BA shall provide written notice to CE of any pattern of activity or practice of the CE that BA believes constitutes a material breach or violation of the CE's obligations under the Contract or Agreement or other arrangement within five (5) days of discovery and shall meet with CE to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

o. **Audits, Inspection and Enforcement.** Within ten (10) days of a written request by CE, BA and its agents or subcontractors shall allow CE to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of Protected Information pursuant to this Agreement for the purpose of determining whether BA has complied with this Agreement; provided, however, that (i) BA and CE shall mutually agree in advance upon the scope, timing and location of such an inspection, and (ii) CE shall protect the confidentiality of all confidential and proprietary information of BA to which CE has access during the course of such inspection. The fact that CE inspects, or fails to inspect, or has the right to inspect, BA's facilities, systems, books, records, agreements, policies and procedures does not relieve BA of its responsibility to comply with this Agreement, nor does CE's (i) failure to detect or (ii) detection, but failure to notify BA or require BA's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of CE's enforcement rights under the Contract or Agreement. BA shall notify CE within ten (10) days of learning that BA has become the subject of an audit, compliance review, or complaint investigation by the Office for Civil Rights.

3. **Termination**

a. **Material Breach**. A breach by BA of any provision of this Agreement, as determined by CE, shall constitute a material breach of the Contract and shall provide grounds for immediate termination of the Contract, any provision in the Contract to the contrary notwithstanding. [45 C.F.R. Section 164.504(e)(2)(iii)].

b. **Judicial or Administrative Proceedings.** CE may terminate the Contract, effective immediately, if (i) BA is named as a defendant in a criminal proceeding for a violation of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws or (ii) a finding or stipulation that the BA has violated any standard or requirement of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

*c.* **Effect of Termination.** Upon termination of the Contract for any reason, BA shall, at the option of CE, return or destroy all Protected Information that BA or its agents or subcontractors still maintain in any form, and shall retain no copies of such Protected Information. If return or destruction is not feasible, as determined by CE, BA shall continue to extend the protections of Section 2 of this Agreement to such information, and limit further use of such PHI to those purposes that make the return or destruction of such PHI infeasible. [45 C.F.R. Section 164.504(e)(ii)(2(I)]. If CE elects destruction of the PHI, BA shall certify in writing to CE that such PHI has been destroyed.

4. **Disclaimer**

CE makes no warranty or representation that compliance by BA with this Agreement, HIPAA, the HITECH Act, or the HIPAA Regulations will be adequate or satisfactory for BA's own purposes. BA is solely responsible for all decisions made by BA regarding the safeguarding of PHI.

5. **Amendment**

The parties acknowledge that state and federal laws relating to data security and privacy are rapidly evolving and that amendment of the Contract of Agreement may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule, and other applicable laws relating to the security or confidentiality of PHI. The parties

understand ad agree that CE must receive satisfactory written assurance from BA that BA will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Agreement embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule or other applicable laws. CE may terminate the Contract upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the Contract or Agreement when requested by CE pursuant to this Section or (ii) BA does not enter not enter into an amendment to the Contract or Agreement providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

6. **Assistance in Litigation of Administrative Proceedings**

BA shall make itself, and any subcontractors, employees or agents assisting BA in the performance of its obligations under the Contract or Agreement, available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its directors, officers or employees based upon a claimed violation of HIPAA by the BA, the HITECH Act, the Privacy Rule, the Security Rule, or other laws relating to security and privacy, except where BA or its subcontractor, employee or agent is named adverse party.

7. **No Third-Party Beneficiaries**

Nothing express or implied in the Contract or Agreement is intended to confer, nor shall anything herein confer, upon any person other than CE, BA and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

8. **Effect on Contract**

Except as specifically required to implement the purposes of this Agreement, or to the extent inconsistent with this Agreement, all other terms of the Contract shall remain in full force and effect.

9. **Interpretation**

The provisions of this Agreement shall prevail over any provisions in the Contract that may conflict or appear inconsistent with any provision in this Agreement. This Agreement and the Contract shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule. The parties agree that any ambiguity in this Agreement shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the Privacy Rule and the Security Rule.

IN WITNESS WHEREOF, the parties hereto have duly executed this Agreement as of the Agreement Effective Date.

| COVERED ENTITY | BUSINESS ASSOCIATE |
|---|---|
| Northern Inyo Healthcare District<br>By: _____ | By:_____ |
| Print Name: _____ | RYAN JONES_____ |
| Title: _____ | Title: Partner, Jones & Mayer |
| Date: _____ | Date: _____ |

**ATTACHMENT B**

**AGREEMENT BETWEEN NORTHERN INYO HEALTHCARE DISTRICT AND JONES & MAYER FOR THE PROVISION OF LEGAL SERVICES**

**TERM:**

**FROM: October 1, 2020 TO: October 1, 2021**

**SCHEDULE OF FEES:**

Monthly retainer: Contractor will provide general legal services for $7,600 per month. That monthly fee is capped at 40 hours per month. For general legal service above 40 hours per month, District will pay an hourly rate of $200 for all attorneys. General legal services are those services which involve regular, recurring legal and factual issues. General legal services include: Attendance at District meetings, work with District staff on all agenda items for Board meetings, drafting, review and revision of District agendas, agreements, contracts, instruments, basic ordinances, reports, resolutions, and other documents as requested by District. The parties agree to assess the rate and proposed hours after 6 months and determine whether the rates are appropriate for both sides.

Litigation and special legal services include those matters which present unique legal and/or factual issues and are billed at a rate of $225 per hour for attorney services and $125 per hour for paralegal services. As with general legal services, all attorneys in our office would bill at this same hourly rate for litigation and special legal services. Special legal services differ from general legal services in that they are of an irregular non-recurring basis. Examples include all litigation, or a complex employment investigation.

The General Counsel may not unilaterally designate any matter as a special project. For any "special" matter, we will first need approval from the CEO or Board of Directors, and we will provide a proposed budget for said work before it is approved. It is our goal to keep as much work as possible under general legal services. While it may seem contrary for a law firm to want to reduce its billings, we have found that in order to maintain a healthy and long-term relationship with our municipal clients, keeping the billing reasonable is essential. If you ask our current clients, you will find that our billing practices are sensible because of our long-term approach to client relationships. Moreover, we appreciate that the money spent on our firm are precious tax dollars that could be used for other important municipal services. Local governments in California have limited resources and must spend their revenues judiciously.

Rate Guarantee. We propose freezing our rates for a period of two years, with rates to vary thereafter based upon the Consumer Price Index increase for the prior year utilizing the standard as established by the Bureau of Labor Statistics of the U.S. Department of Labor for consumers in the Inyo County area, or another mutually agreed upon index.

Expense Reimbursement/Mileage. For all general legal services, we will bill three hours of travel time each way from to Bishop. We generally do not bill fax, word processing, or small reproduction

matters (under 100 pages). The firm will charge the client for actual necessary costs incurred for all of the following including but not limited to: court filing fees, attorney services (includes service of process fees, arbitrators, and mediators), messenger services, Lexis-Nexis research, overnight or express delivery services, mileage, parking fees, travel expenses, if applicable, including hotel, air travel and car rentals, actual costs for large reproduction projects if performed by an outside service, or $0.10 per page (b/w) and $0.20 per page (color) if performed in house, and any other expense not listed above which becomes necessary to the successful resolution of a client matter. In addition to the above, we would charge travel time for litigation and special services.

Method of Payment/Payment terms. A monthly invoice is sent to the client by the 15th of each month. Payment in full is due within 45 days of receipt. Our current practice with our clients is to bill by 1/10th of an hour every month on the first of the month for the prior months' services and costs. Jones & Mayer uses the Timeslips billing system to track attorney fees and expenses. Attorneys are responsible for entering their time directly into the system. Costs are paid by Accounting through the QuickBooks system, then entered separately into Timeslips for billing to the client. The time entries and costs appear on the bill in line item form, enabling the client to easily review and approve individual entries. The invoices will include an itemized statement which indicates work completed and hours of service rendered. Individualized billing entries are made for both retainer and non-retainer services to allow tracking and evaluation of services rendered. We also prepare annual audit responses on behalf of our clients for all pending litigation matters as required by insurance carriers, accounting auditors or joint powers authorities, as applicable.

**ATTACHMENT C**

**AGREEMENT BETWEEN NORTHERN INYO HEALTHCARE DISTRICT AND JONES & MAYER FOR THE PROVISION OF LEGAL SERVICES**

**TERM:**

**FROM: October 1, 2020 TO: October 1, 2021**

**SCHEDULE OF TRAVEL AND PER DIEM PAYMENT**

Travel shall be at the county's request and will be billed at cost.

Per diem travel from portal to portal will be at the current IRS rate.

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

Date: 08/31/2021

Title: **Pioneer Home Health Care Component Presentation by Noel Caughman with BBK Law Frim**

Synopsis: BBK Law Firm will provide a presentation to the Board of Directors with the purpose to define and clarify the component relationship between Northern Inyo Healthcare District and Pioneer Home Health Care.

Prepared by: Kelli Davis
Kelli Davis
Interim Chief Executive Officer

Reviewed by: Kelli Davis
Kelli Davis
Interim Chief Executive Officer

Approved by: Kelli Davis
Kelli Davis
Interim Chief Executive Officer

**FOR EXECUTIVE TEAM USE ONLY:**

Date of Executive Team Approval: 9-1-2021 Submitted by: Kelli Davis
Chief Officer

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

Date: 8/25/2021

Title: **APPROVAL OF THE PHARMACY AND INFUSION PROJECT PRELIMINARY BUDGET $3,000,000.00**

Synopsis: We are asking for Board approval for the Pharmacy / Infusion remodel project budget number. $3,000,000.00

We are asking the Board to approve the Pharmacy / Infusion project budget preliminary number.These numbers are preliminary, as we do not have OSHPD approval yet. This approval is a requirement by OSHPD in order to complete an expedited review of the project. This will also allow our CEO to approve the bid packets and contracts as they come in. allowing us to expedite the start of this project.

Prepared by: Scott Hooker
Director of Facilities

Reviewed by: Kelli Davis
Name
Title of Chief who reviewed INTERIM CEO

Approved by: Kelli Davis
Name
Title of Chief who approved INTERIM CEO

**FOR EXECUTIVE TEAM USE ONLY:**

Date of Executive Team Approval: 9-1-2021 Submitted by: Kelli Davis
Chief Officer

COLOMBO
CONSTRUCTION COMPANY, INC.

August 25, 2021

Northern Inyo Healthcare District
Attention: Mr. Scott Hooker
150 Pioneer Lane
Bishop, CA 93514

*RE: OSHPD Pharmacy Expedited Plan Review*

Dear Scott:

As you are aware, we received some good news from OSHPD and their acceptance of our request for an expedited review for the Pharmacy project. As the letter below suggests, OSHPD is very focused to meet the needs of the North Inyo Healthcare District in doing what they can to significantly reduce the review time for the project plans. However, OSHPD needs reasonable assurance the project team will be ready to receive the approved plans and mobilize the construction team in order to take advantage of OSHPD's efforts to expedite this review. We will need to provide documentation and sign off on the following terms as they have been presented to us:

1. A/E Team to commit to a two week turn around on back check comments.
2. Construction Team (Colombo) to be engaged in the project and ready to start work within two weeks of approval.
3. Preliminary budget approval by the NIHD Board.
4. Lastly, all members of the project team – NIDH Staff, A/E and Construction team must agree to these terms.

Currently, we are forwarding *Item #3, the Preliminary Budget to the Board for review, consideration and approval.* As the NIHD facility team put together its current fiscal year budget, an allowance *of* Three Million Dollars ($3M) was allocated for the new Pharmacy project. Approval of this preliminary budget would complete OSHPD's requirement for expedited review as well as allow for the project team to begin preliminary work to provide an "Early Start" of the project.

Recognizing that by the time the Board receives this request and approves the preliminary budget, three weeks will have lapsed and it is our understanding OSHPD will proceed, in good faith, to move forward with the expedited review.

Please do not hesitate to contact me if you have any questions. Thank you for your time and consideration. See attached letter from Tony Ping to OSPHD explaining this process and agreement.

Sincerely,
COLOMBO CONSTRUCTION CO., INC.

Louis Varga, Vice President Project Development
Vice President of Project Development

COLOMBO
CONSTRUCTION COMPANY, INC.

(Email from Tony Ping to Rick DeSouza (OSHPD) regarding expedited review)

Mr. Rick DeSouza:

Thank you for considering our request to expedite this project. I have been in direct contact with all parties involved in this effort and after review, we are grateful for your willingness to work interactively on this project and we want to proceed on this basis. The process we have undertaken is to have all the project contributors aligned in this effort. The hospital is engaging Colombo Construction to be the contractor/manager of this effort. Colombo is currently bidding/costing the construction plan check documents to fully define the cost of construction and to ensure we have the correct and identified subcontractors available to start this project upon approval. This effort will be updated as we proceed through the process and new information/changes become available. Our intent is to have a fully defined and vetted construction team ready to start construction immediately after approval and Notice of Start of Construction is issued. It is understood that the NOSOC cannot be issued and construction cannot start until the current separation project is fully completed and closed out, which is expected to be forthcoming. The hospital is working to have the contractor along with their subcontractors approved and funded during the review/permitting process to allow an immediate project start upon approval.

Our office is very focused to meet the needs of the hospital and the area's patients. We are committed to the following response times:

1) A/E time to respond to back check comments – 2 weeks from receipt from OSHPD.
2) The contractor will start full construction within 4 weeks of approval to proceed, as an outer limit. Two weeks is our hopeful start.
3) The hospital will work interactively with the A/E team and the contractor/construction manager to support the above timelines.

With this, we ask OSHPD to proceed with this project on a managed project process/approach. We will work within the above timelines to facilitate this effort. When OSHPD is able to identify their timelines, we will jointly keep a tentative calendar as we work toward approval and construction.

Thank you again for your willingness to process this project in an expedited manner. Please advise us of the actions and steps we need to take to support you and
OSHPD.

Tony Ping

**NORTHERN INYO HEALTHCARE DISTRICT**
**SUBMISSION TO THE BOARD OF DIRECTORS**
**FOR ACTION**

Date: August 25, 2021

Title: **COMPLIANCE and BUSINESS ETHICS COMMITTEE – REQUEST BOARD MEMBER**

Presenter(s): Patty Dickson
Compliance Officer

Synopsis: The Compliance Officer chairs the Compliance and Business Ethics Committee (CBEC). This committee is required per the NIHD Compliance Program. The Compliance Program is on this month's agenda for review and approval, and contains an updated membership for the committee. Should the Board of Directors approve the updated Compliance Program, I would request the Board appoint a member to sit upon this committee as directed in the Compliance Program. I have attached the Compliance Program (as submitted to the Board under Policy Approval) for reference.

**It is requested that the Board of Directors take action to appoint a member of the Board to the Compliance and Business Ethics Committee.**

Prepared by: Patty Dickson
Compliance Officer

Reviewed by: Kelli Davis
Name KELLI DAVIS
Title INTERIM CEO

Approved by: Kelli Davis
Name KELLI DAVIS
Title INTERIM CEO

**FOR EXECUTIVE TEAM USE ONLY:**
9-1-2021 Kelli Davis

**NORTHERN INYO HEALTHCARE DISTRICT**

**PLAN**

| | | |
|---|---|---|
| Title: Compliance Program for Northern Inyo Healthcare District | | |
| Owner: Compliance Officer | Department: Compliance | |
| Scope: District Wide | | |
| Date Last Modified: 08/12/2021 | Last Review Date: No Review Date | Version: 4 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 11/18/2016 | |

in approval

## Contents

in approval

***INTRODUCTION***

It is the fundamental policy of NORTHERN INYO HEALTHCARE DISTRICT (hereinafter "NIHD" or "the District"), that quality patient care and governance is provided by the District, its governing board, medical staff, employees and affiliates, in a manner that fully complies with all applicable state and federal laws, and that all of the District's business and other practices be conducted at all times in compliance with all applicable laws and regulations of the United States, the State of California, all other applicable state and local laws and ordinances, and the ethical standards and practices of the medical profession, the health care industry and this organization.

There is significant concern about "waste, fraud and abuse" in healthcare. In light of this, the Office of the Inspector General (OIG) has issued a document entitled "Compliance Program Guidance for Hospitals." The OIG has recommended that an effective compliance program should contain the following seven elements:

> ***1.*** *The development and distribution of written standards of conduct, as well as written policies and procedures that promote the Company's commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals;*
>
> ***2****. The designation of a compliance officer and other appropriate bodies charged with the responsibility of operating and monitoring the compliance program, and who report directly to the CEO and the governing body;*
>
> ***3****. The development and implementation of regular, effective education and training programs for all affected employees;*
>
> ***4.*** *The maintenance of a process, such as a hotline, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect complainants from retaliation;*
>
> ***5.*** *The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or federal health care program requirements;*
>
> ***6.*** *The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas; and*
>
> ***7.*** *The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.*

This Compliance Program outlines the process NIHD will utilize to assure that it is in compliance with all the various laws and regulations established by both the Federal government as well as the State of California.

This Compliance Program (the "Program") is intended as a guide to help implement this policy of compliance with all applicable standards. The federal, state, and local laws, regulations, and ethical rules that govern health care are too numerous to list in the Program. Fundamentally, all individuals associated with NIHD by employment, contract or otherwise, are expected to conduct all business activities honestly and fairly. Each employee or contractor is responsible for his or her own conduct in complying with the Program.

The Program provides for the designation of a Compliance Officer who has ultimate responsibility and accountability for directing, monitoring, and reporting on compliance matters. The Compliance Officer shall implement and administer this Program, together with training and education as necessary to affect the full participation of District governing board, medical staff, employees, affiliates, and other agents.

In approval

This Program provides a framework for individual or departmental compliance efforts, and applies to all District Personnel and activities. However, each individual employee or agent of the District remains responsible and accountable for his or her own compliance with applicable laws, regulations, standards, policies, and procedures.

The Program identifies those organizational imperatives necessary to prevent accidental and intentional non-compliance with applicable laws. It is further designed to detect non-compliance should it occur. Additionally, it is designed to promote such steps as are necessary to prevent future non-compliance, including education and corrective action.

Northern Inyo Healthcare District is committed to maintaining in the community a positive reputation for conduct in accordance with the highest levels of business ethics. This Program supports that objective. The Program fully supports the NIHD mission: Improving our communities, one life at a time. One team. One goal. Your health!

## *SECTION 1 — COMPLIANCE PROGRAM SUMMARY*

### Definitions of Commonly Used Terms

A list of words that are commonly used in this Compliance Program and their meanings follows:

- **"Affiliate"** means any person or entity controlled by, or under common control with, Northern Inyo Healthcare District.
- **"District"** means Northern Inyo Healthcare District, and all of its subsidiaries and affiliates that are covered by this Compliance Program.
- **"Personnel"** means all members of the governing board, medical staff, employees of the District, and all contractors or others who are required to comply with this Compliance Program. Each of these persons must sign an Acknowledgment of Receipt of District Compliance Program and a Conflict of Interest Questionnaire Form.
- **"Board"** means the Board of Directors of the District.

### Purpose of this Compliance Program

Northern Inyo Healthcare District is committed to ensuring compliance with all applicable statutes, regulations, and policies governing our daily business activities. To that end, the District will have a Compliance Program. The document is to serve as a practical guidebook that can be used by all Personnel to assist them in performing their job functions in a manner that complies with applicable laws and policies. Additionally this Compliance Program is to serve as a mechanism for preventing violations and for reporting any violation in a manner that protects those that identify and report the lack of compliance with those laws.

While this Compliance Program contains policies regarding the business of Northern Inyo Healthcare District, it does not contain every policy that Personnel are expected to follow. For example, this Compliance Program does not cover payroll, vacation and benefits policies. Northern Inyo Healthcare District maintains other policies with which employees are required to comply. If you have questions about which policies apply to you, please ask your supervisor.

It is the policy of the District that:

- All employees are educated about applicable laws and trained in matters of compliance;
- There is periodic auditing, monitoring and oversight of compliance with those laws;
- An atmosphere exists that encourages and enables the reporting of noncompliance without fear of

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retribution; and

- Mechanisms exist to investigate and take corrective actions in the event of noncompliance.

## Who is Affected

Everyone employed by Northern Inyo Healthcare District is required to comply with our Compliance Program. Because not all sections will apply to your job function, you will receive training and other materials to explain which portions of this Compliance Program apply to you.

While this is not intended to serve as the compliance program for all of our contractors, it is important that all contractors perform services in a manner that complies with the law. To that end, agreements with contractors may incorporate certain provisions of this Compliance Program.

Please note that compliance requirements are subject to change as a result of new laws and changes to existing laws and regulations. Collectively, we must all keep this Compliance Program current and useful. Therefore, you are encouraged to let the Compliance Officer or your supervisor know when you become aware of changes in law or District policy that might affect this Compliance Program.

## How to Use This Compliance Program

The District has organized this Compliance Program to be understandable and easy to navigate. A brief description of how this manual is organized follows.

1. **Section I – Compliance Program Summary**

2. **Section II – Code of Conduct**

This section contains specific policies related to your personal conduct while performing your job function. The primary objective of these policies is to create a work environment that promotes cooperation, professionalism, and compliance with the law. Compliance with the Code of Conduct is a significant factor in employee performance evaluations. All Personnel will receive training on this section.

3. **Section III – Compliance Program Systems and Processes**

This section explains the roles of the Compliance Officer and the Compliance and Business Ethics Committee. It also contains information about Compliance Program education and training, auditing, and corrective action. Most importantly, this section explains how to report violations anonymously, either in writing or by calling the Compliance Confidential Report Line at 1-888-200-9764 or by emailing the Compliance Officer directly. All Personnel will receive training on this section.

4. **Section IV – Compliance Policies**

The District electronic policy management system houses NIHD Compliance Policies. Some of these policies may not apply to your specific job function, but it is still important that you are aware of their existence and importance. All Personnel will receive training regarding the policies that apply to their job.

Here are some tips on how to use this Compliance Program effectively:

- **Refer to Table of Contents.** The Table of Contents contains a thorough list of topics covered in this Compliance Program. Use the Table of Contents to locate the topic you are looking for quickly.
- **Important Reference Tool.** This Compliance Program should be viewed as an important reference manual that you can refer to on a regular basis to answer questions about how to perform your job. Although it may not contain all of the answers, it will contain many and can save you time.
- **Read it in Context.** The District has created this Compliance Program to incorporate numerous compliance policies, many of which may not apply to you. When reviewing this Compliance

in approval

Program and the policies contained in it, keep in mind that the policies are to be applied in the context of your job. If you are uncertain about if or how a policy applies to you, ask your supervisor.

- **Keep it Handy.** Keep this Compliance Program information easily accessible and refer to it on a regular basis.
- **Talk to Your Co-Workers.** Regular dialogue among co-workers and supervisors is a great way to ensure that policies are applied uniformly. While this discussion is encouraged, always remember that the provisions of this Compliance Program should guide you on compliance matters.

## *SECTION II – CODE OF CONDUCT*

### Our Compliance Mission

The mission of Northern Inyo Healthcare District's Compliance Department is to promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law in order to improve our communities, one life at a time.

Northern Inyo Healthcare District believes that dedication to high ethical standards and compliance with all applicable laws and regulations is essential to its mission. This Code of Conduct is a critical component of the overall District Compliance Program. It guides and assists the District in carrying out daily activities in accordance with appropriate ethical and legal standards. These obligations apply to the District's relationship with patients, affiliated physicians, third-party payers, regulatory agencies, subcontractors, contractors, vendors, consultants, and one another. They require that all program participants comply with all applicable federal, state and local laws and regulations. Participants must also comply with all Northern Inyo Healthcare District Standards of Conduct. The absence of a specific guideline practice or instruction covering a particular situation does not relieve an employee from exercising the highest ethical standards applicable to the circumstances.

### Compliance with Laws

It is the policy of the District, its affiliates, contractors, and employees to comply with all applicable laws. When the application of the law is uncertain, the District Chief Executive Officer or Compliance Officer will seek guidance from legal counsel.

### Open Communication

The District encourages open lines of communication among Personnel. If you are aware of an unlawful or unethical situation, there are several ways you can bring this to the District's attention. Your supervisor is the best place to start, but you can also contact the District's Compliance Officer or call the Compliance Confidential Report Line (1-888-200-9764) to express your concerns. All reports of unlawful or unethical conduct will be investigated promptly. The District does not tolerate threats or acts of retaliation or retribution against employees for using these communication channels.

### Your Personal Conduct

The District's reputation for the highest standards of conduct rests not on periodic audits by lawyers and accountants, but on the high measure of mutual trust and responsibility that exists between Personnel and the District. It is based on you, as an individual, exercising good judgment and acting in accordance with this Code of Conduct and the law.

Ethical behavior on the job essentially comes down to honesty, trust, and fairness in dealing with other Personnel and with patients, vendors, competitors, the government and the public. It is no exaggeration to say

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that the District's integrity and reputation are in your hands.

The District's basic belief in the importance of respect for the individual has led to a strict regard for the privacy and dignity of Personnel. When management determines that your personal conduct adversely affects your performance, that of other Personnel, or the legitimate interests of the District, the District may be required to take corrective action.

## The Work Environment

The District strives to provide Personnel with a safe and productive work environment. All Personnel must dispose of medical waste, environmentally sensitive materials, and any other hazardous materials correctly. You should immediately address and report to your supervisor any situations that are likely to result in falls, shocks, burns, or other harm to patients, visitors, or Personnel.

The work environment also must be free from discrimination and harassment based on race, color, religion, sex, sexual orientation, age, national origin, disability, veteran status, or other factors that are unrelated to the District's legitimate business interests. The District will not tolerate sexual advances, actions, comments or any other conduct in the workplace that creates an intimidating or otherwise offensive environment. Similarly, the use of racial or religious slurs — or any other remarks, jokes or conduct that encourages or permits an offensive work environment — will not be tolerated.

If you believe that you are subject to such conduct, you should bring such activity to the attention of the District, either by informing your supervisor, the District's Compliance Officer, or by calling the Compliance Confidential Report Line (1-888-200-9764). The District considers all complaints of such conduct to be serious matters, and all complaints will be investigated promptly.

Some other activities that are prohibited because they clearly are not appropriate are:

- Threats;
- Violent behavior;
- The possession of weapons of any type on the premises, except for exempt or authorized Personnel;
- The distribution of offensive jokes or other offensive materials via e-mail or any other manner; and
- The use, distribution, sale, or possession of illegal drugs or any other controlled substances, except to the extent permitted by law for approved medical purposes.

In addition, Personnel may not be on the District premises or in the District work environment if they are under the influence of or affected by illegal drugs, alcohol or controlled substances used other than as prescribed.

## Employee Privacy

The District collects and maintains personal information that relates to your employment, including medical and benefit information. Access to personal information is restricted solely to people with a need to know this information. Personal information is released outside the District or to its agents only with employee approval, except in response to appropriate investigatory or legal requirements, or in accordance with other applicable law. Employees who are responsible for maintaining personal information and those who are provided access to such information must ensure that the information is not disclosed in violation of the District's Personnel policies or practices.

## Use of District Property

District equipment, systems, facilities, corporate charge cards, and supplies must be used only for conducting

in approval

District business or for purposes authorized by management.

Personal items, messages, or information that you consider private should not be placed or kept in telephone systems, computer systems, offices, workspaces, desks, credenzas, or file cabinets. Employees should have no expectation of privacy with regard to items or information stored or maintained on District equipment or premises. Management is permitted to access these areas. Employees should not search for or retrieve articles from another employee's workspace without prior approval from that employee or management.

Since supplies of certain everyday items are readily available at District work locations, the question of making personal use of them frequently arises. The answer is clear: employees may not use District supplies for personal use.

## Use of District Computers

The increasing reliance placed on computer systems, internal information, and communications facilities in carrying out District business makes it absolutely essential to ensure their integrity. Like other District assets, these facilities and the information they make available through a wide variety of databases should be used only for conducting District business or for purposes authorized by management. Their unauthorized use, whether or not for personal gain, is a misappropriation of District assets.

While the District conducts audits to help ensure that District systems, networks, and databases are being used properly, it is your responsibility to make sure that each use you make of any District system is authorized and proper.

Personnel are not allowed to load or download software or data onto District computer systems unless it is for business purposes and is approved in advance by the appropriate supervisor. Personnel shall not use District e-mail systems to deliver or forward inappropriate jokes, unauthorized political materials, or any other potentially offensive materials. Personnel are strictly forbidden from using computers to access the Internet for purposes of gambling, viewing pornography or engaging in any illegal activities.

Employees should have no expectation of privacy with regard to items or information stored or maintained on District premises or computer, information, or communication systems.

## Use of Proprietary Information

### Proprietary Information

Proprietary information is generally confidential information that is developed by the District as part of its business and operations. Such information includes, but is not limited to, the business, financial, marketing and contract arrangements associated with District services and products. It also includes computer access passwords, procedures used in producing computer or data processing records, Personnel and medical records, and payroll data. Other proprietary information includes management know-how and processes; District business and product plans with outside vendors; a variety of internal databases; and copyrighted material, such as software.

The value of this proprietary information is well known to many people in the District industry. Besides competitors, they include industry and security analysts, members of the press, and consultants. The District alone is entitled to determine who may possess its proprietary information and what use may be made of it, except for specific legal requirements such as the publication of certain reports.

Personnel often have access to information that the District considers proprietary. Therefore, it is very important not to use or disclose proprietary information except as authorized by the District.

### Inadvertent Disclosure

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The unintentional disclosure of proprietary information can be just as harmful as intentional disclosure. To avoid unintentional disclosure, never discuss with any unauthorized person proprietary information that has not been made public by the District. This information includes unannounced products or services, prices, earnings, procurement plans, business volumes, capital requirements, confidential financial information, marketing and service strategies, business plans, and other confidential information. Furthermore, you should not discuss confidential information even with authorized District employees if you are in the presence of others who are not authorized — for example, at a meeting, conference or in a public area. This also applies to discussions with family members or with friends, who might innocently or inadvertently pass the information on to someone else.

**Direct Requests for Information**

If someone outside the District asks you questions about the District or its business activities, either directly or through another person, do not attempt to answer them unless you are certain you are authorized to do so. If you are not authorized, refer the person to the appropriate source within the District. Under no circumstances should you continue contact without guidance and authorization. If you receive a request for information, or to conduct an interview from an attorney, investigator, or any law enforcement officer, and it concerns the District's business, you should refer the request to your supervisor, the office of the District's Chief Executive Officer, or Compliance Officer. Similarly, unless you have been authorized to talk to reporters, or to anyone else writing about or otherwise covering the District or the industry, direct the person to your supervisor.

**Disclosure and Use of District Proprietary Information**

Besides your obligation not to disclose any District proprietary information to anyone outside the District, you are also required to use such information only in connection with the District's business. These obligations apply whether or not you developed the information yourself.

**Proprietary and Competitive Information about Others**

In the normal course of business, it is not unusual to acquire information about many other organizations, including competitors (competitors are other Districts and health facilities). Doing so is a normal business activity and is not unethical in itself. However, there are limits to the ways that information should be acquired and used. Improper solicitation of confidential data about a competitor from a competitor's employees or from District patients is prohibited. The District will not tolerate any form of questionable intelligence gathering.

## Recording and Reporting Information

You should record and report all information accurately and honestly. Every employee records information of some kind and submits it to the District (for example, a time card, an expense account record, or a report). To submit a document that contains false information — an expense report for meals not eaten, miles not driven, or for any other expense not incurred — is dishonest reporting and is prohibited.

Dishonest reporting of information to organizations and people outside the District is also strictly prohibited and could lead to civil or even criminal liability for you and the District. This includes not only reporting information inaccurately, but also organizing it in a way that is intended to mislead or misinform those who receive it. Personnel must ensure that they do not make false or misleading statements in oral or written communications provided to organizations outside of the District.

## Exception

Nothing contained herein is to be construed as prohibiting conduct legally protected by the National Labor Relations Act or other applicable state or federal law.

## Gifts and Entertainment

The District understands that vendors and others doing business with the District may wish to provide gifts,

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promotional items, or entertainment to District Personnel as part of such vendors' own marketing activities. The District also understands that there may be occasions where the District may wish to provide reasonable business gifts to promote the District's services. However, the giving and receipt of such items can easily be abused and have unintended consequences; giving and receiving gifts, particularly in the health care industry, can create substantial legal risks.

**General Policy**

It is the general policy of the District that neither you nor any member of your family may solicit, receive, offer or pay any money or gift that is, or could be reasonably construed to be, an inducement in exchange for influence or assistance in conducting District business. It is the intent of the District that this policy be construed broadly such that all business transactions with vendors, contractors, and other third parties are transacted to avoid even the appearance of improper activity. Pharmaceutical samples provided to physicians by manufacturers for patient use are generally allowed. Please discuss any concerns with your supervisor or the Compliance Officer.

**Spending Limits — Gifts, Dining and Entertainment**

The District has developed policies that clearly define the spending limits permitted for items such as gifts, dining, and entertainment. Occasional gifts from vendors, of nominal value (less than $10), that do not influence or appear to influence the objective judgment of personnel, such as sales promotional items (an inexpensive pen), or business related meal or snack for a department are permitted with approval. All Personnel are strictly prohibited from making any expenditure of District or personal funds for gifts, dining or entertainment in any way related to District business, unless such expenditures are made in strict accordance with District policies.

**Marketing and Promotions in Health Care**

As a provider of health care services, the marketing and promotional activities of the District may be subject to anti-kickback and other laws that specifically apply to the health care industry. The District has adopted policies elsewhere in this Compliance Program to specifically address the requirements of such laws.

It is the policy of the District that Personnel are not allowed to solicit, offer or receive any payment, compensation or benefit of any kind (regardless of the value) in exchange for referring, or recommending the referral of, patients or customers to the District.

## Marketing

The District has expended significant efforts and resources in developing its services and reputation for providing high-quality patient care. Parts of those efforts involve advertising, marketing, and other promotional activities. While such activities are important to the success of the District, they are also potential sources of legal liability as a result of health care laws (such as the anti-kickback laws) that regulate the marketing of health care services. Therefore, it is important that the District closely monitor and regulate advertising, marketing and other promotional activities to ensure that all such activities are performed in accordance with District objectives and applicable law.

This Compliance Program contains various policies applicable to specific business activities of the District. In addition to those policies, it is the general policy of the District that no Personnel engage in any advertising, marketing, or other promotional activities on behalf of the District unless such activities are approved in advance by the appropriate District representative. You should ask your supervisor to determine the appropriate District representative to contact. In addition, no advertising, marketing, or other promotional activities targeted at health care providers or potential patients may be conducted unless approved in advance by the District's Chief Executive Officer or Compliance Officer.

All content posted on Internet websites maintained by the District must be approved in advance by the District's Compliance Officer or designee.



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## Conflicts of Interest

A conflict of interest is any situation in which financial or other personal considerations may compromise or appear to compromise any Personnel's business judgment, delivery of patient care, or ability of any Personnel to do his or her job or perform his or her responsibilities. A conflict of interest may arise if you engage in any activities or advance any personal interests at the expense of the District's interests.

An actual or potential conflict of interest occurs when any Personnel is in a position to influence a decision that may result in personal gain for that Personnel, a relative or a friend as a result of the District's business dealings. A relative is any person who is related by blood or marriage, or whose relationship with the Personnel is similar to that of persons who are related by blood or marriage, including a domestic partner, and any person residing in the Personnel's household. You must avoid situations in which your loyalty may become divided.

An obvious conflict of interest is providing assistance to an organization that provides services and products in competition with the District's current or potential services or products. You may not, without prior consent, work for such an organization as an employee (including working through a registry or "moonlighting" and picking up shifts at other health care facilities), independent contractor, a consultant, or a member of its Governing Board. Such activities may be prohibited because they divide your loyalty between the District and that organization. While many of these activities are approved with a management plan or Non-Disclosure agreement, failure to obtain prior consent in advance from the District's Compliance Officer may be grounds for corrective action, up to and including termination.

### Outside Employment and Business Interests

You are not permitted to work on any personal business venture on the District premises or while working on District time. In addition, you are not permitted to use District equipment, telephones, computers, materials, resources, or proprietary information for any business unrelated to District business. You must abstain from any decision or discussion affecting the District when serving as a member of an outside organization or board or in public office, except when specific permission to participate has been granted by the District's Compliance Officer or Chief Executive Officer.

### Contracting with the District

You may not contract with the District to be a supplier, to represent a supplier to the District, or to work for a supplier to the District while you are an employee of the District. In addition, you may not accept money or benefits, of any kind, for any advice or services you may provide to a supplier in connection with its business with the District.

### Required Standards

All decisions and transactions undertaken by Personnel in the conduct of the District's business must be made in a manner that promotes the best interests of the District, free from the possible influence of any conflict of interest of such Personnel or the Personnel's family or friends. Personnel have an obligation to address both actual conflicts of interest and the appearance of a conflict of interest. You must always disclose and seek resolution of any actual or potential conflict of interest — whether or not you consider it an actual conflict — before taking a potentially improper action.

No set of principles or standards can cover every type of conflict of interest. The following standards address conduct required of all Personnel and provide some examples of potential conflict of interest situations in addition to those discussed elsewhere in the Compliance Program.

1. Personnel may not make or influence business decisions, including executing purchasing agreements (including but not limited to agreements to purchase or rent equipment, materials, supplies or space) or other types of contracts (including contracts for personal services), from which they, a family member, or a friend may benefit.

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2. Personnel must disclose their "significant" (defined below) financial interests in any entity that they know to have current or prospective business, directly or indirectly, with the District. There are two types of significant financial interests:
    a. Receipt of anything of monetary value from a single source. Examples include salary, royalties, gifts and payments for services including consulting fees and honoraria; and
    b. Ownership of an equity interest exceeding 5 percent in any single entity, excluding stocks, bonds and other securities sold on a national exchange; certificates of deposit; mutual funds; and brokerage accounts managed by third parties.
3. Personnel must disclose any activity, relationship, or interest that may be perceived to be a conflict of interest so that these activities, relationships, and interests can be evaluated and managed properly.
4. Personnel must disclose any outside activities that interfere, or may be perceived to interfere, with the individual's capacity to satisfy his or her job or responsibilities at the District. Such outside activities include leadership participation (such as serving as an officer or member of the board of directors) in professional, community, or charitable activities; self-employment; participation in business partnerships; and employment or consulting arrangements with entities other than the District.
5. Personnel may not solicit personal gifts or favors from vendors, contractors, or other third parties that have current or prospective business with the District. Personnel may not accept cash gifts and may not accept non-monetary gifts including meals, transportation, or entertainment from vendors, contractors, or other third parties that have current or prospective business with the District. Questions regarding the gifts should be directed to the District's Compliance Officer.
6. Any involvement by Personnel in a personal business venture shall be conducted outside the District work environment and shall be kept separate and distinct from the District's business in every respect.
7. Personnel should not accept employment or engage in a business that involves, even nominally, any activity during hours of employment with the District, the use of any of the District's equipment, supplies, or property, or any direct relationship with the District's business or operation. Certain emergency situations may require collaboration with suppliers, vendors, or other healthcare organizations. Disclosure and approval by Chief Executive Officer or Compliance Officer at an appropriate time would further clarify compliance; however, nothing in this Program should be interpreted as interfering with the provision of high quality, efficient patient care in a legally compliant manner. Questions should be directed to the District's Compliance Officer.
8. Personnel must guard patient and District information against improper access, disclosure, or use by unauthorized individuals.
9. The District's materials, products, designs, plans, ideas, and data are the property of the District and should never be given to an outside firm or individual, except through normal channels with appropriate prior authorization.
10. Personnel must avoid even the appearance of impropriety when dealing with clinicians and referral sources.
11. All vendors and contractors who have or desire business relationships with the District must abide by this Code of Conduct. Personnel having knowledge of vendors or contractors who violate these standards in their relationship with the District must report these to their supervisor, manager, the District Compliance Officer, or by using the Confidential Compliance Report Line (1-888-200-9764).
12. Personnel shall not sell any merchandise on District premises and shall not sell any merchandise of a medical nature that is of a type or similar to what is sold or furnished by the District, whether on or off District premises, unless prior approval is obtained from the District's Compliance Officer.

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13. Personnel shall not request donations for any purpose from other Personnel, patients, vendors, contractors or other third parties, unless prior approval is obtained from the District's Compliance Officer.
14. Personnel may not endorse any product or service without explicit prior approval to do so by the District's Compliance Officer.

**Disclosure of Potential Conflict Situations**

You must disclose any activity, relationship, or interest that is or may be perceived to be a conflict of interest and complete the attached Conflict of Interest Questionnaire Form within 90 days of being subject to this Compliance Program (that is, being hired by the District, beginning to volunteer at the District, or assuming any responsibilities at the District). At least annually thereafter, you must review this Compliance Program and Conflict of Interest Questionnaire. You are required to file a Conflict of Interest Questionnaire Form annually, and when there is a change in your circumstances that you have not previously reported. At any time during the year, when an actual, potential, or perceived conflict of interest arises, you must revise your questionnaire form and contact the District's Compliance Officer. It is your responsibility to report promptly any actual or potential conflicts.

All questionnaire forms must be sent to the District's Compliance Officer. The Compliance Officer will review all disclosures and determine which disclosures require further action. The Compliance Officer will consult with the Business Compliance Team if an actual or perceived conflict of interest may exist. The District's Chief Executive Officer or legal counsel may be consulted by the Compliance Officer as needed to determine if further action is required. The outcome of these consultations will result in a written determination stating whether or not an actual conflict of interest exists. If a conflict of interest is determined to exist, the written determination shall set forth a plan to manage the conflict of interest, which may include that:

1. The conflict of interest is not significant and is generally permissible;
2. The activity may represent a potential or perceived conflict of interest, but in many cases would be permitted to go forward after disclosure with a Management Plan or Non-Disclosure Agreement;
3. The conflict of interest will require the Personnel to abstain from participating in certain governance, management or purchasing activities related to the conflict of interest;
4. The activity represents an actual conflict of interest which may be permitted to go forward after disclosure with an appropriate Management Plan or Non-Disclosure Agreement to eliminate the conflict, safeguard against prejudice toward Northern Inyo Healthcare District activities, and provide continuing oversight; or
5. The conflict of interest must be eliminated or, if it involves a proposed role in another organization or entity, must not be undertaken.

The Compliance Officer, or designee, will review any written determination with you and discuss any necessary action you are to take.

## Anti-Competitive Activities

If you work in community relations, sales, or marketing, the District asks you to perform your job not just vigorously and effectively, but fairly, as well. False or misleading statements about a competitor are inappropriate, invite disrespect and complaints, and may violate the law. Be sure that any comparisons you make about competitors' products and services are fair and accurate. (Competitors are other Districts, hospitals, and health facilities.)

## Reporting Violations



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The District supports and encourages each employee and contractor to maintain individual responsibility for monitoring and reporting any activity that violates or appears to violate any applicable statutes, regulations, policies, or this Code of Conduct.

The District has established a reporting mechanism that permits anonymous reporting, if the person making the report desires anonymity. Employees who become aware of a violation of the District Compliance Program, including this Code of Conduct, must report the improper conduct to the District's Compliance Officer. That officer, or a designee, will then investigate all reports and ensure that appropriate follow-up actions are taken.

District policy prohibits retaliation against an employee who makes such a report in good faith. In addition, it is the policy of the District that no employee will be punished on the basis that he/she reported what he/she reasonably believed to be improper activity or a violation of this Program.

However, employees are subject to corrective action, if after an investigation the District reasonably concludes that the reporting employee knowingly fabricated, or knowingly distorted, exaggerated or minimized the facts either to cause harm to someone else or to protect or benefit himself or herself.

***Additional, detailed information may be found in the NIHD Code of Business Ethics and Conduct.***

## *SECTION III — COMPLIANCE PROGRAM SYSTEMS AND PROCESSES*

This Compliance Program contains a comprehensive set of policies. In order to effectively implement and maintain these policies, the District has developed various systems and processes. The purpose of this section of the Compliance Program is to explain the various systems and processes that the District has established for the purpose of providing structure and support to the Compliance Program.

### Compliance Officers and Committee

#### Compliance Officer

The District has a Compliance Officer who serves as the primary supervisor of this Compliance Program. The District's Compliance Officer occupies a high-level position within the organization and has authority to carry out all compliance responsibilities described in this Compliance Program. The Compliance Officer is responsible for assuring that the Compliance Program is implemented to ensure that the District at all times maintains business integrity and that all applicable statutes, regulations and policies are followed.

The Compliance Officer provides frequent reports to the Governing Board about the Compliance Program and compliance issues. The Governing Board is ultimately responsible for oversight of the work of the Compliance Officer, and maintaining the standards of conduct set forth in the Compliance Program. The Governing Board oversees all of the District's compliance efforts and takes any appropriate and necessary actions to ensure that the District conducts its activities in compliance with the law and sound business ethics.

The Compliance Officer and Governing Board shall consult with legal counsel as necessary on compliance issues raised by the ongoing compliance review.

*Responsibilities of the Compliance Officer*

The Compliance Officer's responsibilities include the following:

- Overseeing and monitoring the implementation and maintenance of the Compliance Program.
- Reporting on a regular basis to the Governing Board (no less than quarterly) on the progress of implementation and operation of the Compliance Program and assisting the Governing Board in establishing methods to reduce the District's risk of fraud, waste, and abuse.
- Periodically revising the Compliance Program in light of changes in the needs of the District and changes in applicable statutes, regulations, and government policies.

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- Reviewing at least annually the implementation and execution of the elements of this Compliance Program. The review includes an assessment of each of the basic elements individually and the overall success of the Program, and a comprehensive review of the compliance department.
- Developing, coordinating and participating in educational and training programs that focus on elements of the Compliance Program with the goal of ensuring that all appropriate Personnel are knowledgeable about, and act in accordance with, this Compliance Program and all pertinent federal and state requirements.
- Ensuring that independent contractors and agents of the District are aware of the requirements of this Compliance Program as they affect the services provided by such contractors and agents.
- Ensuring that employees, independent contractors, and agents of the District have not been excluded from participating in Medicare, Medicaid (Medi-Cal) or any other federal or state heath care program.
- Ensuring that the District does not employ or contract with any individual who has been convicted of a criminal offense related to health care within the previous five years, or who is listed by a federal or state agency as debarred, excluded, or otherwise ineligible for participation in Medicare, Medicaid (Medi-Cal), or any other federal or state health care program.
- Coordinating internal compliance review and monitoring activities.
- Independently investigating and acting on matters related to compliance, including design and coordination of internal investigations and implementation of any corrective action.
- Maintaining a good working relationship with other key operational areas, such as quality improvement, coding, billing and clinical departments.
- Designating work groups or task forces needed to carry out specific missions, such as conducting an investigation or evaluating a proposed enhancement to the Compliance Program.

The Compliance Officer has the authority to review all documents and other information relevant to compliance activities, including, but not limited to, patient records, billing records, records concerning marketing efforts and all arrangements with third parties, including without limitation employees, independent contractors, suppliers, agents and physicians.

The Compliance Officer has direct access to the Governing Board, Chief Executive Officer and other senior management, and to legal counsel.

**Compliance and Business Ethics Committee**

The District has established a Compliance and Business Ethics Committee to advise the Compliance Officer and assist in monitoring this Compliance Program. The Compliance and Business Ethics Committee (CBEC) provides the perspectives of individuals with diverse knowledge and responsibilities within the District.

*Members of the Compliance and Business Ethics Committee*

The Compliance and Business Ethics Committee consists of multiple representatives. The members of the CBEC include those individuals designated below and other members as requested, including representatives of senior management, chosen by the District's Chief Executive Officer in consultation with the Compliance Officer:

- Compliance Officer
- Chief Financial Officer
- Cybersecurity Officer

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- Chief Medical Officer
- Chief Nursing Officer
- Chief Executive Officer
- Board of Directors' Representative
- As appropriate, Health Information Management Manager, Revenue Cycle Director, or department designee from Emergency, Human Resources Director Laboratory, Pharmacy, Imaging, Purchasing, and other areas

The Compliance Officer serves as the chairperson of the Compliance and Business Ethics Committee. The CBEC serves in an advisory role and has authority to adopt or implement policies following Board approval. The Compliance Officer will consult with members of the CBEC on a regular basis and may call meetings of all or some members of the CBEC.

The Board of Directors' representative to the CBEC shall be appointed by the full Board of Directors. The Board of Directors' representative shall meet the following qualifications prior to consideration for appointment:

- Completion of ethics and governance training as required by AB1234; and,
- Attended an Association of California Healthcare District (ACHD) Leadership Academy within past two years; and,
- Has completed and filed CA Form 700; and,
- NIHD Conflict of Interest for Members of the Board of Directors has been completed, returned, and reviewed by the Business Compliance Team.

Each member of the CBEC shall sign a Non-Disclosure Agreement (NDA).

*Functions of the Compliance and Business Ethics Committee*
The Compliance and Business Ethics Committee's functions include the following:

- Assessing existing and proposed compliance policies for modification or possible incorporation into the Compliance Program.
- Working with the Compliance Officer to develop standards of conduct and policies to promote compliance.
- Development on Annual Compliance Department Work Plan and Audit Plan, including review and re-prioritizing as necessary
- Recommending and monitoring, in conjunction with the Compliance Officer, the development of internal systems and controls to carry out the standards and policies of this Compliance Program.
- Reviewing and proposing strategies to promote compliance and detection of potential violations.
- Assisting the Compliance Officer in the development and ongoing monitoring of systems to solicit, evaluate, and respond to complaints and problems related to compliance.
- Assisting the Compliance Officer in coordinating compliance training, education and other compliance-related activities in the departments and business units in which the members of the Compliance and Business Ethics Committee work.
- Consulting with vendors of the District on a periodic basis to promote adherence to this Compliance Program as it applies to those vendors and to promote their development of formal

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Compliance Programs.

The tasks listed above are not intended to be exhaustive. The CBEC may also address other compliance-related matters as determined by the Compliance Officer.

The CBEC may, from time to time, create one or more sub-committees which shall have that authority specifically designated thereto. Each sub-committee shall answer directly to the respective Compliance and Business Ethics Committee.

The District has established a Billing, Coding, and Compliance Committee (BCCC), which is a sub-committee of the Compliance and Business Ethics Committee, to advise the Compliance Officer and assist in monitoring of billing, coding, and revenue cycle management. The Billing, Coding, and Compliance Committee shall be renamed the Billing and Coding Compliance Subcommittee (BCCS).

The District has established a Business Compliance Team (BCT) to assist the Compliance Officer in appropriate determinations and plans of action for reported, actual, or perceived conflicts of interest. The Business Compliance Team is a subcommittee of the CBEC.

## Compliance as an Element of Performance

The promotion of, and adherence to, the elements of this Compliance Program is a factor in evaluating the performance of all District employees. Personnel will be trained periodically regarding the Compliance Program, and new compliance policies that are adopted. In particular, all managers and supervisors involved in any processes related to the evaluation, preparation, or submission of medical claims must do the following:

- Discuss, as applicable, the compliance policies and legal requirements described in this Compliance Program with all supervised Personnel.
- Inform all supervised Personnel that strict compliance with this Compliance Program is a condition of continued employment.
- Inform all supervised Personnel that disciplinary action will be taken, up to and including termination of employment or contractor status, for violation of this Compliance Program.

Managers and supervisors will be subject to discipline for failure to adequately instruct their subordinates on matters covered by the Compliance Program. Managers and supervisors will also be subject to discipline for failing to detect violations of the Compliance Program where reasonable diligence on the part of the manager or supervisor would have led to the discovery of a problem or violation and thus would have provided the District with the opportunity to take corrective action.

## Training and Education

The District acknowledges that this Compliance Program will be effective only if it is communicated and explained to Personnel on a routine basis and in a manner that clearly explains its requirements. For this reason, the District requires all Personnel to attend specific training programs on a periodic basis. Training requirements and scheduling are established by the District for its departments and affiliates based on the needs and requirements of each department and affiliate. Training programs include appropriate training in federal and state statutes, regulations, guidelines, the policies described in this Compliance Program, and corporate ethics. Training will be conducted by qualified internal or external personnel. New employees are trained early in their employment. Training programs may include sessions highlighting this Compliance Program, summarizing fraud and abuse laws, physician self-referral laws, claims development and submission processes, and related business practices that reflect current legal standards.

All formal training undertaken as part of the Compliance Program is documented. Documentation includes at a minimum the identification of the Personnel participating in the training, the subject matter of the training,

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the time and date of the training, the training materials used, and any other relevant information.

The Compliance Officer evaluates the content of the training program at least annually to ensure that the subject content is appropriate and sufficient to cover the range of issues confronting the District's employees. The training program is modified as necessary to keep up-to-date with any changes in federal and state health care program requirements, and to address results of the District's audits and investigations; results from previous training and education programs; trends in Hotline reports; and guidance from applicable federal and state agencies. The appropriateness of the training format is evaluated by reviewing the length of the training sessions; whether training is delivered via live instructors or via computer-based training programs; the frequency of training sessions; and the need for general and specific training sessions.

The Compliance Officer seeks feedback to identify shortcomings in the training program, and administers post-training tests as appropriate to ensure attendees understand and retain the subject matter delivered.

Specific training for appropriate corporate officers, managers, and other employees may include areas such as:

- Restrictions on marketing activities.
- General prohibitions on paying or receiving remuneration to induce referrals.
- Proper claims processing techniques.
- Monitoring of compliance with this Compliance Program.
- Methods for educating and training employees.
- Duty to report misconduct.

The members of the District's Governing Board will be provided with periodic training, not less than annually, on fraud and abuse laws and other compliance matters.

Attendance and participation in compliance training programs is a condition of continued employment. Failure to comply with training requirements will result in disciplinary action, including possible termination.

Adherence with the provisions of this Compliance Program, including training requirements, is a factor in the annual evaluation of each District employee. Where feasible, outside contractors will be afforded the opportunity to participate in, or be encouraged to develop their own, compliance training and educational programs to complement the District's standards of conduct and compliance policies. The Compliance Officer will ensure that records of compliance training, including attendance logs and copies of materials distributed at training sessions, are maintained.

The compliance training described in this program is in addition to any periodic professional education courses that may be required by statute or regulation for certain Personnel. The District expects its employees to comply with applicable education requirements; failure to do so may result in disciplinary action.

## Lines of Communicating and Reporting

### Open Door Policy

The District recognizes that clear and open lines of communication between the Compliance Officer and District Personnel are important to the success of this Compliance Program. The District maintains an open door policy in regards to all Compliance Program related matters. District Personnel are encouraged to seek clarification from the Compliance Officer in the event of any confusion or question about a statute, regulation, or policy discussed in this Compliance Program.

### Submitting Questions or Complaints

The District has established a telephone hotline for use by District Personnel to report concerns or possible wrongdoing regarding compliance issues. We refer to this telephone line as our "Compliance Confidential

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Report Line."

The Compliance Confidential Report Line contact number is:

Phone: 1-888-200-9764

Personnel may also submit compliance-related questions or complaints in writing. Letters may be sent anonymously. All such letters should be sent to the Compliance Officer at the following address:

Compliance Officer
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

The Compliance Confidential Report Line number and the Compliance Officer's contact information are posted in conspicuous locations throughout the District's facilities.

All calls to the Compliance Confidential Report Line are treated confidentially and are not traced. The caller need not provide his or her name. The District's Compliance Officer or designee investigates all calls and letters and initiates follow-up actions as appropriate.

Communications via the Compliance Confidential Report Line and letters mailed to the Compliance Officer are treated as privileged to the extent permitted by applicable law; however, it is possible that the identity of a person making a report may become known, or that governmental authorities or a court may compel disclosure of the name of the reporting person.

Matters reported through the Compliance Confidential Report Line or in writing that suggest violations of compliance policies, statutes, or regulations are documented and investigated promptly. A log is maintained by the Compliance Officer of calls or communications, including the nature of any investigation and subsequent results. A summary of this information is included in reports by the Compliance Officer to the District's Governing Board and Chief Executive Officer.

**Non-Retaliation Policy**
It is the District's policy to prohibit retaliatory action against any person for making a report, anonymous or otherwise, regarding compliance. However, District Personnel cannot use complaints to the Compliance Officer to insulate themselves from the consequences of their own wrongdoing or misconduct. False or deceptive reports may be grounds for termination. It will be considered a mitigating factor if a person makes a forthright disclosure of an error or violation of this Compliance Program, or the governing statutes and regulations.

## Enforcing Standards and Policies

**Policies**
It is the policy of the District to use appropriate corrective action with District Personnel who fail to comply with the Code of Conduct or the policies set forth in, or adopted pursuant to, this Compliance Program or any federal or state statutes or regulations.

The guiding principles underlying this policy include the following:

- Intentional or reckless noncompliance will subject Personnel to significant sanctions, which may include oral warnings, suspension, or termination of employment, depending upon the nature and extent of the noncompliance.
- Negligent failure to comply with the policies set forth in this Compliance Program, or with applicable laws, will also result in sanctions.

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- Corrective action will be taken where a responsible employee fails to detect a violation, if this failure is attributable to his or her negligence or reckless conduct.
- Internal audit or review may lead to discovering violations and result in corrective action.

Because the District takes compliance seriously, the District will respond to Personnel misconduct.

**Corrective Action Procedures**

Employees found to have violated any provision of this Compliance Program are subject to discipline consistent with the policies set forth herein, including termination of employment if deemed appropriate by the District. Any such discipline is within the sole discretion of the District. Each instance involving disciplinary action shall be thoroughly documented by the employee's supervisor and the Compliance Officer.

Upon determining that an employee of the District or any of its affiliates has committed a violation of this Compliance Program, such employee shall meet with his or her supervisor to review the conduct that resulted in violation of the Compliance Program. The employee and supervisor will contact the Compliance Officer to discuss any actions that may be taken to remedy such violation. All employees are expected to cooperate fully with the Compliance Officer during the investigation of the violation. The Chief of Human Resources, Compliance Officer, or Chief Executive Officer may consult legal counsel prior to final actions or disciplinary measures, as appropriate.

## Auditing and Monitoring

The District conducts periodic monitoring of this Compliance Program. Compliance reports created by this monitoring, including reports of suspected noncompliance, will be reviewed and maintained by the Compliance Officer.

The Compliance Officer will develop and implement an audit plan. The plan will be reviewed at least annually to determine whether it addresses the proper areas of concern, considering, for example, findings from previous years' audits, risk areas identified as part of the annual risk assessment, and high volume services.

Periodic compliance audits are used to promote and ensure compliance. These audits are performed by internal or external auditors who have the appropriate qualifications and expertise in federal and state health care statutes and regulations and federal health care program requirements. The audits will focus on specific programs or departments of the District, including external relationships with third-party contractors. These audits are designed to address, at a minimum, compliance with laws governing kickback arrangements, physician self-referrals, claims development and submission (including an assessment of the District's billing system), reimbursement, and marketing. All Personnel are expected to cooperate fully with auditors during this process by providing information, answering questions, etc. If any employee has concerns regarding the scope or manner of an audit, the employee should discuss this with his or her immediate supervisor.

The District shall conduct periodic reviews, including unscheduled reviews, to determine whether the elements of this Compliance Program have been satisfied. Appropriate modifications to the Compliance Program will be implemented when monitoring discloses that compliance issues have not been detected in a timely manner due to Compliance Program deficiencies.

The periodic review process may include the following techniques:

- Interviews with Personnel involved in management, operations, claim development and submission, and other related activities.
- Questionnaires developed to solicit impressions of the District Personnel.
- Reviews of all billing documentation, including medical and financial records and other source documents, that support claims for reimbursement and claims submissions.

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- Presentations of a written report on compliance activities to the Compliance Officer. The report shall specifically identify areas, if any, where corrective actions are needed. In certain cases, subsequent reviews or studies may be conducted to ensure that recommended corrective actions have been successfully implemented.

Error rates shall be evaluated and compared to error rates for prior periods as well as available norms. If the error rates are not decreasing, the District shall conduct a further investigation into other aspects of the Compliance Program in an effort to determine hidden weaknesses and deficiencies.

## Corrective Action

### Violations and Investigations

Violations of this Compliance Program, failure to comply with applicable federal or state laws, and other types of misconduct threaten the District's status as a reliable and honest provider of health care services. Detected but uncorrected misconduct can seriously endanger the District's business and reputation, and can lead to serious sanctions against the District. Consequently, upon reports or reasonable indications of suspected noncompliance, prompt steps to investigate the conduct in question will be initiated under the direction and control of the Compliance Officer to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred. The Compliance Officer may create a response team to review suspected noncompliance including representatives from the compliance, audit and other relevant departments.

If such a violation has occurred, prompt steps will be taken to correct the problem, taking into account the root cause of the problem. As appropriate, such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan, a report to the Office of Inspector General (OIG) or any other appropriate government organization, and/or submission of any overpayments. The specific steps that are appropriate in any given case will be determined after consultation between the Chief Executive Officer or Compliance Officer and legal counsel.

Depending upon the nature of the alleged violations, the Compliance Officer's internal investigation could include interviews with relevant Personnel and a review of relevant documents. Legal counsel, auditors or health care experts may be engaged by the Compliance Officer to assist in an investigation where the Compliance Officer deems such assistance appropriate. Complete records of all investigations will be maintained which contain documentation of the alleged violations, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed, results of the investigation (e.g., any disciplinary action taken), and corrective actions implemented.

If an investigation of an alleged violation is undertaken and the Compliance Officer believes the integrity of the investigation may be at stake because of the presence of employees under investigation, those employees will be removed from their current work activity until the investigation is completed. Where necessary, the Compliance Officer will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

### Reporting

If the Compliance Officer or a management official discovers credible evidence of misconduct from any source and, after reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil, or administrative law, then the misconduct will promptly be reported as appropriate to the OIG or any other appropriate governmental authority or federal and/or state law enforcement agency having jurisdiction over such matter. Such reports will be made by the Compliance Officer on a timely basis.

All overpayments identified by the District shall be promptly disclosed and/or refunded to the appropriate public or private payer or other entity.

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## *SECTION IV – COMPLIANCE POLICIES*

The District electronic policy management system houses NIHD Compliance Policies. Some of these policies may not apply to your specific job function, but it is still important that you are aware of their existence and importance. All Personnel will receive training regarding the policies that apply to their job.

**REFERENCES:**

1. Supplemental Compliance Program Guidance for Hospitals (70 Fed. Reg. 4858; January 31, 2005)
2. Compliance Program Guidance for Hospitals (63 Fed. Reg. 8987; February 23, 1998)

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Authority of the Chief Executive Officer for Contracts and Bidding
2. Business Associate Agreements Execution and Management
3. California Public Records Act – Information Requests
4. Communicating Protected Health Information via Electronic Mail (Email)
5. Disclosures of Protected Health Information Over the Telephone
6. Disposal of Equipment
7. Electronic Communication (Email) Acceptable Use Policy
8. False Claims Act Employee Training and Prevention Policy
9. Family Member and Relatives in the Workplace
10. Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information
11. Language Access Services Policy
12. NIHD Code of Business Ethics and Conduct
13. Non-Retaliation Policy
14. Nondiscrimination Policy
15. Patient Rights
16. Pricing Transparency Policy
17. Purchasing Signature Authority
18. Equal Employment Opportunity
19. Sanctions for Breach of Patient Privacy Policies
20. Sending Protected Health Information via Fax
21. Using and Disclosing Protected Health Information for Treatment, Payment and HealthCare Operations
22. Vendor Credentialing
23. Workforce Access to His or Her Own Protected Health Information
24. Workforce Investigations

| Supersedes: v.3 Compliance Program for Northern Inyo Healthcare District |
|---|

in approval

**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: Sierra Bourne, MD, Chief of Medical Staff
DATE: September 7, 2021
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. Medical Staff Resignations (*action item*)
1. Arrash Fard, MD (*cardiology*) – telemedicine staff; Adventist Health – effective 8/31/2021

B. Policies and Procedures (*action items*)
1. *Safe Patient Handling – Minimal Lift Program*
2. *Packing Blood Products in Transport Containers*
3. *Safe-T-Vue 10 Non-reversible Temperature Indicators - Direction for Use*
4. *Returning Dispensed Blood Products to Inventory*
5. *ABO/Rh Confirmation Testing - Patients*
6. *ABO/Rh Testing for Adults*
7. *"Crash Pack" Emergency Dispense of Uncrossmatched Blood - Preparation and Reconciliation*
8. *Dispensing Blood Products - Non-emergent*
9. *Transfusion Criteria*
10. *Cerebrospinal Fluid Cultures*
11. *Principles Of Asepsis In The Operating Room*
12. *Warming Cabinet For Blankets/Solutions*
13. *Credentialing – da Vinci Robotic Surgery*

C. Biennial Review of Medical Staff Policies (*action item*)
1. *Standardized Protocol - General Policy for the Physician Assistant*
2. *Standardized Procedure - Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife*
3. *Standardized Procedure - Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife*
4. *Standardized Protocol - Laboratory and Diagnostic Testing Policy for the Physician Assistant*
5. *Standardized Protocol - Medication/Device Policy for the Physician Assistant*
6. *Standardized Protocol - Minor Surgical Policy for the Physician Assistant*
7. *Standardized Procedure - Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife*
8. *Standardized Procedure - Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife*

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

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Safe Patient Handling – Minimal Lift Program | | |
| Owner: EMPLOYEE HEALTH INFECT PREV SPEC | Department: Employee Health | |
| Scope: Clinical Staff District Wide | | |
| Date Last Modified: 08/17/2021 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 10/01/2014 | |

## PURPOSE:

NIHD wants to ensure that patients are cared for safely, while maintaining a safe work environment for employees. This document describes the practices at NIHD to ensure employees use safe patient handling and movement techniques for patients in patient care areas.

## POLICY:

1. Patient care areas include all areas of the District where care and treatment of services are rendered directly to the District's patient population and include, but are not limited to Rural Health Clinics, Nursing Services, Diagnostic Imaging Services, Cardiopulmonary, NIA Clinics, Lab and Rehabilitation Services.
2. Direct patient care staff members in all patient care areas will assess all patient handling tasks in advance to determine the safest way to accomplish the tasks.
    a. Mechanical lift aids will be used as appropriate for the patient and all direct patient care employees are expected to assist each other in the execution of safe patient handling matters.
    b. District Leaders are required to ensure that employee have appropriate assistance in implementing this policy on a task by task basis and have trained their staff members on appropriate safe patient handling matters.
3. For patients admitted to the hospital, an RN will serve as the coordinator of care assessing the patient's mobility needs (functional screen in the nursing assessment) and identify in the Plan of Care, the level of assistance required and mechanical device usage.
    a. A referral will be generated to Rehabilitation Services based on the Functional Screen and/or physician order for additional patient assessment and care planning.
4. An inventory of mechanical device equipment for patient care areas will be maintained by the department management.
5. Staff training will be provided on the use of mechanical device equipment as appropriate to the position hired.
6. Mechanical lift devices are to be used on patients requiring assistance. Manual lifting without a mechanical lift device is discouraged.
    a. If some degree of lifting is unavailable, caregivers should seek assistance from other staff members and/or employ mechanical aids whenever possible.
7. Employees who do not utilize proper safe patient handling practices may be subject to corrective action.

a. Discipline will not occur with respect to a health care worker who refuses to lift, reposition, or transfer a patient due to concerns about patient or worker safety or lack of equipment or trained lift personnel.

8. Any injury resulting from patient lifting or positioning, including strains, sprains, or any other muscular skeletal injury must be handled according to the Work related Accidents Policy.
9. If a patient is unable to assist the HCW with repositioning or transfers, then the lifting and moving of the patient will be done with minimum of two person assist with or without the use of an assistive device.
10. Transferring patients out of the unit on a gurney or bed to the Radiology Department will be done with a minimum of two-person assistance. If transferring a patient on a gurney, on a flat surface to any inpatient unit or PACU/OR is permissible for 1 person to transport a patient on a gurney.

**DEFINITIONS:**

1. Manual Lifting: Lifting, transferring, repositioning, and moving patients using a caregiver's body strength without the use of lifting equipment/aids that reduce forces on the worker's muscular skeletal structure.
2. Patient Handling Equipment and Aids: Equipment or aids used to decrease the risk of injury from patient handling activities and includes, but is not limited to the following:
    a. **Lifting Equipment** includes portable/floor-based designs and their accompanying slings that function to assist in lifting and transferring patients, ambulating patients, repositioning patients, and other patient handling tasks.
    b. **Lateral Transfer Devices** Provide assistance in moving patients horizontally from one surface to another (e.g., transfers from bed to stretcher).
    c. **Beds** that provide assistance with patient handling tasks such as lateral rotation therapy, transportation, percussion, bringing patients to sitting positions, etc.
    d. **Repositioning Aids** provide assistance in turning patients and pulling patients up to the head of the bed and up in chairs.
    e. **Equipment/bed/wheelchair transport assistive devices** assist caregivers in pushing heavy equipment.
    f. **Patient Handling Aids:** Non-mechanical equipment used to assist in the lift or transfer process. Examples include stand assist aids, sliding boards, and surface friction-reducing devices.
    g. **Powered Height-adjustable exam tables** assist in transfer of patients onto exam tables and in bringing patients to sitting position, and raise the table surface to a more ergonomically safe working level.
3. High Risk Patient Handling Tasks: Patient handling tasks that have a high risk of musculoskeletal injury for staff performing the tasks. These include but are not limited to transferring and lifting tasks, repositioning tasks, bathing patients in bed, making occupied beds, ambulating and dressing patients, turning patients in bed, tasks with long durations, standing for long periods of time bariatric, and other patient handling tasks.
4. Designated Health Care Worker: NIHD staff who have been specifically trained to handle patient lifts, repositioning, and transfers using patient transfer, repositioning, or lifting devices as appropriate for the specific patient. It means staff working together to accomplish these patient related tasks safely.

**PROCEDURE:**

A. Direct Patient Care Employee Responsibility
    1. Take responsibility for their own health and safety, as well as that of their co-workers and their patients during patient handling activities.
    2. Complete initial training and annual training as required.

a. Complete additional training to correct improper use/understanding of safe patient handling and movement.
b. Notify manager of need for re-training in the use of patient handling equipment and aids.

3. Assess patient for condition and ability to cooperate with transfer and appropriate level of patient assist.
   a. Identify and avoid hazardous manual patient handling and movement tasks whenever possible.
4. Use proper techniques, mechanical lifting devices, and other approved equipment and/or aids during performance of high risk patient handling tasks.
5. Promptly report to manager or shift supervisor any injury without fear of negative consequence.
6. Follow procedures for reporting patient handling equipment in need of repair.

B. RN Coordinator of Care Admitted Patients.
   1. To follow initial Nursing Admission Assessment Policy and Procedure.

C. Develop nursing care plan as recommended by EHR documentation for fall risk and mobility scores. Management of Direct Patient Care Employees.
   1. Be educated and remain up-to-date in the use of mechanical lifts and transfer aids. Be aware of department worker's compensation costs and injury rates and continue to make efforts to reduce the number of incidents in all areas of responsibility.
   2. Through employee observation, documentation review and other means, make sure that all employees are assessing the patient prior to any movement and that all patient handling tasks are completed safely, using mechanical lifting devices and other approved handling aids.
   3. Department inventory of mechanical lifting devices/aids are available in proper working order, maintained regularly and stored readily accessible in the clinical areas.
      a. see Patient Lifting Handling Equipment/Aids per Department reference sheet
   4. Review orientation checklists to make sure that employees complete initial training; ensure employees demonstrate competency; provide re-training when employees are non-compliant with safe patient handling practices; maintain training records for a period of three years.
   5. Refer all staff reporting patient handling injuries to the Shift Supervisor and/or Emergency Department for immediate evaluation and treatment.

D. Rehabilitation Services
   1. Physical Therapy and/or designee will:
      a. Complete training of newly hired staff members on the use of the lift equipment/aids and assist with ongoing training for unit staff members. Provide reference materials with the information needed for troubleshooting.
      b. Training will include use of lifting deices and equipment to handle patient safety and the five areas of body exposure: vertical, lateral, bariatric, repositioning, and ambulation.
   2. PT and/or designee will conduct ergonomic rounds quarterly to assess for patient handling lift training opportunities and to encourage and motivate staff in the use of lifts/transfer devices, report unsafe situations related to the use of the lift equipment and assist with organization and accessibility of equipment.
   3. Remain knowledgeable and current on all lift equipment/transfer aids available to staff members and stay abreast of updates/changes.
   4. Assure equipment and any needed supplies are readily available in departments; communicate supply issues to Manager.

E. Facilities Management:
   1. Biomedical Engineering shall maintain patient care equipment in proper working order.
   2. Consult with equipment manufacturers to provide safe equipment installations.

F. Reporting of Injuries:
   1. Employees are required to follow the Work related Accidents Policy for any patient handling injury event

2. Employees who are non-compliant with the Safe Patient Handling Policy must be re-trained and demonstrate competency in equipment use before returning to work. Continued failure to use proper patient handling practices may result in corrective action up to and including termination.

**REFERENCES:**


1. ANA (2013) Safe Patient Handling and Mobility: Inter-professional National Standards. Nursebooks.org.
2. California Code of Regulations (2013) Safe Patient Handling Bill (AB1136). www.dir.ca.gov/oshsb/safe_patient_handling.htm;


**RECORD RETENTION AND DESTRUCTION:**

Training records will be maintained for a minimum of 1 year per Cal/OSHA requirement (2014 regulation).

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Completing Quality Review Report in Performance Excellence Manual
2. Employee Requests to be Excluded from Patient Care in HR /Employee Handbook
3. TJC (2012) Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation. Oakbrook Terrace, Illinois.
4. Work Related Accidents in Human Resources/Employee Handbook
5. Injury and Illness Prevention Program located in Employee Health Manual

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| Supersedes: v.2 Safe Patient Handling – Minimal Lift Program |

**NORTHERN INYO HEALTHCARE DISTRICT**
**LABORATORY SERVICES DEPARTMENT**
**STANDARD OPERATING PROCEDURE**

| | | |
|---|---|---|
| SOP #: TS-009-2021 | | |
| Title: Packing Blood Products in Transport Containers | | |
| Owner: LAB MANAGER | Department: Laboratory | |
| Scope: Blood Bank | | |
| Date Last Modified: 08/16/2021 | Last Review Date: No Review Date | Version: 1 |
| Final Approval by: Medical Director of Lab & Medical Executive Team | Original Approval Date: | |

## I. PURPOSE:

This Standard Operating Procedure (SOP) describes how to pack the three types of transport containers Northern Inyo Hospital Transfusion Service uses for blood products:

- MaxQ Max+ cooler (in-house)
- Thermosafe cooler (in-house)
- Vitalant transport boxes (to accompany patients being air-transferred)

## II. BACKGROUND:

According to the Standards for Blood Banks and Transfusion Services, current edition, published by the American Association of Blood Banks (AABB) and the Food and Drug Administration (FDA) Title 21 of Chapter I, Subchapter F, "Biologics", liquid Red Blood Cells shall remain 1º - 6º C while in storage, and 1º - 10º C during transport. Northern Inyo Hospital (NIH) requires packed red blood cells (PRBCs) to be kept at or below 10º C while issued in a cooler.

The Transfusion Service has validated transport containers to comply with these standards.

## III. SPECIMEN REQUIREMENTS:

- Only PRBCs and fresh frozen plasma (FFP) are transported in chilled transport containers.
- Frozen ice packs and refrigerated gel packs should be maintained at their proper storage temperature for at least 24 hours for best results.

| Container Type | Container Name in CernerCW | Validated Transport Time | Validated Unit Capacity | Ice Pack Type and Temperature |
|---|---|---|---|---|
| MaxQ Max+ Cooler | NIHD Cooler 1 | 6 hours | 2 | 2 white "Kool-it" packs *-20º C* |
| Thermosafe Coolers | NIHD Cooler 2<br>NIHD Cooler 3 | 4 hours | 1-4 | 3 oblong ice packs *-20º C* |

| | | | | |
|---|---|---|---|---|
| Vitalant Transport Box | NIHD Flight Box 1<br>NIHD Flight Box 2<br>NIHD Flight Box 3 | 48 hours<br>(per Vitalant) | 1-5 | 2 square "Blue Ice"<br>*-20º C* <u>OR</u><br>*-30º C left at room temp for 15 minutes* |

See enclosures for photographs of properly packed coolers.

**IV. PROCEDURE:**

<u>PACKING THE MAXQ MAX+ COOLER</u>

*Reserve the small blue Max+ cooler for emergencies/"Crash Packs".*

1. The Max+ cooler should be returned to the Transfusion Service after **4 hours**.
    a. It is **validated for up to 6 hours** of transport to account for unusual circumstances.
2. 2 blue cooler inserts are stored in the refrigerator containing pre-dispensed "Crash Packs".
    *a. See SOP TS-004-2021 "'Crash Pack'" Emergency Dispense of Uncrossmatched Blood – Preparation and Reconciliation" for details*
3. Place a small blue cooler insert containing units in the cooler.
4. Place a white "Kool-it" ice pack stored at -20º C on each side of the insert.
5. The blue insert should be "sandwiched" between 2 white ice packs.
6. Verify a refrigerated silver gel pack is laying in the bottom of the insert.
7. Check the Safe-T-Vue temperature indicators. The centers should be white.
8. Ensure the units and emergency tags are labeled with "Uncrossmatched Blood" stickers (if applicable).
9. Firmly close the lid and deliver the blood.
10. Verify the patient information with care personnel before leaving the cooler.

<u>PACKING THE THERMOSAFE COOLER</u>

*The large Thermosafe coolers are the preferred transport containers for non-emergent dispense of multiple units, or single units not being transfused immediately.*

1. Thermosafe coolers are validated for transport of units for **up to 4 hours**, after which time they must be returned to the Transfusion Service/Blood Bank for new ice packs if the blood still needs to be near the patient.
2. To pack a Thermosafe cooler, remove the plastic bag and place 3 oblong ice packs from the small -20º C freezer – one on the right, one on the left, and one flat on the bottom.
3. Replace the plastic bag. Ensure the white plastic square is over the ice pack in the bottom to protect the blood products from extreme cold.
4. Refer to SOP TS-005-2021 "Dispensing Blood Products – Non-emergent" to determine whether Safe-T-Vue temperature indicators are required.
5. Dispense units in CernerCW according to the SOP.
6. Place the refrigerated basket containing units, gel packs, and thermometer in the plastic bag.
7. Close the Thermosafe cooler and zip shut.
8. Verify the patient information with care personnel when handing off the cooler.

PACKING THE VITALANT TRANSPORT BOXES

*Transport boxes are provided by Vitalant and can be used to accompany patients being transferred to other facilities via helicopter.*

1. Per Vitalant, these boxes maintain an environment that meets AABB blood transport requirements for **48 hours**.
2. Inspect blood products for unit integrity, appearance and labeling.
3. Remove any labels or stickers applied by the NIH Transfusion Service.
4. Place frozen solid "Blue Ice" packs (squares) at each end of the inner box, with the cardboard sleeves in-between the ice packs.
    a. "Blue Ice" packs from the -20$^{o}$ C freezer can be used immediately.
    b. "Blue Ice" packs from -30$^{o}$ C freezer must sit at room temperature for 15 minutes before use.
5. Place the plastic liner (that comes with the box) inside the cardboard sleeve.
6. Place an absorbent pad, absorbent side up, in the bottom of the plastic liner.
7. Place units on top of this absorbent pad.
8. Each inner box may contain up to eight units. If shipping less than five units, add enough white small-sized refrigerated gel packs to add up to five.
    a. For example, if packing 2 PRBCs, add 3 refrigerated gel packs.
9. Place an absorbent pad on top of the units, absorbent side down.
10. Twist and fold over the top of the plastic bag.
11. Close the inner box flaps and replace the insulating lid.
12. **Make a copy of the dispense report that printed when the units were dispensed in CernerCW, and place it in the box**.
13. Tape the box closed, but do not seal it.
14. Verify the patient and unit information with a nurse in the Emergency Department or flight crew in accordance with SOP TS-005-2021 "Dispensing Blood Products – Non-emergent".
15. Seal the box.
16. Instruct the flight personnel that if the units are not transfused, they should be given to the receiving facility's Blood Bank/Transfusion Service.
17. If the receiving facility takes the units into their inventory, complete the transfer by notifying Vitalant and completing applicable documentation.
18. Complete the Flight Blood Box Tracker log.

## V. RESULTS REPORTING:

1. Complete the Patient Cooler Tracker and Flight Blood Box Tracker Logs.
2. Unit dispense information is maintained in CernerCW.

## VI. LIMITATIONS:

1. Coolers and boxes may perform differently if not packed in accordance with the SOP.
2. If refrigerated gel packs and frozen ice packs are not stored at their proper temperature for enough time, the cooler may not perform optimally.

## VII. EQUIPMENT:

1. MaxQ Max+ Cooler
2. Thermosafe Cooler
3. Vitalant transport boxes
4. Frozen gel packs
5. Refrigerated gel packs
6. Safe-T-Vue temperature indicators

## VIII. QUALITY CONTROL PERFORMANCE:

1. Validation information for equipment is available in the Transfusion Service.
2. Safe-T-Vue non-reversible temperature indicators help track how units were handled while dispensed. If the indicators show units warmed past $10^{o}$ C, the products will be destroyed.

## IX. REFERENCES:

1. AABB Standard for Blood Banks and Transfusion Services, current edition.

## X. DISTRIBUTION:

1. Transfusion Service/Blood Bank Section

**NORTHERN INYO HEALTHCARE DISTRICT**
**LABORATORY SERVICES DEPARTMENT**
**STANDARD OPERATING PROCEDURE**

| | | |
|---|---|---|
| SOP #: TS-008-2021 | | |
| Title: Safe-T-Vue 10 Non-reversible Temperature Indicators - Direction for Use | | |
| Owner: LAB MANAGER | Department: Laboratory | |
| Scope: Blood Bank | | |
| Date Last Modified: 07/17/2021 | Last Review Date: No Review Date | Version: 1 |
| Final Approval by: Medical Director of Lab & Medical Executive Team | Original Approval Date: | |

## I. PURPOSE:

This Standard Operating Procedure (SOP) describes when and how Safe-T-Vue (STV) temperature indicators shall be used.

## II. BACKGROUND:

According to the Standards for Blood Banks and Transfusion Services, current edition, published by the American Association of Blood Banks (AABB) and the Food and Drug Administration (FDA) Title 21 of Chapter I, Subchapter F, "Biologics", liquid Red Blood Cells shall remain $1^{o}$ - $6^{o}$ C while in storage, and $1^{o}$ - $10^{o}$ C during transport. Northern Inyo Hospital (NIH) requires packed red blood cells (PRBCs) to be kept at or below $10^{o}$ C while issued in a cooler at patient bedside. Units found to exceed $10^{o}$ C upon return to the Transfusion Service are no longer eligible to be accepted into inventory for transfusion, and will be destroyed.

Use of non-reversible temperature indicators such as Safe-T-Vues helps the Transfusion Service keep control of unit quality. If a unit is left at room temperature and reaches $10^{o}$ C or more, but patient care staff place it back in the cooler to return it to an "acceptable" temperature before return to the Transfusion Service, the Safe-T-Vue (STV) will already have turned red, and the Transfusion Service will know to mark it for destruction. Any instance where any units are returned in unacceptable conditions will be reason to submit a Quality Variance Report (QVR) and an NIHD Unusual Occurrence Report (UOR).

## III. SPECIMEN REQUIREMENTS:

- Safe-T-Vue indicators will be applied to PRBCs being transported in coolers within the hospital.
- A new STV will be used for every unit dispensed. STVs will not be re-used.
- If a single PRBC is being dispensed and will be transfused immediately, the indicator is unnecessary.
- Temperature indicators will **not** be applied to fresh frozen plasma (FFP), cryoprecipitate, platelets, units being returned to the blood supplier, or units dispensed to flight boxes.

## IV. PROCEDURE:

PRECONDITIONING

1. In accordance with manufacturer instructions, Safe-T-Vue indicators shall be refrigerated for at least 24 hours before being applied to unit bags.

2. Every 2 months the STVs shall be taken out of the refrigerator and left at room temperature for 24 hours.
3. The indicators can then be returned to the refrigerator for another 2 months, and the cycle can be repeated.

HANDLING, APPLICATION, AND ACTIVATION

1. Keep PRBCs on refrigerated cold packs.
2. Hold the STV by the outer edges. Take care to avoid touch the temperature sensitive indicator areas, as your hands can pre-warm the indicator and affect its accuracy.
3. Remove the adhesive backing and apply the STV to the lower area of the blood bag, where there is the largest blood volume.
    a. If necessary, prep the blood bag with an alcohol wipe for better adhesion.
4. **Avoid placing the indicator over any unit labels or stickers.**
5. Do not touch the center indicator areas.
6. Once the sticky square part of the indicator is adhered to the unit, remove the remaining foil.
7. To activate, fold the rounds together and firmly snap shut.
8. The STV should have a white center.
9. Return the PRBC to cold gel packs for dispense, or to the refrigerator for storage.

TEMPERATURE MONITORING

1. The STV changes color from white to red when the blood has reached or exceeded 10° C.
2. The indicators are irreversible; once the indicator has turned red, it will not go back to white, even if the unit is brought back under 10° C.

## VI. LIMITATIONS:

- **The Safe-T-Vue manufacturer states an accuracy of +/- 0.4° C**
- Improper physical handling of the indicators could prematurely warm them
- Indicator is not fully activated
- How units are packed into coolers
- Air flow in room
- Configuration of cold packs in coolers

## VII. EQUIPMENT:

1. Safe-T-Vue 10 Non-reversible Temperature Indicators
2. Refrigerated gel packs

## VIII. QUALITY CONTROL PERFORMANCE:

Per manufacturer, Safe-T-Vue 10 Temperature Indicators can be activated for up to 42 days.

Validation documentation is available in the Transfusion Service/Blood Bank.

## IX. REFERENCES:

1. “Suggested Validation Procedure for Safe-T-Vue® 10” Temptime Corporation.

2. Code of Federal Regulations, Title 21, Volume 7. Revised as of April 1, 2020. CITE: 21CFR600.15. https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/CFRSearch.Cfm?fr=600.15
3. AABB Standard for Blood Banks and Transfusion Services, current edition.

## X. DISTRIBUTION:

1. Blood Bank/Transfusion Service Section

**NORTHERN INYO HEALTHCARE DISTRICT**
**LABORATORY SERVICES DEPARTMENT**
**STANDARD OPERATING PROCEDURE**

| | | |
|---|---|---|
| SOP #: TS-006-2021 | | |
| Title: Returning Dispensed Blood Products to Inventory | | |
| Owner: LAB MANAGER | Department: Laboratory | |
| Scope: Blood Bank | | |
| Date Last Modified: 08/16/2021 | Last Review Date: No Review Date | Version: 1 |
| Final Approval by: Medical Director of Lab & Medical Executive Team | Original Approval Date: | |

## I. PURPOSE:

This Standard Operating Procedure (SOP) explains the criteria and process for returning dispensed units to available inventory at Northern Inyo Hospital (NIH) Transfusion service. See respective SOP for returning "Crash Pack" units.

## II. BACKGROUND:

Blood products dispensed to patients within NIH can be returned to the Transfusion Service if they were not used and meet specific criteria. The units must meet standards set by the American Association of Blood Banks (AABB) and the Federal Drug Administration (FDA) in order to be acceptable for future transfusion. Quality Variance Reports (QVR) and Unusual Occurrence Reports (UOR) track deviations from these standards.

## III. SPECIMEN REQUIREMENTS:

**Criteria for returning blood products to available inventory:**

1. The container closure has not been disturbed; the unit has not been pierced.
2. At least one-unit segment is attached (PRBCs).
3. The visual appearance is acceptable: no sign of bacterial growth, hemolysis, etc.
4. The unit was maintained at the proper temperature (see Table 1).

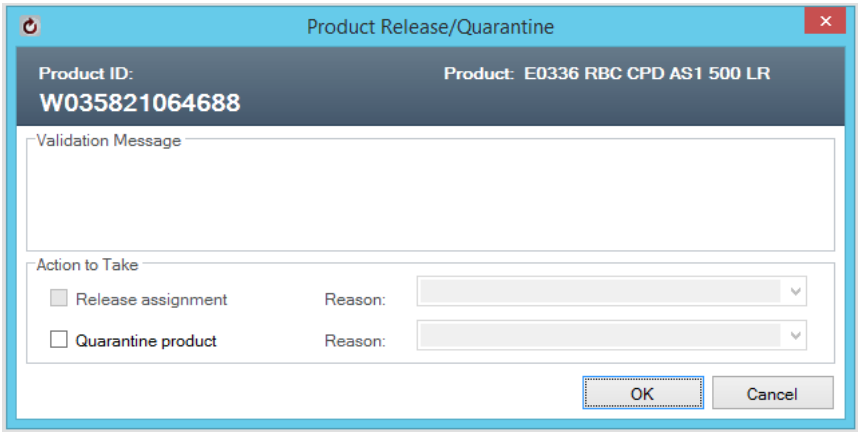
*Table 1.*

| Product Type | Dispensed in Cooler? | Safe-T-Vue Temp Indicator | Time and Temperature Criteria: |
|---|---|---|---|
| PRBC<br>FFP | **No** | **No** | 1. Returned to laboratory within 30 minutes of dispense time AND<br>2. Unit temperature is 10º C or less |
| PRBC | Yes | Yes | 1. STV indicators are white<br>2. File QVR/UOR if >4 hours |
| FFP | Yes | No | 1. Unit temperature is 10º C or less<br>2. File QVR/UOR if >4 hours |

| | | | |
|---|---|---|---|
| Platelets | No | No | 1. Returned to laboratory within 30 minutes of dispense time AND<br>2. Unit was maintained at room temperature |
| Cryoprecipitate | No | No | 1. Unit was maintained at room temperature<br>2. Product is not expired |

**IV. PROCEDURE:**

1. Evaluate all returned products immediately upon their arrival to the Transfusion Service.
2. If products were dispensed in a cooler, update the Patient Cooler Tracker Log.
3. Determine whether the product(s) meet the above criteria. Proceed with the following steps whether criteria is met or not.
4. Open the "Return Products" application in CernerCW.
5. The time and date will automatically populate. Adjust if necessary.
6. Select an appropriate "Return Reason" from the drop-down menu.
7. The "Visual Inspection" field will default to "OK". If the product appears hemolyzed, the bag is broken, or it is too warm, select the appropriate option here.
8. Free text the "Courier" field. "RN" or the CLS's last name is acceptable.
9. Click in the "Product Number" field and scan the unit.
10. The following window will appear:




11. In most "typical" situations meeting return criteria, neither box will be checked. This will keep the unit crossmatched/assigned to the patient and available for dispense later.
12. If the patient no longer needs this product to be crossmatched/assigned to them, check the "Release assignment" box and select an appropriate reason. The unit can now be crossmatched/assigned to a different patient.
13. **If the product did not meet criteria** for returning products to available inventory, check the "Quarantine product" box and select an appropriate reason.
14. If the "Quarantine product" box is automatically checked by the system, it is because a transport container was not selected during the dispense process in CernerCW and the unit was dispensed for more than 30 minutes.

    a. If it is true, the product was dispensed for more than 30 minutes **not** in a cooler, record the temperature of the unit and keep it in quarantine. Notify the Transfusion Service Coordinator and file a QVR/UOR.
    b. Or, if appropriate, use the "Quarantine Products" application to release the product from quarantine **after finishing the return process**.
        i. For example, if the unit was physically dispensed in a cooler, but the CLS did not indicate which one in the "Dispense and Assign" application, the unit should be released from quarantine provided it meets return criteria.
15. After making selections in the pop-up, click "OK".
16. Enter the unit temperature in the "Temp" box.
17. If a Safe-T-Vue Temperature Indicator was used and:
    a. The center is **white**, enter a number under $10^{o}$ C.
    b. The center is **red**, record the current unit temperature and quarantine the unit. File a QVR/UOR and notify the Transfusion Service Coordinator.
    c. It has **fallen off the unit**, record the current unit temperature and file a QVR/UOR.
18. Choose "Deg C" from the "Deg" drop-down menu.
19. Scan additional units and repeat the process if applicable.
20. Click the "Save" button in the upper left hand corner of the screen.
21. Click "Task" and "Exit" to leave the application.
22. Store the returned units at the appropriate temperature
23. Place any quarantined units on the very bottom shelf of the refrigerator for review by the Transfusion Service Coordinator.

## V. RESULTS REPORTING:

1. Complete the Patient Cooler Tracker Log with all necessary information if applicable.
2. If necessary, file QVRs and submit necessary UORs for the Transfusion Service coordinator and Laboratory Services Manager to review.
3. All unit tracking information will be stored in CernerCW.

## VI. LIMITATIONS:

1. Safe-T-Vue temperature indicators do not provide exact temperature measurements and can fall off units.
2. Not immediately evaluating units returned the Transfusion Service could result in inaccurate unit quality tracking.

## VII. EQUIPMENT:

1. Approved thermometer
2. Safe-T-Vue temperature indicators

## VIII. QUALITY CONTROL PERFORMANCE:

Transport containers and other equipment have validation information on file in the Transfusion Service.

## IX. REFERENCES:

1. AABB Standard for Blood Banks and Transfusion Services, current edition.

## X. DISTRIBUTION:

1. Transfusion Service/Blood Bank Section

**NORTHERN INYO HEALTHCARE DISTRICT**
**LABORATORY SERVICES DEPARTMENT**
**STANDARD OPERATING PROCEDURE**

| | | |
|---|---|---|
| SOP #: TS 002-2021 | | |
| Title: ABO/Rh Confirmation Testing - Patients | | |
| Owner: LAB MANAGER | Department: Laboratory | |
| Scope: Blood Bank | | |
| Date Last Modified: 08/16/2021 | Last Review Date: No Review Date | Version: 2 |
| Final Approval by: Medical Director of Lab & Medical Executive Team | Original Approval Date: | |

## I. PURPOSE:

This SOP describes how to confirm a patient's ABO/Rh when they do not have previous history in Cerner LIS.

## II. BACKGROUND:

According to the Standards for Blood Banks and Transfusion Services published by the American Association of Blood Banks (AABB), two ABO determinations and an Rh type are required for pretransfusion testing. In accordance with the AABB, this can be accomplished several ways. At Northern Inyo Healthcare District (NIHD), ABO/Rh testing on two EDTA specimens drawn at different times are required for pre-transfusion testing. Both forward and reverse typing will be performed. If previous history from the legacy Work Cards is available, a "historical" ABO/Rh may be ordered and resulted in Cerner as the second determination.

Only Clinical Laboratory Scientists (CLS) deemed competent will perform this procedure.

## III. SPECIMEN REQUIREMENTS:

*NOTE: For pre-surgical patients with no history in Cerner or Work Cards, order the "ABO/Rh Retype" STAT the morning of their scheduled surgery. Send a accession label to phlebotomy.*

1. Blood collected in EDTA, centrifuged to separate the red blood cells from the plasma. Serum can be used for reverse ABO typing.
1. Only properly labeled specimens will be accepted for testing.
2. The following are **REQUIRED** to be on the retype specimen:
    a. Date and Time of collection
    b. Initials of the person collecting the specimen
3. The confirmation collection tube will match at least 2 patient identifiers that are also on the primary Type and Screen specimen. Possible matching patient identifiers include:
    a. Patient's Full Name
    b. Date of Birth
    c. Medical Record Number
    d. Financial Number ("FIN" in Cerner) – *useful for Jane/John Doe patients*
    e. Alpha-Numeric Blood Bank ID (BBID) – *sticker or written*
        i. The retype specimen is not required to be labeled with the BBID, but it can be used as a second identifier.

4. An EDTA specimen that was drawn **within 24 hours** of the primary Type and Screen tube may be used for the ABO/Rh confirmation.
5. The "ABO/Rh Retype" order in Cerner must be ordered on a DIFFERENT accession number from the Type and Screen. If using a previously drawn EDTA tube, receive the retype order with the collection date and time on the tube.

REASONS FOR REJECTION:

1. Improperly labeled specimens
2. Patient identifiers do not match the primary Type and Screen specimen.
3. Hemolysis
4.

**IV. PROCEDURE:**

**Every CLS performing patient testing is responsible for gathering and understanding that patient's available Blood Bank history.**

1. Check for patient history in Cerner AND in legacy Work Cards.
2. Search for the patient in Cerner by opening the "Patient Product Inquiry" application.
3. **Type the patient's name rather than searching using the Medical Record Number (MRN).** This will ensure a thorough history check in the event the patient has multiple MRNs.
    a. Compare history in all MRNs if applicable. Any discrepancy will be reported to the Transfusion Service Coordinator for resolution.

PATIENTS **WITH** LEGACY WORK CARD HISTORY

4. **If the patient's full name and date of birth match the Work Card**, the ABO/Rh can be entered in Cerner for a second ABO/Rh determination.
    a. Any spelling discrepancies must be resolved before using Work Card history.
5. Result the "Previous History" field in the Type and Screen ABO/Rh as "Yes Prev History". This will prevent reflex of the retype order. If it has already reflexed, it can be canceled.
6. Open the "Order Result Viewer" application in Cerner and search for the patient.
7. Highlight the most recent ABO/Rh order.
8. Branch to the "Department Order Entry" application.
9. Use "Accession add on" function (the blue plus sign).
10. Search for the order "Hx ABO/Rh" and submit.
11. Return to the "Order Result Viewer application," click refresh, and highlight the "Hx ABO/Rh" order.
12. Branch to "Result Entry" using the blue icon near the top of the screen.
13. Use the drop-down menu to choose the ABO/Rh that matches the Work Card history.
14. Press enter, and then click "Verify" to enter the results to the patient's medical record.
15. The patient is now eligible for computer crossmatch (given they have NO antibody history).
16. Place the Work Card in the Transfusion Service Coordinator's wall file for review.
17. **If the ABO/Rh results from the Work Card do not match the Type and Screen specimen results, an investigation is required.**
    a. Request the Type and Screen tube is redrawn.
    b. The CLS may request a different phlebotomist performs the redraw.
    c. File a Quality Variance Report and Unusual Occurrence Report.

PATIENTS **WITHOUT** LEGACY WORK CARD HISTORY

Reagents:

- Anti-A, Anti-B, and Anti-D
- 3% A and B reagent cells
- 6% albumin
- Blood Bank Saline

Storage and handling:

- Store at 2-8$^{o}$ C. Bring reagents and patient specimens to room temperature before testing

4. Reflex an "ABO/Rh Retype" order by selecting "No Prev History" from the drop-down in the Type and Screen ABO/Rh result entry.
    a. See section "III. Specimen Requirements" above.
5. Determine specimen eligibility for testing. Centrifuge the specimen to separate plasma from cells.
6. Properly label clean test tubes for anti-A, anti-B, anti-D, A cell, and B cell reactions.
7. Make a 2-4% suspension of patient red blood cells with saline in a properly labeled tube.
8. Place 1 drop of anti-A in a clean, labeled test tube.
9. Place 1 drop of anti-B in a clean, labeled test tube.
10. Place 1 drop of anti-D in a clean, labeled test tube.
11. Add 1 drop of the patient cell suspension to each tube.
12. Place 2 drops of patient plasma in the A and B cell tubes.
13. Add 1 drop of A reagent cells to the tube.
14. Add 1 drop of B reagent cells to the tube.
15. Mix the contents of the tubes gently and centrifuge them for the saline time posted on the serofuge.
16. Gently shake or tilt the tube to disrupt the red cell button in the tube.
17. Observe the way that cells are dispersed from the red cell button. Roughness may indicate a weak positive reaction.
18. When the red cells have been completely resuspended from the button, grade and record the agglutination by comparing the agglutinates (or lack thereof) to the Ortho Reaction Grading Chart (Enclosure [1]).
19. **If the Anti-A, -B, and -D tubes all show agglutination, a control tube is required.**
    a. Place 1 drop 6% Albumin in a clean, labeled test tube
    b. Add 1 drop 2-4% patient red blood cell suspension.
    c. Centrifuge for the posted saline time and resuspend cells as described above.
20. Immediately enter results in Cerner.

## V. RESULTS REPORTING:

TEST INTERPRETATION

- Negative: No agglutination
- Positive: Agglutination and/or hemolysis
    - Grade reactions from 1+ to 4+ according to Ortho Diagnostics Reaction Grading posted in the Transfusion Service (see Enclosure [1]).

        - Inspect the plasma (supernatant) for hemolysis. If hemolysis is present record the result as positive, provided the pre-test serum was *not* hemolyzed.
    - Mixed Field: Agglutinins are observed in addition to a population of non-agglutinated red blood cells.
1. Open the "ABO/Rh retype" accession in the Blood Bank "Result Entry" application.
    a. This can be done by scanning the specimen tube, typing in the number, or branching from another application.
2. Use the "ABO/Rh" row to enter results.
3. Enter graded reactions for Anti-A, -B, -D, A cells, and B cells.
4. A control tube may or may not have been tested. If a control tube was not tested (NT), choose "NT" or type "N" in the "Dcon" result field.
    a. **If the Anti-A, -B, and -D tubes all show agglutination, a control tube is required.**
    b. A negative reaction in the control tube ensures agglutination with reagents was not erroneous.
5. If "mixed field" is observed, enter a graded reaction that is consistent with the patient's historical type.
    a. Describe the situation in Blood Bank Comments section and include any findings that could explain the "mixed field" reaction.
6. The ABO/Rh interpretation will be automatically computed by Cerner once the field is highlighted (See Enclosure [2]).
    a. If an error message appears saying "pattern match is not found," ensure reactions were entered correctly. Refer to ABO Discrepancy SOP if necessary.
7. **If the ABO/Rh results from the retype specimen do not match the primary Type and Screen specimen results, an investigation is required.**
    a. Consider requesting one or both specimens be redrawn.
    b. The CLS may request a different phlebotomist performs the redraw.
    c. File a Quality Variance Report and Unusual Occurrence Report.

## VI. LIMITATIONS:

1. False positive or false negative test results may occur from bacterial or chemical contamination of test materials, aged blood specimens, inadequate incubation time or temperature, improper centrifugation, improper storage of materials, or omission of test samples.
2. Aged or hemolyzed blood may yield weaker reactions than those obtained with fresh red blood cells.
3. Antibodies to preservatives, medications, and/or cross-contamination may cause false positive or negative reactions.
4. Some weak subgroups of the A, B, or D antigen may not be detected.
5. As patients age, their A cell and B cell reverse reactions may become weaker.
6. Occasionally specimens showing excess particulates may require washing prior to testing.
7. Immunocompromised, elderly or newborn patients may have weakened or missing ABO antibodies.
8. Variations in patient or reagent red blood cell concentration can markedly affect the sensitivity of test results.
    a. Mix red blood cell suspensions well for even distribution.

## VII. EQUIPMENT:

1. Serofuge
    a. Calibrated every 6 months; see maintenance logs.

## VIII. QUALITY CONTROL PERFORMANCE:

Refer to “Daily Quality Control for Tube Testing” SOP and Quality Control and Maintenance Logs.

## IX. REFERENCES:

1. AABB Standard for Blood Banks and Transfusion Services, current edition.

## I. DISTRIBUTION:

**NORTHERN INYO HEALTHCARE DISTRICT**
**LABORATORY SERVICES DEPARTMENT**
**STANDARD OPERATING PROCEDURE**

| | | |
|---|---|---|
| SOP #: TS 001-2021 | | |
| Title: ABO/Rh Testing for Adults | | |
| Owner: LAB MANAGER | Department: Laboratory | |
| Scope: Blood Bank-Laboratory | | |
| Date Last Modified: 08/18/2021 | Last Review Date: No Review Date | Version: 2 |
| Final Approval by: Medical Director of Lab & Medical Executive Team | Original Approval Date: | |

## I. PURPOSE:

This SOP describes how to perform routine adult ABO/Rh testing on patient specimens.

For neonatal, cord, and patient or unit confirmation ABO/Rh testing, please refer to the respective SOPs.

## II. BACKGROUND:

Because of the dire clinical consequences associated with ABO incompatibilities, ABO typing and ABO compatibility testing remain the foundation of pre-transfusion testing. The most immunogenic and clinically important antibodies are those directed against antigens of the ABO and Rh blood group systems. Donor blood samples are routinely typed for ABO and Rh at the time of donation. The ABO group is confirmed when the Red Blood Cell unit is received in the hospital's Transfusion Service, and the Rh type is confirmed on units labeled Rh negative. Recipient samples are grouped and typed before transfusion. (AABB Technical Manual, Methods, current edition).

Patient (recipient) red blood cells are mixed with commercial antisera specified for the A, B, and D antigens. These results can be interpreted as the "forward type". ABO reverse typing demonstrates the presence of indigenous (expected) ABO blood group antibodies by testing patient plasma with commercially produced $A_1$ and B red blood cells. Routine ABO testing on patients includes both forward and reverse testing, each serving as a check on the other. If they disagree, the discrepancy must be investigated. Rh typing is only performed on patient cells, not patient plasma, as circulating anti-D would be considered an acquired antibody (unexpected).

Clinical Laboratory Scientists deemed competent will perform testing.

## III. SPECIMEN REQUIREMENTS:

1. Blood collected in EDTA. Serum can be used for reverse ABO typing.
2. Only properly labeled specimens will be approved for testing. The collection tube will have the following:

a. Patient's Full Name
b. Date of Birth
c. Medical Record Number
d. Financial Number ("FIN" in Cerner) – *only required for Jane/John Doe patients*
e. Alpha-numeric Blood Bank ID (BBID)
    i. A sticker can be applied to the collection tube, or the BBID can be handwritten.

***EXCEPTION**: Only specimens intended for pre-transfusion testing are required to be labeled with a BBID. Patients do not have to be banded and a BBID is not required on the specimen if the ABO/Rh and/or Antibody Screen are ordered for informational purposes only. An example of this is a type and screen that is part of an outpatient prenatal panel.*

***If the provider later orders a transfusion, a new specimen must be collected satisfying all listed Specimen Requirements, including BBID.***

f. Date and Time of collection
g. Initials of the person collecting the specimen

3. Specimen collection shall be performed following the "Blood Bank Sample Collection" SOP.
4. Specimens shall be stored at 2-8º C if there is a delay in testing.

REASONS FOR REJECTION:

1. Improperly labeled specimens.
2. Hemolysis.
    a. **Hemolysis to any degree will be cause for specimen rejection because it can be associated with a "positive" reaction in pre-transfusion testing. A new specimen should be recollected at the discretion of the Clinical Laboratory Scientist (CLS).**
    b. If hemolysis is unavoidable and consistent throughout specimen recollection, pick the specimen showing the least hemolysis for testing. Follow interpretation guidelines below.
    c. Submit a Quality Variance Report (QVR).

## IV. PROCEDURE:

Reagents:

- Anti-A, Anti-B, and Anti-D
- 3% A and B reagent cells
- 6% albumin
- Blood Bank Saline

Storage and handling:

- Store at 2-8º C. Bring reagents and patient specimens to room temperature before testing

1. Determine specimen eligibility for testing.
2. Check for patient history in Cerner AND in legacy work cards.
    a. Search for the patient in Cerner by opening the "Patient Product Inquiry" application.
        i. Type the patient's name rather than searching using the Medical Record Number (MRN). This will ensure a thorough history check in the event the patient has multiple MRNs.

ii. Compare history in all MRNs if applicable. Any discrepancy will be reported to the Transfusion Service Coordinator for resolution.

b. If the patient has history in the legacy work cards, document the most recent ABO/Rh determination, antibody screen history, and transfusion data in the "Patient Product Inquiry" application "Blood Bank" comment box.
   i. If another CLS has already documented legacy history in Cerner, a work card history check still must be performed.
   ii. **Every CLS performing patient testing is responsible for gathering and understanding that patient's available Blood Bank history.**

3. Patient plasma may be separated from cells and kept in a separate properly labeled tube. The aliquot tube must be labeled with 2 patient identifiers, the date/time of collection, and CLS initials.
4. Properly label clean test tubes for anti-A, anti-B, anti-D, A cell, and B cell reactions.
5. Make a 2-4% suspension of patient red blood cells with saline in a properly labeled tube.
6. Place 1 drop of anti-A in a clean, labeled test tube.
7. Place 1 drop of anti-B in a clean, labeled test tube.
8. Place 1 drop of anti-D in a clean, labeled test tube
9. Add 1 drop of the patient cell suspension to each tube.
10. Place 2 drops of patient plasma in the A and B cell tubes.
11. Add 1 drop of A reagent cells to the tube.
12. Add 1 drop of B reagent cells to the tube.
13. Mix the contents of the tubes gently and centrifuge them for the saline time posted on the serofuge.
14. Gently shake or tilt the tube to disrupt the red cell button in the tube.
15. Observe the way that cells are dispersed from the red cell button. Roughness may indicate a weak positive reaction.
16. When the red cells have been completely resuspended from the button, grade and record the agglutination by comparing the agglutinates (or lack thereof) to the Ortho Reaction Grading Chart.
17. If the Anti-A, -B, and -D tubes all show agglutination, a control tube is required.
    a. Place 1 drop 6% Albumin in a clean, labeled test tube
    b. Add 1 drop 2-4% patient red blood cell suspension.
    c. Centrifuge for the posted saline time and resuspend cells as described above.
18. Immediately enter results in Cerner.

## V. RESULTS REPORTING:

TEST INTERPRETATION

- Negative: No agglutination
- Positive: Agglutination and/or hemolysis
  - Grade reactions from 1+ to 4+ according to Ortho Diagnostics Reaction Grading posted in the Transfusion Service (see Enclosure [1]).
  - Inspect the plasma (supernatant) for hemolysis. If hemolysis is present record the result as positive, provided the pre-test serum was *not* hemolyzed.
  - If the pre-test plasma was hemolyzed, grade the reaction by assessing the *increase* in hemolysis.
- Mixed Field: Agglutinins are observed in addition to a population of un-agglutinated red blood cells.

1. Open the accession in Blood Bank "Result Entry" application.

a. This can be done by scanning the specimen tube, typing in the number, or branching from another application.

2. Use the "ABO/Rh" row to enter results.
3. Enter graded reactions for Anti-A, -B, -D, A cells, and B cells.
4. A control tube may or may not have been tested. If a control tube was not tested (NT), choose "NT" or type "N" in the "Dcon" result field.
    a. **If the Anti-A, -B, and -D tubes all show agglutination, a control tube is required.**
    b. A negative reaction in the control tube ensures agglutination with reagents was not erroneous.
5. If "mixed field" is observed, enter a graded reaction that is consistent with the patient's historical type.
    a. Describe the situation in Blood Bank Comments section and include any findings that could explain the mixed field reaction.
6. The ABO/Rh interpretation will be automatically computed by Cerner once the field is highlighted (See Enclosure [2]).
    a. If an error message appears saying "pattern match is not found," ensure reactions were entered correctly. Refer to ABO Discrepancy SOP if necessary.
7. Record the BBID:
    a. Click the Comments button near the top of the screen. A pop-up will appear. While in the default "Blood Bank" tab, click "Add".

        *NOTE: "Add" will automatically create a time/date/initial stamp.*

        *"Edit" is for making changes to the free text.*

    b. In the secondary pop-up, scan the patient's BBID from the collection tube (if it was written, manually type).
    c. Click "Ok" in both pop-up boxes to close them. Check to see the BBID is in the Blood Bank Comments area with a time/date/initial stamp.
8. If an antibody screen is also ordered, enter results when they become available.
9. To complete all entered results in the active spreadsheet, click "Verify". The results will now be visible to patient care personnel.

## VI. QUALITY CONTROL PERFORMANCE:

Refer to "Daily Quality Control for Tube Testing" SOP and Daily Quality Control Logs.

## VII. EQUIPMENT:

1. Serofuge
    a. Calibrated every 6 months; see maintenance logs.

## VIII. LIMITATIONS:

1. False positive or false negative test results may occur from bacterial or chemical contamination of test materials, aged blood specimens, inadequate incubation time or temperature, improper centrifugation, improper storage of materials, or omission of test samples.
2. Aged or hemolyzed blood may yield weaker reactions than those obtained with fresh red blood cells.
3. Antibodies to preservatives, medications, and/or cross-contamination may cause false positive or negative reactions.
4. Some weak subgroups of the A, B, or D antigen may not be detected.
5. As patients age, their A cell and B cell reverse reactions may become weaker.
6. Occasionally specimens showing excess particulates may require washing prior to testing.

7. Immunocompromised, elderly or newborn patients may have weakened or missing ABO antibodies.
8. Variations in patient or reagent red blood cell concentration can markedly affect the sensitivity of test results.
    a. Mix red blood cell suspensions well for even distribution.

## IX. REFERENCES:

1. AABB Technical Manual, Methods, current edition.

## X.DISTRIBUTION:

1. Transfusion Service/Blood Bank Section of Laboratory Department

Supersedes: ABO and Rh Grouping – Tube Method Version #1

**NORTHERN INYO HEALTHCARE DISTRICT**
**LABORATORY SERVICES DEPARTMENT**
**STANDARD OPERATING PROCEDURE**

| | | |
|---|---|---|
| SOP #: TS-004-2021 | | |
| Title: "Crash Pack" Emergency Dispense of Uncrossmatched Blood - Preparation and Reconciliation | | |
| Owner: BLOOD BANK COORDINATOR | Department: Laboratory | |
| Scope: Blood Bank | | |
| Date Last Modified: 08/16/2021 | Last Review Date: No Review Date | Version: 5 |
| Final Approval by: Medical Director of Lab & Medical Executive Team | Original Approval Date: 03/17/2010 | |

## I. PURPOSE:

This procedure describes how a "Crash Pack" of uncrossmatched blood should be prepared, requested, dispensed, and reconciled once the emergency is over.

A Crash Pack contains 2 units of type O, Rh negative packed red blood cells that can be packed into a cooler and brought to an emergency situation within minutes. To expedite the process, the blood will be pre-dispensed in the LIS without any patient identifiers. When a provider requests a Crash Pack, patient identifiers will be added to the Emergency Tags already on the units by writing or applying patient labels. The blood can then be packed in a cooler and delivered to the patient's bedside.

## II. BACKGROUND:

A blood transfusion may be able to save a patient's life when they are in critical condition. In some emergencies, a provider may request blood for a patient that does not have current pre-transfusion testing. These situations require uncrossmatched units of red blood cells.

Only Clinical Laboratory Scientists (CLS) will be performing this procedure. Laboratory Assistants (LA) may assist when stated.

## III. SPECIMEN REQUIREMENTS:

When pre-transfusion testing cannot be performed in critical emergencies, a type and screen should be drawn and tested as soon as possible. It is ideal for a type and screen to be drawn before the patient is transfused, but if this is not possible, it can be collected after the transfusion has started. If this is the case, the type and screen specimen should be drawn on the opposite side of the body from where the donor blood is being infused.

See SOP# TS-001-2021 "ABO/Rh Testing for Adults" for type and screen specimen requirements.

## IV. PROCEDURE:

1. <u>Preparing a Crash Pack</u>
    a. Assembly of a Crash Pack should occur during a time when there is not an emergency situation that requires immediate attention. A Crash Pack should be maintained in the blood bank fridge at all times, if possible.

b. Select 2 O negative packed red blood cells with the shortest expiration date from the inventory.
c. For each unit: remove 2 segments and place in a 12x75 tube (preferably plastic). Label the tube with a unit barcode running lengthwise so it can be scanned.
d. Store the segment tubes in the "Crash Pack Segments" container in the refrigerator.
e. Open the "Dispense and Assign Products" application in Cerner.
    i. Select "Emergency Dispense" from the functions near the top of the screen.
    ii. In the **"Emergency Patient" field**, type "EMERGENCY DISPENSE".
    iii. Click in the **"Product Number" field** and scan both unit numbers that start with a "W".
    iv. Click the **"Save" button** at the top of the screen.
    v. In the "Save" pop-up fields:
        1. **Physician**: type "UN" followed by the Tab key to fill in "Unavailable, Physician".
        2. **Reason**: type "E" then Tab, or select "Emergency" from the drop-down menu.
        3. **Visual Inspection**: OK.
        4. **Courier**: type "COURIER" then Tab.
        5. **Location**: type "INYO ED" then press "**ENTER"**.
            a. If Tab key is used, the text will disappear.
        6. **Cooler**: Select "NIHD Cooler 1" from the drop-down menu.
        7. **Blood Bank ID**: type "EMERGENCY DISPENSE"
        8. Click "OK" in the pop-up.
        9. Print the emergency tags and the emergency dispense report to the printer named "inyobloodbank" using the automatic prompts.
f. Compare the unit information on the printed emergency tag to the unit label and ensure they match. Punch a hole in the emergency tag and attach it to the unit.
g. Apply "UNCROSSMATCHED BLOOD" stickers to the front of the units and the emergency tags.
h. Fill out a "Crash Pack Unit List" (Enclosure [1]) and attach the emergency dispense report.
i. Return the units to the refrigerator for at least 10 minutes.
j. Working quickly with chilled units, attach a Safe-T-Vue (STV) temperature indicator to each unit.
    i. Place the STV near the center of the unit, or near the bottom with the most blood volume.
    ii. Do not stick STVs on top of unit labels.
    iii. Fold the round side of the STV over on itself, and snap shut to activate the device.
k. Return the units to the cooler insert in the refrigerator immediately.
l. A second CLS will verify the emergency tag information against the units, "Crash Pack Unit List" form, and emergency dispense report.
    i. During night shift, a Laboratory Assistant can perform the verification. The second CLS or LA verifying the documents will sign their initials on the form.
m. Store the units with emergency tags and activated STVs in the MaxQ cooler insert in the refrigerator near the Crash Pack segments.
n. Store the Crash Pack paperwork in the blood bank in its designated location.

2. <u>Receiving requests for Crash Packs</u>

*It is strongly recommended to use the "Verbal Request for Emergent/Uncrossmatched Blood" form (Enclosure [2]) when taking a request for a Crash Pack.*

a. The CLS should confirm the provider understands they will receive uncrossmatched blood.
b. **Obtain at least 2 patient identifiers from the person phoning the request – preferably name and MRN.**
c. **A room number alone is not enough to identify the patient.**
d. If the patient is registered, ask for labels to be tubed or print them out using the "Label Reprint" application. Any test accession number ordered on the patient is ok to use.

e. In extreme circumstances when a name, MRN, date of birth, or BBID are unavailable, get as much information as possible to direct the units toward the patient.
    i. For example: "*50-year-old male BBID: GR1234*" or *"30-year-old female black hair ED Room 2"* are acceptable ways to direct the units if the patient has not been registered.

3. Packing the Crash Pack

*NOTE: all uncrossmatched blood shall be transported in a cooler.*

a. Apply patient labels or write the identifiers on the Crash Pack unit emergency tags.
b. **Blood shall not leave the laboratory without patient identifiers on the emergency tags.**
c. Pack the cooler:
    i. Verify the STV center is white.
    ii. Use the blue MaxQ cooler if it is available. Pack it according to SOP.
d. Record the packing date and time on the "Patient Cooler Tracker" log.
e. Deliver the blood. **Verify the patient identifiers with patient care personnel.**
f. Upon return to the blood bank, finish filling out the left half of the "Patient Cooler Tracker" log.
g. After 4 hours, retrieve the cooler if it has not already been returned to the blood bank.

4. Reconciliation of Crash Pack units that were **returned** to the Transfusion Service (not transfused)
    a. Check STV temperature indicators on units immediately upon the cooler's return to the blood bank. They are the primary way to determine if a unit's temperature is acceptable (see Figure [1]).
        *i. ONLY if a unit is missing an STV: measure the unit temperature with a thermometer. Only units1-10º C can be returned to inventory. File a Quality Variance Report.*

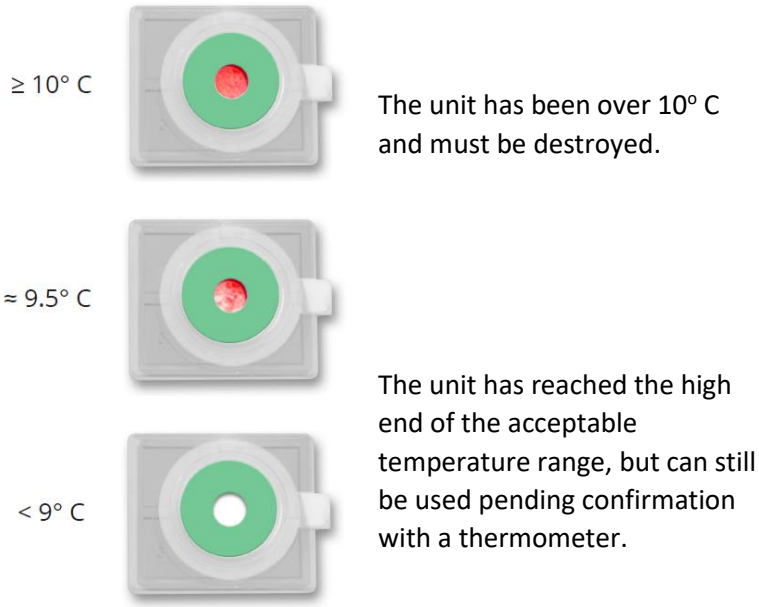



*Figure 1.*

b. **If the STV center is completely red, the unit is unacceptable and must be destroyed, even if it is cool to the touch.**
    i. Use the "Final Disposition" application to remove the units from inventory.
        1. Select "Dispose" mode at the top.
        2. **Dispose Reason**: select "Product Expired"
        3. **Destruction Method**: select "Biohazard"
    ii. Discard the unit in the biohazardous trash.
    iii. File a Quality Variance Report (QVR).
c. **If the STV center is mostly white with some red spots:**
    i. **C**heck the unit temperature using the thermometer.
    ii. If it is 1-10$^{o}$ C, accept the unit. Use the "Return Products" application.
    iii. If it is over 10$^{o}$ C, destroy the unit in "Final Disposition" and discard. File a QVR.
d. **If the STV center is white, the unit is acceptable. Proceed returning the unit to inventory.**
    i. Discard the used STV and shred the emergency tag.
    ii. Reprint the emergency tag by opening the "Generate Tags and Labels" application:
        1. Select the "Reprint" and "Emergency tag" functions.
        2. Skip the "medical record number" field.
        3. Scan the product number and click "Retrieve".
        4. Click on the unit information that shows up in the lower part of the screen.
        5. Click on the printer button at the top of the screen.
        6. Attach the new emergency tag the unit.
    iii. Apply and activate a new STV.
        1. For best results, return the unit to the refrigerator for approximately 10 minutes before applying the new STV.
    iv. Store the units in the MaxQ cooler insert in the refrigerator. Ensure the unit's segments are still in the refrigerator and the information on the "Crash Pack Unit List" is accurate.
e. Update the "Patient Cooler Tracker" log.

5. Reconciliation of Crash Pack units **that were transfused**
    a. Update the "Patient Cooler Tracker" log.
    b. Open the "Correct Inventory" application.
        i. Select "Emergency Dispense" mode.
        ii. Scan the product number.
        iii. Enter the patient's MRN.
        iv. Verify the patient information and click the "save" button.
    c. "Return" the unit(s) in Cerner so they will be available for crossmatch:
        i. Open the "Return Products" application.
        ii. The current date and time will default.
        iii. **Return Reason**: select "Not used".
        iv. **Visual inspection**: OK.
        v. **Courier**: type "RN".
        vi. Scan the product number.
        vii. Do not select the "quarantine" or "release crossmatch" options.

        *Note: If a cooler was **not** selected in the "Dispense and Assign" application when the Crash Pack was set up, Cerner will force quarantine of the unit. Return the unit, then release it from quarantine in the "Quarantine Products" application.*

viii. Enter a temperature under 10, and choose “Deg C”.
ix. Click the save button. The unit is now in a proper state for crossmatch.

d. Crossmatch the unit(s):
   i. Open the patient’s “Crossmatch” order in result entry. The crossmatch order MUST be on the same accession number as the current completed ABO/Rh and antibody screen orders.
      1. It may be necessary to add a crossmatch order to the accession using the “Department Order Entry” application.
   ii. Scan the BBID label on the type and screen tube into the appropriate field.
   iii. Scan the unit number into the appropriate field.
   iv. An electronic crossmatch will automatically be resulted if the patient does not have antibody history. Perform a serological crossmatch if indicated and enter results.
   v. Click “Verify” and then “Yes to all” in the pop-up asking to crossmatch units. Print the crossmatch tag(s) to “inyobloodbank” printer.
e. Backdate dispense the unit(s):
   i. Open the “Dispense and Assign” application. Use the “Dispense” mode.
   ii. Enter the patient’s MRN.
   iii. Check the “Back Date” box and enter the date and time the cooler left the blood bank (this should be documented on the “Patient Cooler Tracker” Log).
   iv. Click in the **“Product Number” field** and scan unit number(s).
   v. Click the **“Save” button** at the top of the screen.
   vi. In the “Save” pop-up fields:
      1. **Physician**: type enough of the physician’s name (Last, First) for it to auto-populate.
      2. **Reason**: type “E” then Tab, or select “Emergency” from the drop-down menu.
      3. **Visual Inspection**: OK (prefilled).
      4. **Courier**: type “COURIER” then Tab.
      5. **Location**: type “INYO ED” then press **ENTER**.
         a. If Tab key is used, the text will disappear.
         b. If the units were actually delivered to a different location, this was documented on the “Patient Cooler Tracker” log during dispense.
      6. **Cooler**: Select “NIHD Cooler 1” from the drop-down menu.
      7. **Blood Bank ID**: scan BBID from type and screen tube.
   vii. Click “OK” and print the dispense report. Staple all print-outs from the reconciliation process together and file in the Transfusion Service coordinator’s mailbox.
f. Manually transfuse the unit(s): (required for units dispensed to a cooler)
   i. Open the “Final Disposition” application. Select the “Transfuse” mode.
   ii. Scan the unit number.
   iii. Verify the patient information is correct and click the “save” button.
   iv. Repeat this process if a second Crash Pack unit was transfused.
g. Use the “Patient Product Inquiry” application to verify units were properly reconciled with the patient.

## VI. LIMITATIONS:

1. Transfusing uncrossmatched blood has inherent risks. The physician will sign an electronic order in Cerner indicating the state of their patient was grave enough to warrant the use of uncrossmatched blood.

2. Due to the nature of emergency situations with trauma patients, routine patient identifiers may not be available. The priority is to get the blood to the patient. The Transfusion Service will make all efforts to balance safety with urgency.
3.

**VII. EQUIPMENT**:

1. MaxQ Blood Cooler, or other validated blood cooler
2. Safe-T-Vue non-reversible temperature indicators

**VIII. QUALITY CONTROL PERFORMANCE:**

Validation documentation for coolers, temperature indicators, and Cerner Blood Bank module are available in the Transfusion Service.

**IX. REFERENCES:**

1. Safe-T-Vue 10 product sheet, Temptime Corporation.

**X. DISTRIBUTION:**

1. Transfusion Service section.

**NORTHERN INYO HEALTHCARE DISTRICT**
**LABORATORY SERVICES DEPARTMENT**
**STANDARD OPERATING PROCEDURE**

| | | |
|---|---|---|
| SOP #: TS-005-2021 | | |
| Title: Dispensing Blood Products - Non-emergent | | |
| Owner: LAB MANAGER | Department: Laboratory | |
| Scope: Blood Bank | | |
| Date Last Modified: 07/17/2021 | Last Review Date: No Review Date | Version: 2 |
| Final Approval by: Medical Director of Lab & Medical Executive Team | Original Approval Date: | |

## I. PURPOSE:

This Standard Operating Procedure (SOP) describes the process for dispensing blood products in non-emergent situations from the Northern Inyo Hospital (NIH) Transfusion Service/Blood Bank.

## II. BACKGROUND:

Northern Inyo Hospital (NIH) supplies packed red blood cells (PRBCs), platelets, fresh frozen plasma (FFP), and cryoprecipitate to both inpatients and outpatients requiring transfusion.

This SOP is in accordance with the American Association of Blood Banks (AABB) Standards for Blood Banks and Transfusion Services requirements.

Only CLSs trained and deemed competent will perform this SOP.

## III. SPECIMEN REQUIREMENTS:

Blood products must be crossmatched (PRBCs) or assigned (platelets, FFP, cryoprecipitate) by a CLS before they can be dispensed in non-emergent situations.

It is strongly recommended nursing prints the blood product or transfuse order from Powerchart and attaches a BBID sticker from the patient's wristband. The printed order and BBID sticker will provide all required information.

## IV. PROCEDURE:

*NOTE: If dispensing to a flight box for a patient being air-transferred:*

- *Dispense the unit in Cerner as described below, but verify the patient and unit information with a nurse or member of the flight crew upon delivery to the Emergency Department.*

1. Couriers retrieving any type of blood product must bring at least the following patient information:
    a. **Blood Bank ID (BBID) –** *sticker from wristband or written*
    b. **Full Name**
    c. **Medical Record Number (MRN)**

2. If any of the identifiers do not match the Transfusion Service's/Blood bank records, the discrepancy must be investigated and resolved before products can be dispensed.
3. Retrieve the unit(s) and the product requisition.
4. If units are being dispensed to a cooler and require Safe-T-Vue temperature indicators: **keep the units on refrigerated gel packs until they are packed in the cooler** (see Table 1).
5. Multiple PRBC and/or FFP units MUST be packed in a cooler.

*Table 1.*

| Product Type | Cooler | Dispensed Storage Temperature | Safe-T-Vue Indicator |
|---|---|---|---|
| Single product of any type for immediate transfusion | No | Room Temperature | No |
| **PRBCs – Multiple, or single NOT for immediate transfusion, or if uncrossmatched** | **Yes** | **1-10º C** | **Yes** *Keep units on cold gel packs* |
| FFP – Multiple, or single NOT for immediate transfusion | Yes | 1-10º C | No |
| Platelets | No | Room Temperature | No |
| Cryoprecipitate | No | Room Temperature | No |

***Note: Units issued to flight boxes do NOT need Safe-T-Vue indicators.***

6. Open the "Dispense and Assign" application.
7. Select the "Dispense" mode.
8. Scan or enter the patient's MRN.
    a. The barcode on the left side of the unit tag will enter the MRN.
9. Click in the product number field and scan the unit(s).
10. Click the "save" button near the top of the screen. A pop-up will appear:
    a. **Physician**: should auto-populate. If not, start typing a few letters of the last name then Tab.
    b. **Reason**: select from the drop-down menu.
    c. **Visual Inspection**: OK (if unit inspection is acceptable).
    d. **Courier**: scan the courier's hospital ID badge or type their last name.
    e. **Location**: should auto-populate. If not, try searching using "*INYO"
    f. **Cooler**: if using a cooler or box, choose the appropriate cooler number, or one of the flight box options if the products are being flown with the patient.
        i. Physical flight boxes are not numbered.
    g. **Blood Bank ID**: Scan the BBID sticker supplied by the courier.
    h. Do not click "OK" yet!

11. Before handing the blood product to the courier, verify the BBID on the unit tag matches the one supplied by the courier, and the one in the patient's "Blood Bank" comment section in Cerner.
    a. **Cerner does NOT have the capability to compare these fields.**
    b. **It is the CLS's responsibility to ensure the BBIDs match.**
12. The CLS reads the patient information in Cerner from the computer screen:
    a. Full name
    b. MRN
    c. Date of Birth
    d. BBID
    e. Patient's ABO/Rh
    f. Antibodies or special requirements, if applicable
13. The courier shall read the same information from the unit tag.
14. The CLS compares what the courier reads against the product requisitions (one that printed in Transfusion Service/Blood Bank, and the one printed by nursing, if applicable).
15. The CLS reads the product information displayed in Cerner:
    a. Product Number
    b. ABO/Rh
    c. Expiration Date
    d. Special attributes, if any (antigen negative, irradiated, etc)
16. The courier reads the same information from the unit tag.
17. The CLS and courier confirm the unit is ABO/Rh and/or crossmatch compatible, if applicable.
18. If there are any discrepancies, stop the dispense process and resolve the issue.
19. Click "OK" in the "save" pop-up window to dispense the product.
20. Click "OK" in the printing prompt to print the dispense report.
21. Staple the product requisitions from the blood bank and nursing to the dispense report. File in designated area.
22. Fill out the "Patient Cooler Tracker" or "Flight Blood Box Tracker" log if using a transport container (Enclosures [1] and [2]).

## V. RESULTS REPORTING:

See "Final Disposition of Units" SOP for documentation of unit outcomes.

Keep all product requisitions, dispense reports, and other relevant documents together for the duration of the patient's type and screen. After the Type and Screen expires, the Transfusion Service/Blood Bank Coordinator should keep the documents for audit.

Applicable documentation required by the AABB Standards for Blood Banks and Transfusion Services is stored in Cerner.

## VI. LIMITATIONS:

1. Clerical errors are possible, but unlikely if following the SOP.
2. The ambient room temperature, and the starting temperature of units, can affect the length of time blood products will maintain acceptable temperature in a cooler or box.

## VII. EQUIPMENT:

1. Thermosafe cooler and accessories
2. Safe-T-Vue non-reversible temperature indicators
3. MaxQ cooler and accessories
4. Blood product transport boxes (property of Vitalant)

## VIII. QUALITY CONTROL PERFORMANCE:

1. Cooler and Safe-T-Vue validation documentation is available in the Transfusion Service.
2. The Cerner Blood Bank module is validated; documentation is available in the Transfusion Service.

## IX. REFERENCES:

1. AABB Standard for Blood Banks and Transfusion Services, current edition.

## X. DISTRIBUTION:

1. Transfusion Services/Blood Bank Section.

**NORTHERN INYO HEALTHCARE DISTRICT**
**LABORATORY SERVICES DEPARTMENT**
**STANDARD OPERATING PROCEDURE**

| | | |
|---|---|---|
| SOP #: TS 010-2021 | | |
| Title: Transfusion Criteria* | | |
| Owner: BLOOD BANK COORDINATOR | Department: Laboratory | |
| Scope: Hospital Wide | | |
| Date Last Modified: 08/16/2021 | Last Review Date: No Review Date | Version: 2 |
| Final Approval by: Medical Director of Lab & Medical Executive Team | Original Approval Date: 03/05/2017 | |

## I. PURPOSE:

To define transfusion criteria adopted by the Tissue, Surgery and Transfusion Committee at Northern Inyo Hospital.

## II. BACKGROUND:

The Laboratory Services Transfusion Service/Blood Bank Coordinator and Medical Director continually monitor nation-wide, evidence-based patient blood management strategies to ensure adherence to current best practice. This data provides advice and recommendations to the Tissue, Surgery, and Transfusion Committee in order to optimize hemostasis, minimize blood loss and reduce transfusion associated risks.

## III. PROCEDURE:

1. **RED BLOOD CELL** transfusion is indicated when:
   a. Hgb </= 7g/dL in a stable patient
   b. Hgb </=8g/dL in a patient with symptoms of cardiac ischemia, orthostatic hypotension or tachycardia
   c. The ordering physician documents a clinical circumstance that would benefit from transfusion
   d. Active bleeding is present
2. **FROZEN PLASMA** transfusion is indicated if:
   a. INR >1.8 in a patient with bleeding, a planned invasive procedure, or a planned surgery with anticipated significant blood loss
   b. Active bleeding is present
3. **PLATELET** transfusion is indicated if:
   a. Platelet count</=10,000/uL in a stable patient
   b. Platelet count </=20,000/uL in a patient with a coagulopathy or with an anatomic lesion likely to bleed.
   c. Platelet count</=50,000/uL in a patient with a current bleed or surgical procedure
   d. Massive transfusion
4. **CRYOPRECIPITATE** transfusion is indicated if:
   a. Fibrinogen </=100 mg/dL
   b.

## IV. REFERENCES:

1. Carson JL, Grossman JB, Kleinman S, et al. Red Blood Cell Transfusion: A Clinical Practice Guideline from the AABB. *Ann Intern Med*. 2012; 157:49-58 [PMID:22751760]
2. Fung MK, Grossman jB, Hillier C et al, eds. AABB Technical Manual, current edition, Bethesda, MD; AABB Press.
3. Kaufman RM, Djulbegovic B, Gemsheimer T, et al. Platelet Transfusion: A Clinical Practice Guideline from the AABB. *Ann Intern Med*. 2015; 162:205-13
4. Qaseem A, et al. Treatment of Anemia in Patients with Heart Disease: A Clinical Practice Guideline from the American College of Physicians. *Ann Intern Med*. 2013;159(11):770-779.
5. Shander A, Gross I, Hill S, et al, A New Perspective on Best Transfusion Practices; *Blood Transfusion* 2013; 11:193-202 DOI 10.2450/2012.0195-12

## X. DISTRIBUTION:

1. Transfusion Service/Blood Bank Section of Laboratory Department.

**NORTHERN INYO HEALTHCARE DISTRICT**
**LABORATORY SERVICES DEPARTMENT**
**STANDARD OPERATING PROCEDURE**

| | | |
|---|---|---|
| SOP #: MB 001-2021 | | |
| Title: Cerebrospinal Fluid Cultures | | |
| Owner: LAB MANAGER | Department: Laboratory | |
| Scope: Microbiology - Lab | | |
| Date Last Modified: 08/16/2021 | Last Review Date: No Review Date | Version: 2 |
| Final Approval by: Medical Director of Lab & Medical Executive Team | Original Approval Date: 03/22/2019 | |

## I. PURPOSE:

This Standard Operating Procedure (SOP) outlines the process for isolation, identification, and characterization of agents that cause bacterial meningitis.

## II. BACKGROUND:

Bacterial meningitis is the result of infection of the meninges. Identification of the infecting agents is one of the most important functions of the diagnostic microbiology laboratory because acute meningitis is life-threatening. CSF from a patient suspected of meningitis is an emergency specimen that requires immediate processing to determine the etiologic agent.

CSF is obtained by transcutaneous aspiration, and therefore, all organisms recovered from the culture are potential pathogens and must be reported to the physician immediately. Because the number of organisms in the CSF can be as low as $10^3$ cfu/mL, concentration of the gram stain by cytocentrifugation is important for rapid diagnosis. Cytospin concentration can increase the sensitivity up to 100-fold compared with both uncentrifuged and conventionally centrifuged fluid. Concentration for culture is unnecessary, since the plate inoculum is sufficient to detect the usually low numbers of organisms.

Aerobic bacteria commonly cause bacterial meningitis but anaerobes may be present in CSF when a meningeal abscess or a similar infectious process is adjacent to the meninges. These include traumatic head injury or prostheses, such as metal cranial plates and shunt drains. Inoculation of anaerobic media is not recommended for diagnosis of community-acquired meningitis. Because slow-growing anaerobic organisms such as *Cutibacterium acnes* (formerly *Proprionibacterium*) are common pathogens of central nervous system shunt infections, anaerobic cultures of CSF should be incubated for a minimum of 7 days. The addition of a broth culture that will grow aerobes and anaerobes may enhance isolation in low-number infections. However, growth of low-number contaminants is also enhanced by CSF broth culture. Specific comment should be appended to laboratory reports of isolates from CSF in broth only to aid the physician in interpreting the clinical relevance of such isolates.

## III. SPECIMEN REQUIREMENTS:

1. Refer to Chapter 3.7.II of the Clinical Microbiology Procedures Handbook for specimen collection requirements, sterile container or tube are acceptable
2. Submit to the laboratory as soon as possible and alert to critical significance
3. Each sterile tube should be labeled with patient name, date of birth, MR number, specimen source, initial of collector and date and time of collection
4. Tube 1 is for Chemistry, tube 2 for microbiology and tube 3 and/or 4 for hematology and specialty testing
   NOTE: Call physician/provider to prioritize requests if there is insufficient volume
5. Reasons for specimen rejection(s)
   Refer to "Rejection Criteria" for Microbiological Specimens [see Enclosure (1)]
   A. Clerical errors pending resolution
   B. Improper or non-sterile container
   C. Leaking container

## IV. PROCEDURE:

1. Inoculate media according to the Microbiology Culture Set Up Chart [see Enclosure (2)]
2. Prepare a Cytospin slide for the Gram Stain
3. Incubate media at 35-37°C in 5% $CO_2$, or anaerobic condition respectively
4. Examine all plates and broth media for macroscopic evidence of growth after overnight incubation
5. If no growth, read aerobic and anaerobic plates and examine broth daily for an additional 4 days
6. Hold anaerobic plates for a minimum of 7 days if the specimen is from a ventricular shunt
7. If gram stain is positive and there is no growth on the plates, hold all plates for 1 week
8. If growth, identify all organisms using flow charts, etc.
9. Test all alpha hemolytic streptococci with Optochin Disk to identify *S. pneumoniae*
10. Perform catalase and Gram stain of organisms growing on BAP and/or CHOC. Identify further according to Gram Stain and rapid tests. *Listeria* and group B streptococci are significant CSF pathogens
11. Perform oxidase test on gram-negative diplococci. If positive, colony is grayish to white and catalase is positive, send out for identification of possible *Neisseria meningitidis*
12. For all staphylococci, perform Staphaurex. Set up Vitek 2 ID and AST cards
13. Do not perform complete identification or antimicrobial susceptibility testing if the isolate is clearly a plate contaminant or the isolate is a coagulase-negative staphylococcus (CoNS) isolated from broth only, report as "In enrichment broth only". NOTE: Isolates of CoNS and *Corynebacterium* are probably contaminants in community-acquired infection but may or may not be a cause of infection in shunt infections and those with head injuries. A few colonies of catalase-positive, gram-positive rods growing only on CHOC should be sub-cultured to BAP to check hemolysis and rule out *Listeria* before being reported as *Corynebacterium*
14. Perform AST on enteric and non-fermenting, gram-negative rods, enterococci, *S. pneumoniae, Staphylococcus aureus,* and other significant staphylococci
15. Perform beta-lactamase test for *Haemophilus influenzae*. Consult physician and sent out for AST for penicillin or ampicillin if the beta-lactamase test is negative and either agent will be used for therapy

NOTE: For *Listeria, Streptococcus agalactiae,* and *N. meningitidis,* do not perform beta-lactamase testing, which can lead to erroneous results. Resistance to penicillin in these isolates is rare. For a penicillin-allergic patient, consult with the physician to guide AST

16. Hold positive culture plates for 5 days

## V. RESULT REPORTING

1. Normal Range: No growth
2. Isolation of *Neisseria meningitidis* from CSF (sterile site) should immediately be reported to infection control, state and local public health. Contacts of cases should receive prompt antibiotic prophylaxis to prevent transmission to health care workers, as well as family members and close contact in the community. The isolate should also be immediately submitted to the local or state public health laboratory
   A. Interpretation:
      1) Generally, a positive culture indicates infection with the organism
      2) Lack of white blood cells in CSF does not rule out infection, especially in listeriosis
      3) Isolation of enterococci from CSF is always a cause for concern. The presence of the organism may be an indication of strongyloidiasis as strongyloidiasis can predispose immunocompromised individuals to meningitis caused by enteric flora.

## VI. LIMITATIONS:

1. False positive results can result from contamination of the specimen or culture with skin contaminants
2. False negative results can be caused by low numbers of organisms, prior antimicrobial treatment, or the fastidious nature of the infectious organism

## VII. EQUIPMENT:

1. Vitek 2
   A. Maintenance Requirements
      1) Daily Maintenance
         - Clean nozzle of saline dispenser with alcohol
         - Set up saline sterility on CHOC and incubate at 35-37°C in 5% $CO_2$ for 18-24 hours
         - Check carousel temperature and optics system
         - Empty waste collection bin
      2) Monthly Maintenance
         - Clean cassettes, waste bin, filler station load and unload station, carousel and optics according to Instrument User Manual
         - Print temperature and optics report
         - Delete reports that are more than 3 months' old
         - Check and record DensiChek calibration
      3) As needed
         - Clean exterior surfaces, screen and keyboards

## VIII. QUALITY CONTROL PERFORMANCE:

1. Media is routinely tested following the Media Distribution and Quality Control (QC) procedure prior to patient testing
2. Standard biochemical tests and kits are routinely tested with both known positive and negative controls following manufacturer's recommendations e.g. new lot and new shipment as well as daily, weekly or as needed, respectively, prior to patient testing
3. Vitek 2 Compact system QC process encompasses annual service and certification of the instrument by BioMérieux

4. Vitek 2 identification cards are tested with CLSI-recommended ATCC quality control strains with each new lot and new shipment prior to patient testing
5. Vitek 2 AST cards are tested weekly with CLSI-recommended ATCC quality control strains following conversion after successful completion of QC according to CLSI M100-S23 prior to patient testing

## IX. REFERENCES:

1. Clinical Microbiology Procedures Handbook
2. Vitek 2 Compact Instrument User Manual
3. CLSI M100-S23
4. Media Distribution and Quality Control Standard Operating Procedure

## X. DISTRIBUTION:

1. Microbiology Section

**NORTHERN INYO HEALTHCARE DISTRICT**

**PLAN**

| | | |
|---|---|---|
| Title: Principles of Asepsis in the Operating Room | | |
| Owner: Surgery Manager | Department: Surgery | |
| Scope: Surgery, DI Tech, Perinatal, Respiratory Care Practitioner, House Supervisor | | |
| Date Last Modified: 08/22/2021 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 05/03/2013 | |

## PURPOSE:

- To assure a clean environment for all surgical patients.
- To maintain the cleanest air possible and a temperature comfortable enough for the surgical team yet inhibit bacterial growth.
- To reduce potential contamination from outside sources.
- To promote strict adherence to aseptic techniques.
- To ensure all hospital, particularly perioperative personnel, share in the responsibility to maintain a safe, clean environment for the patient

## DESCRIPTION:

- The operating room is considered a clean environment. The design and location within the hospital is to help maintain its clean environment.
- The Operating Room is located away from major traffic areas.
- The operating room is divided into three areas based on level of contamination. These areas are restricted, semi restricted and unrestricted.

### RESTRICTED:

In restricted areas, surgical attire, including hats, shoe covers, and masks are worn. This area includes the operating rooms, procedure rooms, and the clean core area. Masks are required where open sterile supplies or scrubbed persons are located. All persons entering the restricted area should follow the AORN "Recommended practices for surgical attire".

### SEMIRESTRICTED:

In semi-restricted areas, masks need not be worn. These areas include Ante-Room and Scrub Sink Area, storage and instrument processing areas and corridors leading to restricted areas. Personnel are required to wear surgical attire and cover all head and facial hair. Traffic in this area is limited to authorized personnel and patients.

**UNRESTRICTED:**

In unrestricted areas street clothes are permitted.

This includes areas where operating room personnel interface with the outside departmental personnel, locker rooms, patient reception areas, clerk areas, and areas where supplies are received.

**Ventilation:**

The operating room has a separate ventilation and air filtration system. Filters are designed to

remove dust and aerosol particles from the air. Airflow is from ceiling to floor. Air pressure is within each operating room is greater than the semi restricted areas. Because of this pressure difference, doors to each operating room need to be kept closed to prevent disruption of air flow, except during movement of patients, personnel supplies and equipment.

**Air Exchange:** The air in the operating room is maintained under positive pressure with a minimum of 15 total room air exchanges per hour with a recommend range of 20 to 25 air exchanges. When doors are left open, the heating, ventilation, and air conditioning system is unable to maintain these critical environmental parameters. Leaving the door open can disrupt pressurization and cause turbulent airflow that could increase airborne contamination. Traffic in and out of the operating room should be minimized during procedures or when sterile supplies are opened.

**Temperature and Humidity:** Operating rooms, sterile storage areas, and Sterile Processing temperatures are maintained between 68 and 73 degrees. The relative humidity should be between 35 % and 60 % within the perioperative unit and is maintained between 20%-60% per CMS waiver (see below**).

A daily temperature and humidity log will be filled out for the ORs, Sterile Processing and sterile equipment storage rooms. If any parameters are not met, maintenance will be notified. Before any surgical case is started, the circulating RN documents the OR Room temperature and humidity in the Intraoperative Record. The surgeon is notified if the temperature and/or humidity fall outside of the parameters and will make the decision whether to proceed with the surgery or not. This also is noted by the circulating RN in the Intraoperative Record.

**Low humidity** increases the risk of electrostatic charges, which pose a fire hazard in an oxygen rich environment and increase the potential for dust.

**High humidity** increases the risk of microbial growth in areas where sterile supplies are stored or procedures are performed.

**Waste:** Waste will be contained before transportation through hallways. Soiled instruments and equipment are cleaned in dirty area before transporting into area where clean or sterile supplies are located.

**Attire:** Persons entering the semi restricted or restricted areas of the surgical suite for a brief period or time for a specific purpose (e.g., law enforcement officers, parents, biomedical engineers) should cover all head and facial hair and may don freshly laundered surgical attire or a single-use coverall (e.g., jumpsuit) designed to totally cover outside apparel.

**Flow of Traffic:** The flow of traffic should be such that contamination from outside the suite is excluded and within the suite a separation of clean and contaminated areas should exist.

Shipping cartons will not be taken into the restricted area. All supplies will be sorted in the unrestricted area and transported into the restricted area for restocking.

Movement of personnel from unrestricted areas to either semi restricted or restricted areas should be through a transition zone. A transition zone exists where one can enter the area in street clothing and exit into the semi restricted or restricted zone in surgical attire and may serve as security point to monitor people admitted to the suite.

**Patients:** Patients entering the surgical suite should wear clean gowns, be covered with clean linens, and have their hair covered.

Clean gowns, linens, and hair coverings are worn by patients to minimize particulate shedding during surgical procedures. Patients are not required to wear masks while in the surgical suite unless they are under airborne precautions (e.g., a patient with active pulmonary disease).

Personal undergarments may be worn when they will not interfere w/ the surgical site. Specific patients such as those undergoing cataract procedures are allowed to wear clean personal clothing, including socks and underwear into the surgical suite to promote patient's comfort and sense of dignity.

**Aseptic Technique:** Aseptic technique is the method by which contamination with microorganisms is prevented. Anyone who is present in the operating room has a responsibility to maintain a safe environment or the patient.

- All items within a sterile field must be sterile.
- All scrubbed persons should wear sterile gowns and gloves.
- The neckline, shoulders, underarms, and back of the surgical gown are not considered sterile.
- Gloved hands are kept in sight and at or above waist level.
- Sterile drapes will be used to establish a sterile field.
- All items introduced into a sterile field should be dispensed by methods that maintain sterility of item and integrity of sterile field.
- Draped tables are sterile only at table level.
- Movement within or around a sterile field must not cause contamination of the sterile field.
- A sterile barrier that has been permeated must be considered contaminated.
- Items of doubtful sterility are considered unsterile.
- Sterile persons and items contact only sterile areas; unsterile persons and items contact only unsterile areas.
- The edges of sterile containers are not considered sterile once the package is opened.
- A sterile field should be constantly monitored and maintained.
- Sterile fields should be prepared as close as possible to scheduled time of use and not covered.
- Any breaks in technique will be corrected immediately.

**DOCUMENTATION:**

Any breaks in sterile technique or compromise to the sterile field will be documented in the comment section on the operative record, reported to the Surgery Nurse Manager, and documented on a performance improvement analysis sheet if indicated.

**REFERENCES:**

- AORN Guidelines for Perioperative Practice (2018): Sterile Technique, Surgical Attire
- Title 22: 70227, 70837, 70839, 70845
- TJC: IC.02.02.01
- Humidity Waiver Information**
  The Centers for Medicare and Medicaid Services (CMS) is issuing a categorical LSC (REF; S&C: 13-25-LS & ASC) waiver permitting new and existing ventilation system supplying hospital and critical access hospital (CAH) anesthetizing locations to operate with a relative humidity greater than 20 percent, instead of greater than or equal to 35% in these locations. They also recommend that relative humidity not exceed 60%. There must be written documentation stating that the facility has elected to use the waiver. A copy of this waiver is maintained in the maintenance department.

  Northern Inyo Hospital District has elected to use the relative humidity waiver (**Ref: S&C: 13-25-LSC & ASC)** issued April 19th 2013 by CMS.
  At the entrance conference for any survey assessing LSC compliance, the facility that has elected to use this waiver must notify the survey team. Facilities must monitor relative humidity in anesthetizing locations and take corrective actions when needed to ensure relative humidity remains at or above 20 percent.

**CROSS REFERENCE POLICIES/ PROCEDURES:**
Lippincott Surgical Asepsis: Maintaining a sterile field
TJC: IC.02.02.01

| Supersedes: v.2 Principles of Asepsis in the Operating Room |
|---|

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Warming Cabinet for Blankets/Solutions | | |
| Owner: DON Perioperative Services | Department: PACU | |
| Scope: Hospital Clinical Areas | | |
| Date Last Modified: 08/16/2021 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 06/27/2011 | |

**PURPOSE:**

To ensure a safe method of warming textiles/fluids for patient use achieved by circulating air warmed by heaters throughout the heating compartment Warming cabinets are designed to raise the temperature of irrigation, IV solutions and or textiles
(blankets) for patient use.

**POLICY:**

- Temperature will be monitored to ensure it is appropriate for solutions/textiles.
- Adequate room for airflow will be considered when stocking warmer with textiles/solutions.
- Solutions must not come in contact with metal or the heating elements in the warming units.
- Mannitol solutions may not be stored in the warmer.
- Solutions are warmed per manufacture recommendations.

**PROCEDURE:**

- If utilizing unit for both textiles and fluids, place solutions and textiles on shelves as indicated in operator's manual for specific unit. They should be on separate shelves.
- To ensure proper heat distribution, allow airflow space on the top and all sides of textiles. **Do not block air vent.**
- If it is necessary to remove only part of a load from the cabinet, then a FIFO (First in First Out) routine is recommended.
- After setting temperature per manufacture recommendation, the alarm will alert if the temperature exceeds the temperature control setting plus 10°°F.
- Allow temperatures to stabilize after loading the warmer:
  Bottles of solutions: Allow approximately 8 hrs. for temperature to stabilize
  Bags of solutions: Allow approximately 12 hours for temperature to stabilize
  Blankets: Allow approximately 8 hours for temperature to stabilize

BLANKETS

- Textiles (Blankets) can be warmed to a temperature 130° F plus or minus 5°F. Always feel the blanket to assure it is not too warm for patient use prior to placing on patient.
- Rotate textiles when stocking cabinet.
- Blankets must be folded and stacked to allow a 2" to 3" open space between the blankets and the interior walls and door to allow for even heat distribution and proper cabinet operation

SOLUTIONS FOR INJECTIONS

- Solutions are stocked in the warming cabinet daily as needed. Stock is re-ordered at least twice weekly and is rotated as new solutions are put away.
- Bottled solutions are dated for two months and bag solutions are dated for two weeks when being placed in the warming cabinet per manufacturer recommendation.
- Solutions are checked routinely for outdating and disposed of as needed if the time in the warming cabinet has elapsed.
- Solutions should remain in their overwraps and can remain in the warmer for a period **not longer than 14 days at 104° f.**
- Solutions should not come in contact with metal components within the warming unit.
- Once removed from the warming unit, solutions should be used within 24 hours or discarded and not returned to stock supply.
- Solutions should not be rewarmed.
- Solutions should be dated with REMOVAL DATE when placed in warming unit and the temperature checked daily.

IRRIGATION SOLUTIONS

- Flexible Irrigation solutions (bags) should remain in their overwraps and can remain in the warmer for a period NOT LONGER THAN 14 DAYS. Flexible irrigation containers can be warmed up to a temperature of 150° F according to Solution Manufacture Recommendation.
- Semi- rigid pour bottles may remain in the warming cabinet for up to 60 days at a temperature up to 150° F according to Solution Manufacture Recommendation.
- To ease cap removal for the pour bottles it is recommended that you wait for four minutes after removal of the product from the warming cabinet.
- For both flexible irrigation solutions and rigid pour bottle irrigations, then you must use the lower temperature when warming the solutions which is 104° F.
- When placing solutions in the warmer, the solutions should be dated with date placed into warmer and date of expiration. Preprinted labels are available and should be used. Writing with a pen on the bag should not be done.

**DOCUMENTATION:**
The temperature is monitored electronically by a central temperature monitoring system

**REFERENCES:**
AORN Guidelines for Perioperative Practice, 2018: Environment of Care Part 1, Recommendation V

**RECORD RETENTION AND DESTRUCTION:**

**CROSS REFERENCED POLICIES AND PROCEDURES:**

| |
|---|
| Supersedes: v.2 Warming Cabinet for Blankets/Solutions |

**NORTHERN INYO HOSPITAL**
**POLICY AND PROCEDURE**

| Title: Credentialing - da Vinci Robotic Surgery* | |
|---|---|
| Scope: Medical Staff | Manual: Medical Staff |
| Source: MEDICAL STAFF DIRECTOR | Effective Date: 11/4/16 |

**PURPOSE:**
To provide criteria for use in credentialing physicians who request privileges in da Vinci robotic surgery. For purposes of this policy, terms "da Vinci" and "robotic" are interchangeable.

**POLICY:**
1. Surgeons must be M.D. or D.O. Board Certified within their surgical specialty or surgical subspecialty.
2. Physicians performing robotic surgery must have privileges to perform the underlying procedure either as an open or laparoscopic procedure.
3. Surgical assistants in robotic surgery must have unrestricted privileges to assist in surgery.
4. Initial credentialing and reappointment of physicians and surgical assistants for robotic surgery must include satisfactory completion of training and proctoring, as outlined below.

**PROCEDURE:**
1. Initial Credentialing For Multiple Port Procedures
    a. For surgeons with prior da Vinci experience:
        i. Physicians must have privileges to perform the underlying procedure either as an open or laparoscopic procedure.
        ii. If residency/fellowship training included robotic surgery training, provide:
            1. letter from program director certifying competency for the requested privilege(s) and in the use of the da Vinci device; and
            2. The surgical log of a minimum of ten (10) da Vinci cases;
            3. Proctoring: A minimum of two (2) cases within a one-hundred-eighty (180) day period must be proctored by a da Vinci robotic-credentialed surgeon (preferably in their field).* Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame.
        iii. For surgeons with prior da Vinci experience at an outside institution, and not through residency/fellowship training:
            1. Certification of delineated training from Intuitive Surgical (i.e., completion of Internet training module, Overview/Didactic session, and Skills Lab at the ISI Training Center).
            2. Ten (10) cases beyond proctoring and within the previous 24-month period must be submitted for review.
            3. Proctoring: A minimum of one (1) case within a one-hundred-eighty (180) day period must be concurrently proctored by a da Vinci robotic-credentialed surgeon (preferably in their field).*
        iv. The above-listed proctoring requirements may be waived for any surgeon on the Intuitive Surgical, Inc. List of Approved Proctors. However, privilege-specific proctoring requirements must be followed.
    b. For surgeons without prior da Vinci experience:
        i. Privileges to perform the underlying procedure either as an open or laparoscopic procedure.
        ii. Completion of an Intuitive Training Program or comparable program, which includes didactic and hands-on training including cadaver, animal lab, or simulator.
        iii. Training: Specific to da Vinci Robotic Surgery System's instrumentation.
            1. Viewing of Intuitive Surgical's Procedure Video(s). AND

2. Completion of the on-line da Vinci Surgical System Training Module (one-hour). (Certificate of Completion on file). AND
3. Completion of the Intuitive Surgical System's overview and didactic session. (3-4 hours). (Certificate of Completion on file). AND
4. Completion and verification of a minimum of five (5) hours of da Vinci simulator training with scores of 90% or better on training modules included in the Morristown Protocol [see Appendix I]. AND
5. A minimum of one (1) live case observation. AND
6. Participation in Intuitive Surgical System's Skills Lab at any ISI Training Center (one day course and animal lab) (Certificate of Completion on file). Note that Intuitive Surgical recommends that at least three (3) surgical cases for proctoring be scheduled prior to or immediately upon completion of off-site training.

iv. Proctoring: A minimum of three (3) to five (5) cases within a one hundred eighty (180) day period must be concurrently *proctored* by a da Vinci robotic-credentialed surgeon (preferably in their field)*, or more if deemed necessary. Also, a minimum of five (5) additional cases must be *observed*, or more if deemed necessary. Additional training will be required prior to scheduling further cases if proctoring has not been completed within the specified time frame.

**Proctoring requirements include a completed proctoring form from the elected proctor that includes satisfactory outcomes of the procedure, assessment of intraoperative and postoperative complications, and review of pathology reports if indicated. Proctor may recommend to the Chair of the Department or Chief that additional training and/or proctoring be completed. Robotic surgery is viewed as an advanced laparoscopic technique and for surgeons who are already expert laparoscopists, the proctor needs to understand how to give advice on the use of the robot, not on the surgical procedure itself (NMCSD, 2011). As is standard in other communities, urologists, general surgeons, and gynecologists may proctor within and between specialties.*

c. For all physicians granted robotic surgery privileges, the first ten (10) cases will be reviewed for evaluation of case selection, OR time, blood loss, conversion to open procedure, complications, length of hospital stay, etc.
d. For privileges to assist in robotic surgery (for MD/DO, PA~~, RNFA~~):
    i. Unrestricted surgical assisting privileges
    ii. Documented experience in robotic assisting or completion of Intuitive Training Program for assistants (including on-line module and on-site training by Intuitive or a robotics-trained assistant)
    iii. Proctoring: A minimum of six (6) cases must be proctored by the primary surgeon. Surgeons granted privileges for both robotic surgery and to assist in robotic surgery may be deemed to have satisfied proctoring requirements as an assistant in robotic surgery once proctoring requirements as the robotic surgeon have been fulfilled.

2. Initial Credentialing For Single Port Procedures
    a. Unsupervised multiple port robotic surgery privileges;
    b. Completion of either:
        i. Single port Intuitive (or comparable) training program OR
        ii. Training modules
            1. Proctoring: Two (2) cases with a qualified single port surgeon.

3. Reappointment Criteria
    a. A minimum of ten (10) cases performed successfully (may be reviewed by the appropriate Division or Department or Committee) during the previous 24-month period without a proctor present.
    b. If less than ten (10) but greater than or equal to five (5) cases have been performed successfully during the previous 24-month period, the next two (2) cases must be successfully performed with the assistance of either a da Vinci robotic-certified surgeon on staff from within the same field or an outside proctor/preceptor.
    c. If fewer than five (5) cases have been performed successfully within the previous 24-month period, additional certified hands-on training must be obtained either by simulator (with completion of Morristown Protocol and score of >90% [see Appendix I]), cadaver or animal lab AND the next two (2) cases must be successfully performed with the assistance of either a da Vinci robotic-certified surgeon on staff from within the same field or an outside proctor/preceptor.
    d. If time between robotic cases is more than one (1) month, one (1) hour of simulator training must be completed prior to the upcoming robotic case.
    e. For single port procedures, a minimum of two (2) procedures during the previous 24-month period. If fewer than two (2) cases, training modules must be redone or the next one (1) case must be concurrently proctored by a qualified single port surgeon.
    f. To be a proctor, robotic credentialed providers need to have done at least 20 cases. ~~and a current proctor needs to write a statement to the credentialing committee attesting to the proctoring skills of the individual applying to be a proctor.~~
4. Ongoing Professional Practice Evaluation
    a. Robotic-performed cases may be reviewed on an ongoing basis by the appropriate Division/Department/Committee with the goal of patient safety and successful performance of the procedure(s). This may include OR time, blood loss, conversion to open procedure, complications, length of hospital stay.

| **Approval** | **Date** |
|---|---|
| Credentials Committee | 08/02/2021 |
| Medical Executive Committee | 9/12/16 |
| Board of Directors | 9/21/16 |
| Last Board of Directors Review | 8/21/19 |

Developed: 9/2/16
Reviewed:
Revised:
Supersedes:

**REFERENCES:**

1. Culligan, P., Gurshumov, E., Lewis, C., Priestley, J., Komar, J., and Salamon, C. (2014). Predictive Validity of a Training Protocol Using a Robotic Surgery Simulator. *Female Pelvic Medicine and Reconstructive Surgery, 20,* 48-51. doi: 10.1097/SPV.0000000000000045
2. Lawson, L. (2015). Credentialing Criteria for Computerized DaVinci Surgical Platform (DVSP). Indiana University Health North Hospital. Bloomington, IN.

3. Naval Medical Center San Diego (NMCSD). (2011). Departmental Criteria for Robotic Surgery Itemized Privilege. Rev. ed. San Diego, CA.
4. Society of American Gastrointestinal and Endoscopic Surgeons. (2007). A Consensus Document on Robotic Surgery. New York, NY.
5. Tri-City Medical Center. (2014). Credentialing Policy, da Vinci Robotic Surgery. Rev. ed. *Medical Staff Policy Manual.* Oceanside, CA.

**ADDITIONAL READING:**

1. AAGL Advancing Minimally Invasive Gynecology Worldwide. (2014). Guidelines for Privileging for Robotic-Assisted Gynecology Laparoscopy. *The Journal of Minimally Invasive Gynecology*, *21*, 157-167. doi:10.1016/j.jmig.2014.01.024
2. Kim, B., Chang, A., Kaswick, J., Derboghossians, A., Jung, H., Slezak, J., … Chien, G. (2013). Achieving proficiency with robot-assisted radical prostatectomy: Laparoscopic-trained versus robotic-trained surgeons. *Canadian Urological Association, 7,* 11-12. doi:10.5489/cuaj.360
3. Lee, J.Y., Mucksavage, P., Sundaram, C.P., and McDougall, E.M. (2011) Best Practices for Robotic Surgery Training and Credentialing. *The Journal of Urology, 185,* 1191-1197. doi:10.1016/j.juro.2010.11.067

**Index Listings:** Robotic Credentialing, da Vinci Robotic Surgery

# Northern Inyo Healthcare District

**LABORATORY SERVICES DEPARTMENT**
**STANDARD OPERATING PROCEDURE**

| | |
|---|---|
| SOP #: POCT 001-2021 | |
| Title: Urinalysis – Chemstrip 10 MD | |
| Scope: NIA/RHC Clinics, Perinatal, POCT | Department Section: Point-of-Care-Testing |
| Written/Authored By: POCT Coordinator | Date Implemented: 5/27/2021 |

## I. PURPOSE:

Rapid, semi-quantitative measurement of multiple urine chemistry parameters at the point-of-care. The test is useful in the initial evaluation and monitoring of renal, urinary, and metabolic disorders. Chemstrip 10 MD with specific gravity (SG) urine test strips manufactured by Roche-Cobas are intended for use visually or on Urisys 1100 urine analyzer, or Cobas U 411 urine analyzer.

## II. BACKGROUND:

The Chemstrip urine test system is a multi-parameter test strip that simultaneously measures specific gravity, pH, nitrite, protein, glucose, ketones, the presence of leukocytes, urobilinogen, bilirubin, blood and hemoglobin in urine. Different reagent pads attached to inert plastic strips change color as they react with the various constituents measured. The color change provides semi-quantitative measurements which at NIHD are read visually against a standard color chart on the test strip container.

1. Analytes:

a. **Specific Gravity:** In the presence of cations, protons are released by a complexing agent in the test strip and produce a color change of the indicator bromthymol blue from blue to blue-green to yellow.
b. **pH:** Methyl red and bromthymol blue are indicators that give clearly distinguishable color changes (orange through yellow, green, and blue) over a pH range of 5 – 9.
c. **Leukocytes:** Leukocyte esterase, present in granulocytic leukocytes, catalyzes the hydrolysis of an indoxylcarbonic acid ester to indoxyl. The indoxyl formed reacts with a diazonium salt to produce a purple color.
d. **Nitrite:** The conversion of nitrate (derived from the diet) to nitrite by the action of gram negative bacteria in the urine. Nitrite reacts with an aromatic amine to give a diazonium salt, which couples with sulfanilamide to yield a red-azo dye to produce a pink color.
e. **Protein:** The detection of protein is based on the so-called "protein error of pH indicators", using the indicator – tetrachlorophenol-tetrabromosulfophthalein. A positive reaction is indicated by a color change from yellow to green.
f. **Glucose:** Enzymatic glucose oxidase catalyzes the formation of gluconic acid and hydrogen peroxide from the oxidation of glucose. A second enzyme, peroxidase, catalyzes the reaction of hydrogen peroxide with the chromogen tetramethylbenzidine to form a green dye complex. A positive reaction is indicated by a color change from yellow to green.
g. **Ketones:** The test principle is based on Legal's test where sodium nitroprusside and glycine react with acetoacetate and acetone in an alkaline medium to form a violet dye complex. A positive result is indicated by a color change from beige to violet.
h. **Urobilinogen:** Urobilinogen couples with 4-methoxybenzene-diazonium-tetraflouroborate in an acid medium to form a red-azo dye to produce a pink-red color. This is based on a modified Ehrlich reaction.
i. **Bilirubin:** Bilirubin is detected by the coupling reactions of a diazonium salt with bilirubin in an acid medium with an application of a chemical indicator that yields a pink to red-violet color proportional to the total bilirubin concentration.

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j. **Blood/Hemoglobin:** Hemoglobin and myoglobin, if present, catalyze the oxidation of an indicator (0-tolidine) by the organic peroxidase in the test paper. Intact erythrocytes hemolyze on the test paper, and the liberated hemoglobin produces a green dot. A uniform green coloration indicates free hemoglobin, myoglobin, or hemolyzed erythrocytes. The color ranges can be from yellow with green dots (free red blood cells) to dark greens and very high levels of blood may cause the color of dark blue.

Note: Proper specimen collection, testing, and interpretation is the responsibility of trained testing personnel. All personnel must have orientation and hands on training followed by an initial Competency Assessment (CA) prior to patient testing. The initial CA is followed by a 12-month, and then annual CA. Personnel are required to be knowledgeable of the procedures in this SOP.

## III. SPECIMEN REQUIREMENTS

1. Acceptable specimens
   1. Freshly voided urine in a clean container deep enough to allow complete immersion of the reagent pads on the test strip. Collect clean catch urine if possibility of culture is considered.
   2. The same urine tested at bedside can be submitted to the laboratory for complete urinalysis if it is < 2 hours old and held at room temperature.
   3. When urine has been refrigerated, bring to room temperature before testing. Urines stored from
      2-8°C are stable for 12 hours for urine chemistries.
2. Unacceptable specimens
   a. Do not use preservatives
   b. Urines that are > 2 hours old at room temperature

3. Labeling
   a. Write the patient name and a second identifier with a sharpie or attach a patient label to the specimen that has 2 unique identifiers
   b. When the urine is sent to the laboratory for further testing, make sure to add the time of collection and the method of collection (i.e. void, clean catch, catheterized-in and out or Foley catheter)
4. Precautions and Warnings
   a. Universal precautions shall be practiced whenever blood or body fluids are handled.
   b. Avoid contact with skin and mucous membranes, flush with copious amounts of water. Get immediate medical attention if in contact with the eyes or ingested.

## IV. PROCEDURE

1. Using 2 patient identifiers, verify patient's identity, and explain procedure to patient and/or family
2. Observe universal precautions. Wear gloves and other protective equipment as needed
3. Urine should be in a container that permits complete immersion of the test strip reagent area

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| Written/Authored By: POCT Coordinator | Date Implemented: 5/27/2021 |

4. Mix specimen thoroughly by swirling container before testing
5. Briefly (no longer than 1 second) dip strip into the urine. Ensure that all pads have been immersed then immediately remove the strip from the specimen. Alternatively, use a transfer pipette to let urine run horizontally over the strip for 1 second
6. Draw the edge of the test strip along the edge of the container to remove excess urine
7. Turn the test strip on its side and press lightly against absorbent paper to remove remaining urine
8. After 1 minute, read the strip as follows:
9. Hold strip close to the color blocks and match carefully
10. Ensure that strip is oriented properly to the color chart on the vial label
11. Read all tests at 1 minute
    a. If the Leukocyte pad indicates a trace result, it should be read again at 2 minutes
    b. **Color changes that occur after 2 minutes from immersion are not of clinical value.**
    c. Color changes that occur along the edge of test pad should be ignored (removal of urine in above steps should eliminate this effect)

## V. RESULTS REPORTING:

| Parameter | Normal Value | Abnormal Result |
|---|---|---|
| Specific gravity | 1.001-1.035 | < 1.000 or > 1.035 |
| pH* | 5-9 | < 5.0 or > 9.0 |
| Leukocytes | Negative | 1-2+ (should repeat trace amount with fresh urine) |
| Nitrite | Negative | Positive |
| Protein | Negative | Trace – 3+ |
| Glucose | Negative | 50-1000 mg/dL |
| Ketones | Negative | 1- 3+ |
| Urobilinogen | Normal – 1 mg/dL | 4 - 12 mg/dl |
| Bilirubin | Negative | 1- 3+ |
| Blood/Hemoglobin | Negative | Trace or > |

NOTE: *In cases of the pH equal to or > 7.0, 0.005 may be added to the specific gravity readings. Urine results shall be added to nursing notes including reagent strip lot number and expiration date. If the testing site uses an intermediate worksheet to manually record patient results, it needs to be stored at the testing facility for a minimum of 3 years.

## VI. LIMITATIONS

1. Limitations-interferences are listed in the package insert following this procedure
2. Extreme temperature changes outside the manufacturers' recommendations may compromise the results of the test

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3. Avoid subjecting test strips to moisture when not in use (KEEP THE LID TIGHTLY CLOSED)
4. Certain medications such as pyridium cause intense color change that make the dipstick difficult to read, send the urine to lab for a complete urinalysis and microscopic exam

**VII. EQUIPMENT:**

1. Reagent Strips (order though purchasing)
   One vial of Chemstrip 10 MD contains 100 test strips. Store at room temperature. Keep lid closed when not in use.
   a. Storage
      1) Store test strips at 2-30°C
      2) Do not freeze
      3) Strips are stable in the original capped vial until listed expiration date
      4) Avoid moisture to strips by capping the vial immediately after removal of test strip
   b. Direct visual color comparison color chart is printed on the container label
2. Liquid controls, LiquiCheck Urinalysis Controls, Bilevel by Bio-Rad (order through purchasing)
   Store at 2-8°C. Open stability is 30 days
3. Additional equipment
   a. Timer
   b. Specimen collection containers
   c. Disposable pipettes

**VIII. QUALITY CONTROL PERFORMANCE:**

1. Testing
   a. Each department is required to maintain a QC logbook for QC results
   b. QC must be performed at least once per day or day of use depending upon the frequency of testing in each department
      NOTE: QC must be performed on each newly opened reagent container
   c. Expiration date on the vial should be checked on a regular basis and replaced as needed. Each open vial should have the date it was opened and the open expiration date on it
   d. If there are questionable results, stability of test strips can be verified by retesting a specimen with a new vial and comparing the results
   e. Take care to immerse the strip for only 1 second
   f. Any issues or problems encountered must be recorded in the logbook along with explanation how it was resolved
2. QC material
   a. Liquid QC is stable for 30 days *after* opening the vial OR until the expiration date printed on the vial if it is less than 30 days
   b. Ranges for the material will vary with each new lot and is established by the manufacturer
      1) Range values for the new lot of control material must be recorded on the log
      2) The new QC lot package insert must be retained in the QC logbook after the ranges are added to the QC log. The package insert will be retained minimum of 3 years

| | |
|---|---|
| SOP #: POCT 001-2021 | |
| Title: Urinalysis – Chemstrip 10 MD | |
| Scope: NIA/RHC Clinics, Perinatal, POCT | Department Section: Point-of-Care-Testing |
| Written/Authored By: POCT Coordinator | Date Implemented: 5/27/2021 |

c. Corrective Action
   1) Check expiration dates of strips and controls
   2) Ascertain that controls and strips have been stored correctly
   3) Open new control bottle or strip container
   4) Note problem on the QC log
   5) If further troubleshooting is needed, contact the laboratory POCT Coordinator or Assistant POCT Coordinator

**IX. REFERENCES**

1. Package Insert 2020-06 V 8.0

**XIII. DISTRIBUTION:**

1. NIA Internal Medicine Clinic
2. NIA Pediatrics and Allergy Clinic
3. NIA Specialty Clinic
4. NIHD Rural Health Clinic
5. NIHD Rural Health Women's Clinic
6. PACU (Post-Anesthesia-Care-Unit)
7. Perinatal Department
8. Point-of-Care-Testing Section

Revised: 5/2021

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL STANDARDIZED PROTOCOL**

| | | |
|---|---|---|
| Title: Standardized Protocol - General Policy for the Physician Assistant | | |
| Owner: MEDICAL STAFF DIRECTOR | Department: Medical Staff | |
| Scope: Physician Assistants | | |
| Date Last Modified: 08/27/2021 | Last Review Date: No Review Date | Version: 4 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 02/20/2019 | |

**PURPOSE:**

To outline the general policy for the development of standardized protocols and the evaluation of those authorized to perform the standardized protocol functions, as promulgated by the guidelines of the Medical Board of California and the Physician Assistant Board.

**DEFINITIONS:**

1. **Physician Assistant (PA)** is licensed by the State of California Department of Consumer Affairs and possesses preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards.

**POLICY:**

1. Development and Review of Standardized Protocols
    a. All Physician Assistant Protocols are developed collaboratively and approved by the Northern Inyo Healthcare District (NIHD) Interdisciplinary Practice Committee (IDPC) and must conform to guidelines as specified in Title 16, Chapter 7.7, section 3502.
    b. All Physician Assistant Protocols will be kept in a manual (either hardcopy or electronic) that includes date and signature of the Physician Assistant who is approved under the protocol and the Physician Supervisor(s).
    c. All Physician Assistant Protocols are to be reviewed biennially by the PA(s), Chiefs of Service, and by the IDPC. Standardized protocols will be updated as practice changes.
    d. All changes or additions to the Protocols are to be approved by the IDPC. All Protocols approved by the IDPC will be sent to the Medical Staff Executive Committee and, if so approved, to the NIHD Board of Directors.
2. Setting of Practice:
    a. Northern Inyo Healthcare District (NIHD) and affiliated locations, as appropriate for specialty.
3. Scope of Practice
    a. The PA may perform the following functions within his/her specialty area and consistent with their experience and credentialing: assessment, management, and treatment of episodic illness, chronic illness, contraception, and the common functions of health promotion, and general

evaluation of health status (including but not limited to ordering laboratory procedures, x-rays, and physical therapies as well as recommending diets, and referring to specialty services when indicated).

b. Protocol functions, such as prescribing medications, are to be performed at an approved setting of practice. Consulting Supervising Physician(s) will be available to the PA(s) in person, by electronic means or by phone.

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, supervising physician, or upon request of the PA.

d. Medical Records:
    i. Medical record entries by the PA shall include, for all problems addressed: the patients' statement of symptoms, the physical findings, results of special studies, the PA's assessment and management plan including further studies ordered, medication or procedures, information given patient and the names of any physicians consulted.
    ii. Each time a PA provides care for a patient and enters his or her name, signature, initials or computer code on a patient's record, chart or written order, the PA shall also enter the name of his or her supervising physician who is responsible for the patient (as specified in CA Code of Regulations 1399.546)

4. Qualifications and Evaluations

a. Each Physician Assistant performing PA Protocol functions must have a current California Physician Assistant license, be a graduate of an approved Physician Assistant program, and have current certification as a Physician Assistant by the California Physician Assistant Committee and the Department of Consumer Affairs.

b. Evaluation of PA's competence in performance of Protocol functions will be done in the following manner:
    i. Initial: Within the initial focused professional practice evaluation (FPPE) period the Supervising Physician(s) will evaluate performance via direct observation, consultations and chart review/co-signature and provide feedback to the interim PA. Input from other physicians and colleagues will be utilized. Recommendations to move from interim status to full status once the FPPE has been satisfactorily completed will be considered as per the Medical Staff OPPE/FPPE policy. Nurse Manager(s) along with the Medical Director(s) and Supervising Physician(s) will provide feedback utilizing performance evaluation based upon the PA job description.
    ii. Routine: frequency in accordance with the Medical Staff Ongoing Professional Practice Evaluation (OPPE) policy.
    iii. Follow-up: areas requiring increased proficiency, as determined by the initial or routine evaluation, will be reevaluated by the supervising physician(s) at appropriate intervals until acceptable skill level is achieved.

c. The scope of supervision for the performance of the functions referred to in this area shall include chart review as per the Delegation of Services Agreement.

d. Further requirements shall be regular continuing education in primary care or other relevant medical care, including reading of appropriate journals and new text books, attending conferences sponsored by hospitals, professional societies, and teaching institutions equaling 50 hours every 2 years, minimum.

i. A record of continuing education must be submitted to the Medical Staff Office every other year at re-credentialing.

5. Protocols
    a. The protocols developed for use by the Physician Assistant are designed to describe the steps of medical care for given patient situations.

**REFERENCES:**


1. UpToDate-evidence-based, Physician-authorized clinical decision support resource
2. Title 16, California Code of Regulations, Sections 1399.540, 1399.544, 1399.546
3. Laws and Regulations Relating to the Practice of Physician Assistants. Issued May 2018.
4. Title 16, California Code of Regulations, Chapter 7.7, Section 3502.


**ATTACHMENTS:**

1. List of Authorized Physician Assistants and Supervising Physicians

**RECORD RETENTION AND DESTRUCTION:**

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|---|
| Supersedes: v.3 Standardized Protocol - General Policy for the Physician Assistant |

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL STANDARDIZED PROCEDURE**

| | | |
|---|---|---|
| Title: Standardized Procedure - Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife | | |
| Owner: MEDICAL STAFF DIRECTOR | Department: Medical Staff | |
| Scope: Nurse Practitioner, Certified Nurse Midwife | | |
| Date Last Modified: 08/27/2021 | Last Review Date: No Review Date | Version: 4 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 02/20/2019 | |

**PURPOSE:**
This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to cover the management of drugs and devices for patients of all ages

**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. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.
3. The NP or CNM may initiate, alter, discontinue, and renew medication included on, but not limited to the formulary referenced in Appendix A. Schedule I medications are excluded. NPs and CNMs will be required to have a current "Furnishing Number" which has been obtained from the Board of Registered Nursing. All NP & CNM providers will be required to have a DEA certificate and will prescribe within the constraints of this certification.

**PROCEDURE:**
1. Database – Nursing Practice
    a. Subjective data information will include but is not limited to: Relevant health history to warrant the use of the drug or device, no allergic history specific to the drug or device, and no personal and/or family history which is an absolute contraindication to use the drug or device.
    b. Objective data information will include but is not limited to: Physical examination appropriate to warrant the use of the drug or device and laboratory tests or procedures to indicate/contraindicate use of drug or device if necessary.
    c. Assessment: Subjective and objective information consistent for the use of the drug or device. No absolute contraindications of the use of the drug or device.
2. Treatment – Common Nursing Functions
    a. Medications/devices furnished by the NP or CNM may be either over-the-counter or medications/devices requiring a prescription.
    b. Medications/devices may be furnished directly to the patient, or the patient's direct care giver, by the NP or CNM (section 2725.1 of the NPA).

c. Medications may be furnished by transmittal. The NP or CNM may write and sign "transmittal orders" of any prescription personally stated or written by the physician. This is in accordance with the Pharmacy Law, Business and Professions Code, Section 34021

d. Office samples may be dispensed per NIHD policy.
e. The drug or device will be appropriate to the condition being treated:
    i. Dosage will be in the effective range per formulary references
    ii. Not to exceed upper limit dosage per formulary references.
    iii. Indications or uses as specified by the formulary references.
    iv. No absolute contraindications of the use of the drug or device.

f. Medication history has been obtained including other medications being taken, medication allergies, and prior medications used for current condition.
g. All medications/devices furnished shall be documented in the patient's medical record. The effectiveness of the medication/device shall be documented in the patient's medical record.

3. Patient Education
    a. Provide the patient with information and counseling in regard to the drug or device. Caution the patient regarding potential side effects or complications with chosen drug or device. Document the education process in the medical record.
4. Physician consultation is to be obtained under the following circumstances:

    a. Non-responsiveness to appropriate therapy and/or unusual or unexpected side effects and as indicated in general policy statement.
    b. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
    c. Acute decompensation of patient situation.
    d. Problem which is not resolving as anticipated.
    e. History, physical, or lab finding inconsistent with the clinical picture.
    f. Upon request of patient, nurse, or supervising physician.

5. Documentation
    a. A current drug list will be maintained in the patient's record. All medications furnished, changes in medications, and renewals will be documented on this list.
    b. The name and furnishing number of the NP or CNM is written on the transmittal order.

**REFERENCES:**

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

**RECORD RETENTION AND DESTRUCTION:**

**APPENDIX A:**

FORMULARY SPECIFICATIONS for

Furnishing Medications/Devices Policy for the Nurse Practitioner/Physician Assistant

STANDARDIZED PROCEDURE/PROTOCOL

Formulary: Lexicomp drug database as accessed through UpToDate online reference, current as published and updated online.

Deletions: None.

## APPROVALS

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

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

1. _____ _____ NAME
DATE

2. _____ _____ NAME
DATE

3. _____ _____ NAME
DATE

4. _____ _____ NAME
DATE

5. _____ _____ NAME
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6. _____ _____ NAME
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7. _____ _____ NAME
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DATE

10. _____ _____ NAME
DATE

Supersedes: v.3 Standardized Procedure - Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL STANDARDIZED PROCEDURE**

| | | |
|---|---|---|
| Title: Standardized Procedure – Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife | | |
| Owner: MEDICAL STAFF DIRECTOR | Department: Medical Staff | |
| Scope: Nurse Practitioner, Certified Nurse Midwife | | |
| Date Last Modified: 08/27/2021 | Last Review Date: No Review Date | Version: 4 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 02/20/2019 | |

## 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 ordering of laboratory and diagnostic tests.

## 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. Laboratory and diagnostic tests may be ordered by the NP or CNM under the following conditions:
    a. As an appropriate adjunct to the determination of diagnosis.
    b. When necessary, to implement, monitor or adjust treatment.
3. Circumstances:
    a. Patient population: neonatal, pediatric, adult and geriatric patients – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

## PROCEDURE:

1. Conditions
    a. The following diagnostic tests can be initiated by the NP or CNM without prior consultation with M.D.:
        i. Any blood work
        ii. Urine: any urine test
        iii. Cultures: any culture
        iv. Radiologic/Sonographic: any radiologic/sonographic exam including CT scans and MRI examinations
        v. Audiometric testing/speech evaluation
        vi. Pregnancy Tests
        vii. Cardiac Testing
        viii. EEG

b. All other diagnostic tests will be ordered by the NP or CNM in consultation with the physician, including:
    i. When diagnostic test of choice is in doubt.

**REFERENCES:**

**RECORD RETENTION AND DESTRUCTION:**

## APPROVALS

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

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

1. _____ _____ NAME
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10. _____ _____ NAME
DATE

Supersedes: v.3 Standardized Procedure – Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL STANDARDIZED PROTOCOL**

| | | |
|---|---|---|
| Title: Standardized Protocol – Laboratory and Diagnostic Testing Policy for the Physician Assistant | | |
| Owner: MEDICAL STAFF DIRECTOR | Department: Medical Staff | |
| Scope: Physician Assistants | | |
| Date Last Modified: 08/27/2021 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 02/20/2019 | |

## PURPOSE:

This protocol is designed to establish guidelines that will allow the Physician Assistant (PA) to order laboratory and diagnostic tests.

## 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. Laboratory and diagnostic tests may be ordered by the PA under the following conditions:
    a. As an appropriate adjunct to the determination of diagnosis.
    b. When necessary, to implement, monitor or adjust treatment.
3. Circumstances:
    a. Patient population: neonatal, pediatric, adult and geriatric patients – as appropriate for specialty.
    b. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians as indicated in the Delegation of Services Agreement.

## PROTOCOL:

1. Conditions
    a. The following diagnostic tests can be initiated by the Physician Assistant Provider without prior consultation with supervising physician:
        i. Any blood work
        ii. Urine: any urine test
        iii. Cultures: any culture
        iv. Radiologic/Sonographic: any radiologic/sonographic exam including CT scans and MRI examinations
        v. Audiometric testing/speech evaluation
        vi. Pregnancy tests
        vii. Cardiac Testing
        viii. EEG

b. All other diagnostic tests will be ordered by the Physician Assistant in consultation with the physician including:
    i. When diagnostic test of choice is in doubt.

**REFERENCES:**

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

**ATTACHMENTS:**

1. List of Authorized Physician Assistants and Supervising Physicians

**RECORD RETENTION AND DESTRUCTION:**

| |
|---|
| Supersedes: v.2 Standardized Protocol – Laboratory and Diagnostic Testing Policy for the Physician Assistant |

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL STANDARDIZED PROTOCOL**

| | | |
|---|---|---|
| Title: Standardized Protocol – Medication/Device Policy for the Physician Assistant | | |
| Owner: MEDICAL STAFF DIRECTOR | Department: Medical Staff | |
| Scope: Physician Assistants | | |
| Date Last Modified: 08/27/2021 | Last Review Date: No Review Date | Version: 4 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 02/20/2019 | |

## PURPOSE:

This standardized protocol developed for use by the Physician Assistant (PA) is designed to cover the management of drugs and devices for patients of all ages.

## 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. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in Delegation of Services Agreement
3. The PA may initiate, alter, discontinue, and renew medication included on, but not limited to the formulary referenced in Appendix A. Schedule I medications are excluded. PAs will be required to have completed a controlled substances course. All PA providers will be required to have a DEA certificate and will prescribe within the constraints of this certification.

## PROTOCOL:

1. Data Base:
    a. Subjective data information will include but is not limited to: Relevant health history to warrant the use of the drug or device, no allergic history specific to the drug or device, and no personal and/or family history which is an absolute contraindication to use the drug or device.
    b. Objective data information will include but is not limited to: Physical examination appropriate to warrant the use of the drug or device and laboratory tests or procedures to indicate/contraindicate use of drug or device if necessary.
    c. Assessment: Subjective and objective information consistent for the use of the drug or device.
2. Treatment
    a. Physician assistants may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device per Business and Professions Code, Title 16, §3502.1.(a)

b. Medications/devices prescribed by the PA may be either over-the-counter or medications/devices requiring a prescription.
c. Medications/devices may be furnished directly to the patient, or the patient's direct care giver, by the PA.
d. Physician assistants may only prescribe medication/devices appropriate for use in the type of practice engaged in by the current supervising physician(s) defined in the Delegation of Services Agreement.(Business and Professions Code, Title 16, §3502.1(a)(2))
e. Office samples, when applicable, may be dispensed per NIHD policy.
f. The drug or device will be appropriate to the condition being treated:
    i. Dosage will be in the effective range per formulary references
    ii. Not to exceed upper limit dosage per formulary references.
    iii. Indications or uses as specified by the formulary references.
    iv. No absolute contraindications of the use of the drug or device.
g. Medication history has been obtained including other medications being taken, medication allergies, and prior medications used for current condition.
h. All medications/devices furnished shall be documented in the patient's medical record. The effectiveness of the medication/device shall also be documented in the patient's medical record.

3. Patient Education:
    a. Provide the patient with information and counseling in regard to the medication/device. Caution the patient regarding potential side effects or complications with chosen medication/device. Document the education process in the medical record.
4. Physician consultation is to be obtained under the following circumstances:
    a. Non-responsiveness to appropriate therapy and/or unusual or unexpected side effects and as indicated in general policy statement.
    b. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
    c. Acute decompensation of patient situation.
    d. Problem which is not resolving as anticipated.
    e. History, physical, or lab finding inconsistent with the clinical picture.
    f. Upon request of patient, nurse, or supervising physician.
5. Documentation
    a. A current drug list will be maintained in the patient's record. All medications furnished, changes in medications, and renewals will be documented on this list.
    b. The name and DEA of the PA is written on the transmittal order.

**REFERENCES:**

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

**ATTACHMENTS:**

1. List of Authorized Physician Assistants and Supervising Physicians

**RECORD RETENTION AND DESTRUCTION:**

**APPENDIX A:**

FORMULARY SPECIFICATIONS for

Furnishing Medications/Devices Policy for the Nurse Practitioner/Physician Assistant

STANDARDIZED PROCEDURE/PROTOCOL

Formulary: Lexicomp drug database as accessed through UpToDate online reference, current as published and updated online.

Deletions: None.

Supersedes: v.3 Standardized Protocol – Medication/Device Policy for the Physician Assistant

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL STANDARDIZED PROTOCOL**

| | | |
|---|---|---|
| Title: Standardized Protocol – Minor Surgical Policy for the Physician Assistant | | |
| Owner: MEDICAL STAFF DIRECTOR | Department: Medical Staff | |
| Scope: Physician Assistants | | |
| Date Last Modified: 08/27/2021 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 02/20/2019 | |

**PURPOSE:**

1. This standardized protocol is designed to establish guidelines that will allow the Physician Assistant (PA) to perform minor surgical procedures incidental to the provision of routine primary care to ambulatory patients of Northern Inyo Healthcare District and affiliated locations.

**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. Circumstances:
    a. Patient population: pediatric and adult patients
    b. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians as indicated in the Delegation of Services Agreement

**PROTOCOL:**

1. Conditions: after appropriate training and experience (which includes a minimum of 5 proctored procedures each by a supervising physician), minor procedures that can be performed by the PA without direct physician supervision include:
    a. Pessary placement
    b. Electrocautery of external, non-malignant, e.g. warts
    c. Epidermal cyst removal
    d. Incision and drainage of abscess (excluding peri-rectal abscesses)
    e. Suture laceration without nerve or tendon involvement
    f. Mole removal
    g. Punch or shave biopsy
    h. Toe nail removal
    i. Cryotherapy
    j. IUD insertion and removal
    k. Excision of simple lesions
    l. Simple foreign body removal
    m. Endometrial biopsy

n. Arthrocentesis/Steroid joint injection
o. Excision of hemorrhoid thrombus
p. Nexplanon insertion/removal
q. Circumcision of newborn
r. Urologic procedures, such as:
    i. Diagnostic cystoscopy
    ii. Difficult foley catheter placement
    iii. Prostate and bladder biopsies
    iv. Catheterizations
    v. Change of bladder tubes
    vi. Irrigation of bladder

2. Data Base:
    a. Subjective:
        i. Obtain pertinent history including involved organ system, injury, trauma, dermatology problems, etc.
        ii. Obtain information regarding review of system, risk taking behaviors, prior surgery, allergies, and immunizations.
    b. Objective:
        i. Perform physical examination pertinent to assessment of the problem.
        ii. Collect appropriate diagnostic/radiological studies.
3. Assessment:
    a. Formulate diagnosis consistent with the above data base.
    b. Document
4. Plan:
    a. Develop therapeutic regimen
        i. Perform appropriate procedure utilizing standard aseptic technique.
        ii. Obtain additional diagnostic studies as indicated.
        iii. Physician consultation/assistance in performing the procedure as per policy statement or above conditions.
        iv. Patient education and self-care techniques.
        v. Development of appropriate follow-up care plan.
        vi. Update problem list.
    b. Provide written discharge instructions to the patient.

**REFERENCES:**

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

**ATTACHMENTS:**

1. List of Authorized Physician Assistants and Supervising Physicians

Supersedes: v.2 Standardized Protocol – Minor Surgical Policy for the Physician Assistant

**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL STANDARDIZED PROCEDURE**

| | | |
|---|---|---|
| Title: Standardized Procedure – Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife | | |
| Owner: MEDICAL STAFF DIRECTOR | Department: Medical Staff | |
| Scope: Nurse Practitioner, Certified Nurse Midwife | | |
| Date Last Modified: 08/27/2021 | Last Review Date: No Review Date | Version: 4 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 02/20/2019 | |

**PURPOSE:**

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines that will allow the NP or CNM to manage minor surgical procedures.

**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. This standardized procedure is designed to establish guidelines that will allow NP and CNM to perform minor surgical procedures incidental to the provision of routine primary care to ambulatory patients presenting to the listed settings.
3. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

**PROCEDURE:**

1. Conditions
    a. After appropriate training and experience (which includes a minimum of 5 proctored procedures each by a supervising physician), minor surgical procedures that can be performed by the NP or CNM without direct physician supervision include:
        i. Pessary placement
        ii. Electrocautery of external, non-malignant lesions, e.g. warts
        iii. Epidermal cyst removal
        iv. Incision and drainage of abscess (excluding peri-rectal abscesses)
        v. Suture laceration without nerve or tendon involvement
        vi. Mole removal (non-facial)
        vii. Punch or shave biopsy
        viii. Toe nail removal
        ix. Cryotherapy
        x. IUD insertion and removal
        xi. Excision of simple lesions

xii. Simple foreign body removal
xiii. Endometrial biopsy
xiv. Arthrocentesis/Steroid joint injection
xv. Excision of hemorrhoid thrombus
xvi. Nexplanon insertion/removal
xvii. Circumcision of newborn

2. Data Base
    a. Subjective
        i. Obtain pertinent history including involved organ system, injury, trauma, dermatology problems, etc.
        ii. Obtain information regarding review of system, risk taking behaviors, prior surgery, allergies, and immunizations.
    b. Objective
        i. Perform physical examination pertinent to assessment of the problem.
        ii. Collect appropriate diagnostic/radiological studies.
    c. Assessment
        i. Formulate diagnosis consistent with the above data base.
    d. Plan
        i. Develop therapeutic regimen
        ii. Provide informed consent. Utilize universal protocol "Time Out" prior to all invasive procedures.
        iii. Perform appropriate procedure utilizing standard aseptic technique.
        iv. Obtain additional diagnostic studies as indicated.
        v. Physician consultation/assistance in performing the procedure as per policy statement or above conditions.
        vi. Patient education and self-care techniques.
        vii. Development of appropriate follow-up care plan.
        viii. Update problem list.

**REFERENCES:**

**RECORD RETENTION AND DESTRUCTION:**

| |
|---|
| Supersedes: v.3 Standardized Procedure – Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife |

## APPROVALS

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

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

1. _____ _____ NAME
DATE

2. _____ _____ NAME
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3. _____ _____ NAME
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**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL STANDARDIZED PROCEDURE**

| | | |
|---|---|---|
| Title: Standardized Procedure – Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife | | |
| Owner: MEDICAL STAFF DIRECTOR | Department: Medical Staff | |
| Scope: | | |
| Date Last Modified: 08/27/2021 | Last Review Date: No Review Date | Version: 4 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: | |

## PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines that will allow the NP or CNM to medically manage acute illness and conditions.

## 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. This standardized procedure covers the medical management of acute illness, allergies, symptomatic complaints, minor trauma and emergencies in children and adults in the ambulatory care setting.
3. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

## PROCEDURE:

1. Data Base
    a. Subjective:
        i. Historical information relevant to the acute illness.
        ii. Historical information regarding concurrent problems.
        iii. Historical information regarding relevant past medical problems.
        iv. Patient's/family's efforts to treat the illness/condition.
        v. History of allergic/adverse reactions to medications.
        vi. Status of patient's functional and instrumental abilities.
    b. Objective:
        i. Perform physical exam pertinent to presenting symptoms.
        ii. Evaluate severity of complaint (i.e., vital sign changes, level of consciousness, unusual or unexpected symptoms).
        iii. Order laboratory testing and diagnostic procedure as indicated.
    c. Assessment
        i. Diagnosis consistent with subjective and objective findings.

ii. Record data on appropriate areas on patient's chart.

d. Plan
   i. Medications as indicated (see *Furnishing of Medications/Devices Standardized Procedure*).
   ii. Order further diagnostic testing as indicated.
   iii. Patient education appropriate to acute illness and any procedures, diagnostic testing, or medications ordered.
   iv. Order/perform therapeutic procedures as appropriate.
   v. Order medical supplies and necessary equipment for treatment.
   vi. Consult with and/or refer to supervising M.D. for:
      1. Presence of unexpected or ambiguous historical, physical or diagnostic findings.
         a. Signs of sepsis/toxic patient.
         b. Alteration in level of consciousness (i.e., seizure, etc.).
         c. Emergency situations which may be life threatening.
         d. Any patient whose condition warrants hospitalization.
         e. Unresolving problems.
         f. Any needs of the NP or CNM requiring information/confirmation of management plans.
         g. Upon request of patient/family.
   vii. Refer as indicated to other services/specialties.
   viii. Follow-up as indicated.

**REFERENCES:**

**RECORD RETENTION AND DESTRUCTION:**

| |
|---|
| Supersedes: v.3 Standardized Procedure – Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife |

## APPROVALS

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

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

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NORTHERN INYO HEALTHCARE DISTRICT

*Improving our communities, one life at a time.*
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150 Pioneer Lane
Bishop, California 93514

(760) 873-5811

DATE: August 25, 2021

TO: Board of Director's
Northern Inyo Healthcare District

FROM: Kelli Davis, Interim Chief Executive Officer (CEO)

RE: Bi-Monthly Interim CEO Report– Northern Inyo Healthcare District

## REPORT DETAIL

### Employee & Physician Engagement Survey

Our Employee Engagement Survey highlighted the strong desire of our team for increased communication here at NIHD. Through discussions and feedback, implementation of key ways the Executive Team will begin sharing information on a regular basis has been identified. Two areas that have been rolled out include a "monthly email" and a "monthly Team Town Hall" as routine ways to reach our team members with information and new topic forums.

On August 23, 2021, the first version of "Chiefly Speaking" was sent to all employees and providers. The first monthly Town Hall, "The NIHD Strategic Plan Update" was held on August 26, 2021, with good participation and great feedback from the attendees on future topics they would like to see for monthly Town Hall Meetings. Information on the Chiefly Speaking and Town Hall are attached for your reading.

### COVID-19

NIHD continues to move forward with the implementation of required workflows and policies to meet the requirements for the CDPH "Health Care Worker Vaccine Requirement" Order issued on August 5, 2021. On August 26, 2021, the Executive Team sent a letter to the Director and State Public Health Officer for CDPH, Tomas J. Aragon, MD, DrPH, outlining the impacts NIHD is facing during this time and most notably, those that are escalating due in part to the mandate. Attached, please find a copy of this letter for your reading.

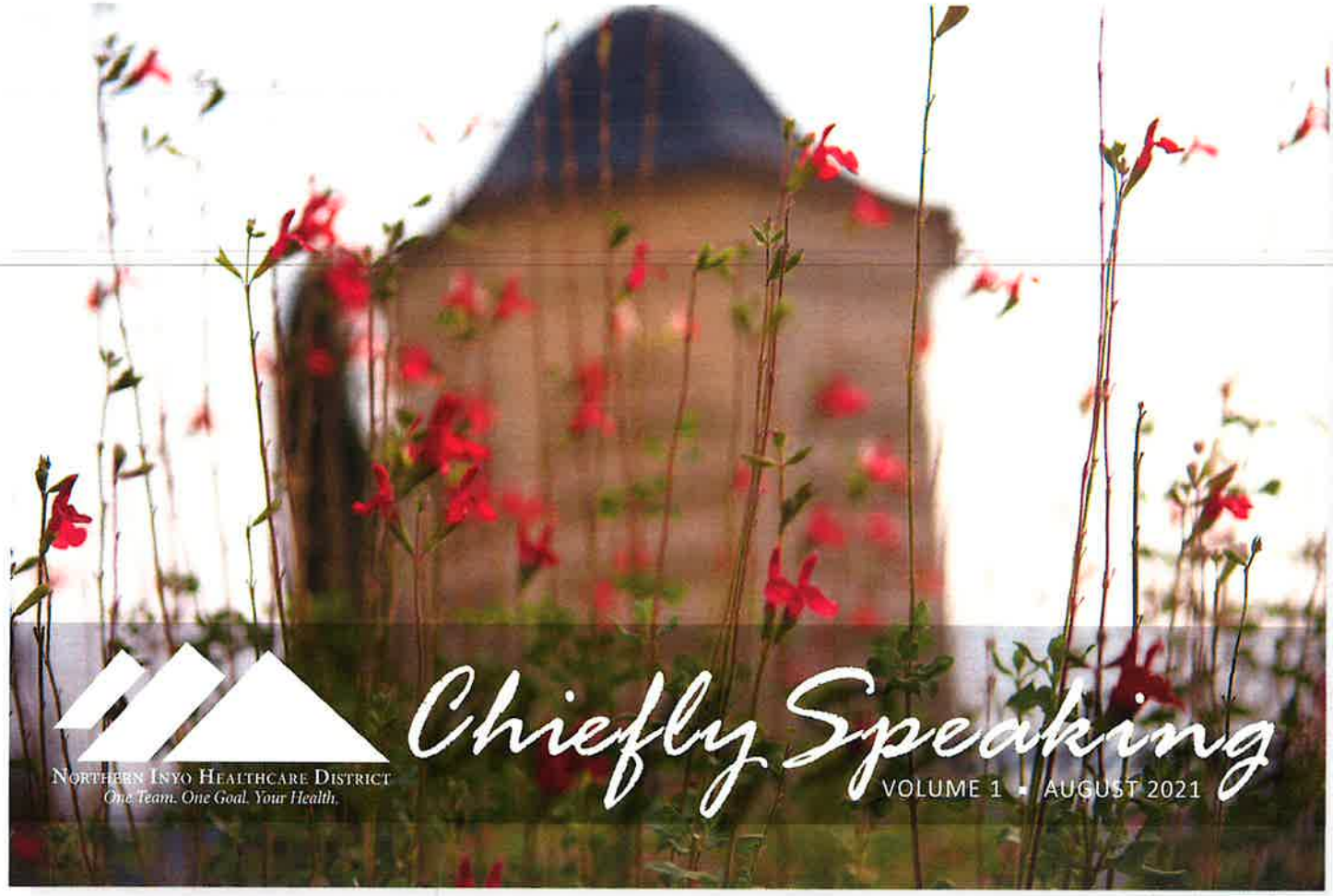
### Department Reports

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




## KELLI DAVIS MBA  INTERIM CHIEF EXECUTIVE OFFICER

Welcome to Chiefly Speaking, a periodic review by the District Executive Team of what is happening at Northern Inyo Healthcare District. With these reports, our goal is to keep staff aware of initiatives, efforts, and events that support our District's ongoing growth and improvement.

**You asked. We listened.**

In our recent Employee and Physician Engagement Survey, you told us you wanted more communication with the District's Chief Officers. In addition to this update, we will begin hosting monthly **Employee Town Halls** with the first set for **Thursday, Aug. 26, 12:30 to 1:30 PM** via Zoom. The topic of the day: An update on the newly adopted NIHD Strategic Plan. Then you will be allowed to ask the Chiefs any question you would like during a Q&A session. These Town Halls will be recorded and made available to all NIHD employees on the Intranet.

**Strategic Plan**

A few words about the NIHD Strategic Plan: Adopted in July by the Board of Directors, this document establishes the District's direction for the next three years. It outlines business and operational strategies the Board and Chiefs have prioritized for the District.

Every one of you will help us bring the plan to life. Your support and participation are critical to the success of this project. We encourage you to ask questions and get involved. Know where NIHD hopes to go in the next three

*Continued on Page 3*

## ALLISON PARTRIDGE MSN RN
CHIEF NURSING OFFICER

I would like to take a moment to recognize all our staff for the amazing effort they continue to put forth in combatting the COVID-19 pandemic. There is not a department in this healthcare organization that has not contributed to the efforts Northern Inyo Healthcare District has put forward. **The Executive Team sincerely appreciates the continued hard work**. It is an honor to serve alongside each of you.

We are working closely with Clinical Engineering on a **project to replace and update all of our defibrillators**. Our existing models reach end of service life and it was determined that newer models were better geared toward ease of use. The newer models also offered improved tools and feedback that would better promote positive outcomes.

In response to the **recent Physician and Employee Engagement Survey**, all Clinical leaders have met with their teams to receive feedback. They are now working to develop department-specific action plans. I greatly appreciate the feedback given in the survey and then openly in the meetings.

Many congratulations to **Brittney Cooper**, a Certified Nurse Assistant on the Acute/Subacute Floor, for being named **NIHD's Employee of the Month for August**. Brittney received her honor at the first Birthday Celebration we have held (outdoors) since the start of the Pandemic. She is shown here with her Department manager Justin Nott.

## JOY ENGBLADE MD MMM
CHIEF MEDICAL OFFICER

Thank you for reading this Internal Communication from the Executive Team. I'm grateful to be given the opportunity to represent NIHD as the Chief Medical Officer. Only starting this position in April 2021, I'm open to feedback about what kind of information the District employees would like to hear moving forward. Please email me with suggestions.

We have several new physicians starting in 2021, including **Dr. Jane Yoon**, Pediatrics; **Dr. Siyavash Fooladian**, Anesthesia; and, **Dr. David Coffman**, General Surgery. We are excited to welcome them to NIHD! Our Medical Staff Office continues to work hard on a new electronic credentialing system, provider enrollment with insurance providers, and ongoing physician recruitment. Remember, if you know of a physician who is interested in joining NIHD, please let the Medical Staff Office and myself know. You can also complete a "Finders Fee" form to possibly earn $2,000 with your referral. The form is on the Intranet (forms, Finders Fee Flyer).

From a pharmacy standpoint, I'm happy to announce that **Jeff Kneip**, PharmD, has assumed the role of Interim Pharmacy Director. Another change in the pharmacy includes transitioning our sterile compounding of hazardous drugs to Dwayne's Pharmacy as we continue on the pharmacy remodel. This only means that some medications that were previously compounded at NIHD will be compounded at Dwayne's. The medications will still be administered to our patients here at NIHD without change.

Our Quality Department continues to focus on Cerner workflows and education, starting a provider "Cerner Tip of the Week." We are also starting more education and focus on survey readiness. You may see folks from other departments in your areas, asking questions and observing your work. This is our team making sure we are ready for to have a great survey.

VINAY BEHL MS MBA CPA
CHIEF FINANCIAL OFFICER

Thank you for your interest in the financial health of the District. This report will cover highlights from the month of May, 2021.

**Revenue continues to be robust given strong inpatient days and outpatient visits.** May's inpatient days were 206 compared to budgeted of 144. Outpatient visits in May were 8,535 compared to 7,688 budgeted for the month.

**Salaries are in line with our budget** -- 34% to actual of 28% of net patient revenues. Our gross margins are considerably higher due to an Inter-Governmental transfer being recorded.

**Accounts Receivable continues with clean up efforts and contractuals and bad debt reserves are starting to stabalize.** Cash balances have stabilized due to good collections at $80 million year-to-date. AR days trending lower with increased collection efforts and a **new Revenue Cycle Director, Andrew McKie,** in place.

We recorded $4.4 million for Inter-governmental transfers in Fiscal Year 2020 revenues. We anticiapte recording $2.8 million for Inter-governmental transfers in Fiscal Year 2021 revenues in June.

**NIHD's Year-to-Date Net Income is $4.5 Million.**

## CEO Message

*Continued from page 1*

years and how it plans to get there. Please understand we cannot address everyone's deepest desires for the District at one time, but we can begin building a solid foundation for a better tomorrow.

### Diversity, Equity & Inclusion

I am proud to report that NIHD was one of five healthcare districts selected to participate in the Diversity, Equity, and Inclusion (DEI) pilot program, sponsored by the Association of California Healthcare Districts (ACHD). This program aims to bring healthcare districts together to learn about relevant diversity, equity, and inclusion topics specific to the five participating districts and the staff members they represent. The four other participating districts include Plumas District Hospital, Sequoia Healthcare District, Desert Healthcare District, and Fallbrook Health District.

Pamela Abner, MPA, will lead the program. Ms. Abner has more than 14 years of experience working to establish best practices and set strategic, innovative, and programmatic plans for diversity, equity, and inclusion in the healthcare industry. As a certified patient experience professional, a certified unconscious bias educator, and an inclusion trainer, Ms. Abner strives to develop and guide initiatives to create inclusive and culturally aware environments. She is the Vice President and Chief Diversity Operations officer for Mount Sinai Hospital Groups in New York.

Initial assessment sessions are underway, with much more to come.

### Of Fairs and Entertainment

NIHD is pleased to help sponsor the upcoming Eastern Sierra Tri-County Fair. Ours is a true country fair that shows off all that Inyo, Mono, and Alpine counties offer. The Fair boasts a wide array of hand and homemade exhibits for all tastes and interests, interesting commercial and educational exhibits, and tons of free entertainment, all for the price of admission. There are main arena events for the more adventurous, including a Wynonna Judd concert, a traditional rodeo, and the ever-popular destruction derby, which benefits the Bishop Volunteer Fire Department. Please watch for more information in coming days.

# Northern Inyo Healthcare District
# Workforce Town Hall
# August 26, 2021
# "The NIHD Strategic Plan" Update

# Agenda

- Welcome
- "NIHD 2021 – 2024 Strategic Plan" Overview
- Future Town Hall Topics
- Expanded Communication Venues
- Q&A Opportunity

Inspiration

# "Good communication is the bridge between confusion and clarity"

# Recognition

"The single biggest problem in communication is the illusion that it has taken place" George Bernard Shaw

# Responsibility

"Coming together is a beginning;
Keeping together is progress;
Working together is success" Henry Ford

# NIHD Mission Statement

## Improving our communities, one life at a time. One Team. One Goal. Your Health

# NIHD Vision

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

# Strategic Plan Basics

- What is a Strategic Plan?
  - A Board approved document used to define and communicate:
    - NIHD's goals
    - Actions/tasks needed to achieve those goals
- Why is Having a Strategic Plan Important?
  - Organizational Roadmap to:
    - Set priorities
    - Focus energy and resources
    - Strengthen operations
    - Ensure workforce and other stakeholders are working toward common goals
    - Outline agreements around intended outcomes/results
    - Assess and adjust NIHD's direction in response to an ever-changing environment

# NIHD's 3 Year Strategic Goals

## Pillars of Focus

- Financial
- People
- Service/Patient
- Growth
- Quality
- Community

# Financial Goals

- Implement transparent and compliant processes for meeting the annual approved budget
- Strengthen internal financial controls
- Develop/initiate a Capital Improvement Plan
- Continuous improvement of gross margins

# People (Workforce) Goals

- Improve workforce (employee and provider) satisfaction and engagement
- Solidify Executive (CEO, CFO, CMO & CNO) Leadership team

# Service/Patient Goals

- Increase outpatient satisfaction scores
- Optimize outpatient electronic health record (EHR) portal to increase patient engagement and access to care
- Improve continuity of care across regional and local health care entities
- Focus on health and wellness in our community
- Increase/improve clinic same day access to care for patients
- Re-open Bronco Clinic with sustainability plan in place

# Growth Goals

- Our Strategic Marketing team will promote everything NIHD
- Collaborate with community partners to implement and strengthen needed services locally so patients can stay close to home (health care needs)
- Invest in technology upgrades to our telehealth, online portal, and robotic systems
- Develop a 10-year plan (organizational) plan with annual review and actions steps for long range projects
- Utilize Return on Investment (ROI) Committee to analyze all new service line proposals

# Quality Goals

- Create quality metrics that are aligned with our mission, vision and strategic plan within every clinical department; provide visibility for public, workforce and Board of Director's
- Continue to focus on efficiency to optimize workflows
- Comply with 2030 seismic building requirements
- Finalize the Pharmacy project
- Promote and support District Workforce and Community Safety Program

# Community Goals

- Identify and strengthen community and regional partnerships both on an Administrative and a Board level
- Incorporate Auxiliary, Foundation and Pioneer Home Health Care into strategic planning

# Strategic Plan Conclusion, Q&A

- Current state
- Next steps
- Questions?

# Future Town Hall Topics/Structure

# Expanded Communication Venues for Our Team

- Department Meetings
- Monthly "Chiefly Speaking" Email to all Workforce
- Monthly Town Halls
- Talking Points
- Board Meeting Minutes
- Employee and Provider Engagement Survey 2021

# Let's Talk – Open Forum

# Thank You!

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**Northern Inyo Healthcare District**

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

August 26, 2021

Tomás J. Aragón, MD, DrPH
Director and State Public Health Officer
California Department of Public Health
P.O. Box, 997377, MS 0500
Sacramento, CA 95899-7377

Dear Director Aragón:

We write on behalf of the Northern Inyo Healthcare District "The District" regarding the "Health Care Worker Vaccine Requirement" Order issued by the California Department of Public Health ("CDPH") on August 5, 2021. The District recognizes the grave and unprecedented challenges posed by the COVID-19 pandemic, particularly in the context of healthcare. The District also acknowledges the critical value of increasing vaccination rates within California, and its mitigating impact on the risks posed by COVID-19. However, as the Executive team for the District, a rural healthcare system, we write to express the hardships and concerns posed by the August 5 Order for our employees as well as the community at large.

The District serves as the leading healthcare provider within our rural region. Many residents of this rural community lack options or access to alternatives to obtain healthcare. The pandemic forces many residents to travel significant distances to obtain healthcare services at the District. As with other acute care hospital facilities, the pandemic has also resulted in recurring shortages of available beds due to COVID-19-infected patients, causing strain on other healthcare services sought by members of our community.

The pandemic has already created strain on staffing levels, and continues to challenge the District's ability to continue providing the fully staffed healthcare services our community depends on. For example, since the inception of the pandemic in March 2020, the District has experienced recurring staffing shortages due to contact tracing and resulting self-quarantine and self-isolation. Cal/OSHA's COVID-19 prevention emergency temporary standards have also adversely impacted the District's ability to provide fully-staffed healthcare services. While these pandemic safety protocols serve a vital and critical function to lower infection and hospitalization rates within the local community, they continue to raise inevitable personnel staffing challenges for the District.

The August 5 CDPH Order exacerbates these challenges in several respects. The District has learned that a notable minority of valuable employees have expressed firm opposition to obtaining the COVID-19 vaccine. Many of these employees occupy central positions for directly providing healthcare services on hospital premises, duties which are not conducive to remote work. The previous Order issued by CDPH on July 26, 2021 provided the District with critical flexibility to ensure staffing levels could be maintained, by permitting unvaccinated employees to undergo weekly or biweekly testing. The August 5 Order eliminates this alternative, and likely will prevent the District's ability to maintain sufficient staffing levels.

Further, this "single-track" system results in a stark outcome for District employees — set aside objections and obtain the COVID-19 vaccine, or remain ineligible to work for the District. Given the proportion of staff voicing strident opposition, and the relatively short window for coming into compliance, the District faces the daunting prospect of losing critically-needed healthcare employees in less than five weeks. This staffing shortage will prevent the District from maintaining its current

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operations, and will deprive members of the public from receiving the full panoply of healthcare services upon which they rely.

The District faces few options if it loses significant staff due to the pressures of the CDPH vaccine mandate. The District operates in a rural and geographically-isolated location, with a relatively-low supply of potential workers possessing the skills, credentials, and experience needed to fill District positions. The COVID-19 pandemic also poses challenges for recruiting, training, and implementing new staff, particularly in the healthcare setting. These circumstances will make it particularly difficult for the District to persevere and resolve the imminent staffing challenges posed by CDPH's August 5 Order. The result will be closing entire departments at the District due to a lack of staffing options.

Finally, this mandate threatens to increase divisions among employees. I trust that the CDPH is acutely aware of the objections to the COVID-19 vaccine that have arisen across the state and country. Regardless of the merits of those objections, the District is responsible for ensuring that employee morale and anxieties do not interfere with the provision of healthcare service to patients and the community. To that end, the District strives to avoid taking any action that unnecessarily inflames the tensions within its workplace with respect to COVID-19 vaccines. As with the impact on staffing, I respectfully request that the Department take action to calm the tensions within healthcare provider workforces and provide employees the ongoing option to undergo testing in lieu of vaccination.

To be clear, we recognize the value of the COVID-19 vaccine, as well as the critical need to ensure both staff and patients remain safe from the persistent threat of the COVID-19 virus. The District has been committed to providing the highest quality healthcare for patients within the community throughout the COVID-19 pandemic. The District has endeavored to adapt to the evolving demands on healthcare services posed by the COVID-19 pandemic, and to ensure its operations remain calibrated to the latest standards, best practices, and science provided by public health authorities.

As a Healthcare District, our mission is to provide healthcare services to our rural community. The current Order threatens the ability of the District to ensure that it remains fully staffed and able to provide critical services. We urge the CDPH to reconsider its decision to remove critical alternative safety measures from its mandate. Please consider delaying the implementation of the vaccine mandate or permit unvaccinated healthcare workers to continue to undergo regular testing as an accommodation.

Respectfully,

Kelli Davis, MBA
Interim Chief Executive Officer

Allison Partridge, MSN, RN
Chief Nursing Officer

Joy Engblade, MD, MMM
Chief Medical Officer

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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 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Larry Weber, Director of Diagnostic Services

RE: Department Update

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## REPORT DETAIL

**NEW BUSINESS**

**Cardiopulmonary (CP):**

Cardiopulmonary is currently working to fill a vacant nightshift respiratory therapist position. Due to the position being vacant, many team members have been inconvenienced by having to back fill the scheduled shifts. The team has stepped up and accommodated the need without hesitation, a true indication of the team's commitment to the district and the community. With the rise in Covid cases and hospitalizations, the workload for the team is significantly increasing. Again, the team is successfully caring for all patients, regardless of the workload, and doing it with enthusiasm and positive energy.

On a fun note, the cardiopulmonary department is spearheading an initiative to bring fun and competition to NIHD. The cardiopulmonary department led by Casey Solomon, Austin Archer, and Morgan Nutting is organizing an NIHD kickball league for NIHD staff and families. The intent is to get departmental participation and develop a league / tournament or event that will allow us to get to know each other outside of work and create fun spirited competition within the district. More to come on this effort.

**Diagnostic Imaging (DI):**

As part of our employee engagement action planning, DI leadership has gained support from Executive leadership to relocate some key staff members within the DI department. The move of some of our employees ultimately allows for DI technical staff to have access to more desktop computers, which they feel is important in the delivery of high quality care for our DI patients. Currently DI technologists are using tablets to review patient exam orders and prior studies. The tablets do not allow for complete visualization of all pertinent information and requires the staff to "scroll" to find the information. The use of desktop computers allows for complete visualization of all necessary data that allows for quicker review of information and the completion of the study. This was listed as a top priority for the team and was listed as a need under the category of having the tools and equipment to do their job. Many other efforts are being made to increase our staff's perception of how valued they feel by leadership and all are

expected to have a positive impact to our employee engagement scores within the DI department. The DI department is happy to report that we successfully renewed our ACR accreditation for our breast imaging program. This reaccreditation is clear evidence of the very high standard of care delivered by our Mammography and Breast Imaging Department.

**Laboratory Services (the Lab):**
Work continues within Laboratory Services relative to updating our standard operating procedures within the lab. Countless hours by multiple individuals have been committed to this effort and it is expected that the work will require a minimum of 6 months to complete. The process of updating the SOP's is critical work for medical laboratory services as all work completed within the lab must be completed in a standard fashion to ensure the reliability of testing results. The SOP updates are critical to our accreditation readiness requirements and will be instrumental in the successful accreditation process conducted by the Joint Commission.

**OLD BUSINESS**
**Cardiopulmonary:**
No old business to report for Cardiopulmonary

**Diagnostic Imaging:**
No old business to report on for Diagnostic Imaging

**Laboratory Services:**
No old business to report on for the Lab

.

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150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: September 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Bryan Harper, Director of ITS/CISO

RE: Department Update

---

## REPORT DETAIL

**NEW BUSINESS**
Service Desk staff continue working on hardware upgrades and patches.

The technical team is in the process of a large VMware Platform upgrade.

Internal Security Pre-Penetration testing has started. Quotes from three vendors have been received and selection will happen first week in Sept and the 3rd party testing to begin Oct/Nov timeframe.

The team is currently testing the secure in house messaging platform.

The ITS team has rolled out SSON with 2FA which will meet the requirements to obtain and keep Cyber security insurance going forward.

Clinical Engineering has completed all tasks associated with Cerner implementation. We are in the process of going live with Worxhub, our new medical equipment maintenance software. We are also currently working on a district wide defibrillator replacement project. In addition, we are in the process of scoping for larger district-wide projects such as the OR floor replacement.

**OLD BUSINESS**
ITS is adding new SHA 256 certs to all servers (replacing all outdated SHA1).

Multiple smaller projects and housekeeping items complete.

Clinical Engineering has had a successful launch for integration with Cerner for Patient Monitors, Fetal Monitors, EKG, Anesthesia, and OR Integration. Internal Medicine Efficiency project is now complete pending some minor remodels. Bronco Clinic and Pediatric are on the Horizon for new equipment installs.

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150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811

DATE: September 2021

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 were fairly quiet for the Foundation, as the Board went dark for its July meeting and held our regularly scheduled August meeting still over Zoom. The Foundation Board approved some funding in August for a project that was started back in 2018, the Steris Clarity (now Steris Hexavue) system. This software if for capturing images in the OR and imports them directly to the patient's medical record. The total cost of this system is being split between the Foundation and the Auxiliary, with the Foundation contributing $32,000 and the Auxiliary $25,000.

## GRANT WRITING

On the Grant Writing side, the District is pursuing some reimbursement funding through HRSA's new DATA 2000 Waiver Training Payment Program. They are providing $3,000 to RHCs for any practitioner who received their X-waiver to treat opioid abuse patients after January of 2019. At this time, only Dr. Brown received his waiver within their funding window.

Administration and maintenance for our current grants is ongoing. There were no new grants that were under consideration or being applied for during this period.

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150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: September 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Andrew McKie, Interim Director of Revenue Cycle

RE: Department Update

---

## REPORT DETAIL

**NEW BUSINESS**
Month End Financials:
Charges - $15,334,670.00 (July)
A/R - $41,014,867.00

MTD Financials:
Charges – $12,310,506.00 (August)
A/R - $38,848,415.00

Staffing Up-date:
Helen Zurek's last day with NIHD was August 16th
We are currently looking to hire a new HIM Manager

Hired two new staff to work in Credit & Billing Department with a focus to process charity applications

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150 Pioneer Lane
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DATE: September 2021

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 GPO (Group Purchasing Organization) transition. We are compiling data for analysis to determine contract compliance rate.

GHX EDI integration has begun. IT continues has completed set up on the back end, purchasing staff is training and will be testing system through October.

**OLD BUSINESS**

Purchasing will wrap up Cerner item master cleanup, continue GPO transition, and begin pre-work with GHX for EDI integration with Cerner.

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*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 2021

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:**

Working very closely with the OSHPD Fire Life Safety Officer to complete the final items to close out this project. OSHPD agreed on 8/24/21 to perform an expedited review of the Pharmacy and Infusion remodel plans. We had to have a contractor on board which we do (Colombo Construction), and our design team had to agree to turn all of their comments around in two weeks, which they can. This is good news.

Ping and Associates Architectural firm is preparing OSHPD documents for the Omnicell replacement project.

**Old Business:**

Work continues on the chiller plant upgrade. Contract signed documents submitted to OSHPD. We will continue to push as hard and fast as we can on this project so that we can get the temporary chiller returned.

Work is almost complete on the building maintenance program. Access points for this system are being installed at key points in the plant system is up and running.

**Temp Chiller:**

Received our building permit from OSHPD 8/24/21.

**SECURITY**

**New Business:**

Security is running smoothly we hired two new Security Officers; Patrick Powell and Patrick Olson.

**Old Business:**

Security is currently operating with 5 officers. Security is onsite Sunday – Thursday 600p-330a Friday and Saturday noon-400a.

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150 Pioneer Lane
Bishop, California 93514

(760) 873-5811

DATE: September 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Rich Miears, Manager of Environmental Services & Laundry

RE: Department Update

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# REPORT DETAIL

## ENVIRONMENTAL SERVICES

The Environmental Service 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 24 fulltime employees in ES with one vacant spot to fill.

## LAUNDRY

The Laundry team operates Monday –Friday from 500am to 1530pm. We currently have 5 employees with one staff member out on LOA that stagger starts thru the day. No issues with our chemical line. All equipment is working well. Our staff is doing great.

## OTHER INFORMATION

Talent Pool: Talent Pool is currently staffed with 2 employees and 8 spots to fill. We received 2 applicants in ADP since the end of April, 2021. We are trying to use Sierra Employment to help fill in spots, but no luck so far.

Screeners: We have 4 temporary screeners and 2 back up screeners with no vacant spots to fill from Sierra Employment. The Screeners cover Radiology 5 days per week, Main and the ED entrance 7 days per week. We have 2 new back –up screeners and 2 Fulltime screeners coming 9/7/2021. Our Screeners all are really nice and do a great job!

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150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: September 2021

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Interim CEO Board Report
Lynda Vance, Manager of Project Management

RE: Department Update

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## REPORT DETAIL

**NEW BUSINESS**

**Manager of Project Management:** I have transitioned into a Manager position at NIHD. I am excited to have the opportunity to grow more in my career and as a person. I am currently working with human resources to formulate a new position to help in the project management office.

**Cerner Project:** Final items on the Cerner project are being completed to close out the implementation phase and move to a maintenance phase. The Revenue and HIMS teams have continued to work through challenges.

**Project Process updates:** Continuing working on streamlining project processes, tracking, and reporting has been happening. An updated Project Priority Matrix is in the works with the InfoShare team and the executives. It is great to see processes maturing at NIHD to ensure we keep improving.

**Projects** *(this is a summary of the high-level work, not a complete list)*

**Discovery – 12** (DI Staff office update, Supply requisition Challenges, EcoLab Sanitizer, Hematology Analyzer, Onboarding Workflow Efficiency, Myla Lab/Micro Middleware, FEEs system, Defibrillator Replacement, City of Hope Telehealth, BDM Interface Cerner project, Phlebotomy draw area update, Omnicell Cabinets).

**Actively Working – 20** (Imprivata SSO, HIMS desk ergonomic update, Kitchen Update, HCIQ and Valify GPO CHC Project, Report Governance Committee, GHX, MAT Grant Project, Smartsheet upgrade for PHI compliance, InQdocs Subscription Service, State Mandate Tracking, Scanning-clinic efficiency, i2i with athena, i2i with Cerner, Bronco Clinic Restart, Experian Pricing transparency, OneContent Centricity upload, OneContent athena upload, Internal Med Office update, Central Registration office updates, OR Flooring)

**Closing – 8** (Ortho Clinic Provider office update, LRV (CPN Viewer), PPM Upgrade policy manager Navex, Reference Lab price updates, Cerner (EHR), Cerner Project outside Wipfli Scope, X-HIS Care Portal Users, ADP to Replace Kronos Time areas)

**Moves Completed - 4** (Compliance office desk update, Ancillary Specialist, Auth and Ref Clinics, RHC front Office)

**On Hold Projects - 6** (Additional Ortho Services, Logisticare/Modivcare Transport, Surgery/ PACU office changes, SAP Concur, Door Access Badge standard workflow, Employee Health Management System)

**Northern Inyo Healthcare District**

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

Date: 8/24/21

To: Board of Directors

From: Joy Engblade, MD, MMM, FACP, Chief Medical Officer

Re: Bi-Monthly CMO report

**Medical Staff Department update**

We are excited to be welcoming 2 new Urologists to NIHD; Dr. George Chiang from San Diego and Dr. Milan Shah from Los Angeles. They will both be coming to Bishop once monthly, offering us every other week coverage starting in mid-October. They will be working with a nurse practitioner, Bridget Miranda who also comes from San Diego. Our clinic and OR teams have met with the new team and we are looking forward to working with all of them.

**Pharmacy Department update**

We continue to work with Dwayne's Pharmacy to transition our hazardous drug sterile compounding to Dwayne's. This is planned to start in early September.

The Antibiotic stewardship committee and the Pharmacy department have been working closely with ID Connect, a consulting company out of Pittsburg who are helping us with antibiotic stewardship initiatives. We've had several meetings that have been very informative and educational.

Jeff Kneip continues to serve as the Interim Pharmacy Director. We have had several candidates apply to the Pharmacy Director position and will be conducting Zoom and/or in-person interviews over the next few weeks.

**Quality Department update**

Several employees across the District completed 3 days of Report Writing training. This training was hosted by Cerner and will give us local expertise when pulling data out of our new EMR. We have created a Report Writing Governance structure to ensure that no duplicate work is done and that reports are created and vetted in an organized way.
Quality continues to work diligently to submit data to the multiple regulatory agencies and are working to create a dashboard with the data, so the information can be shared throughout the District.

**Covid 19**

We continue to have weekly Incident Command meetings and recently, we have been having twice weekly State Mandate meetings, to ensure we are creating processes to comply with the multiple state mandates. We continue to encourage everyone to get Covid 19 vaccinated. We have also been in discussions with the County regarding the possibility of Booster shots, likely to be made widely available with mass vaccination events.

At our last Board meeting, we heard from employees and community members about their concerns with the vaccination mandate, due to take effect October 1st. We, as an executive team continue to do our due diligence to comply with the state mandates, as well as advocate for our employees and our community. The Executive team has crafted a letter to CDPH and this letter will be made available to those who wish to review it.

**Physician Compensation**

I continue to meet with each department at the District to discuss pros and cons of different compensation models and how they will effect each physician and their practice. With the new Report Writing Governance structure, I will be requesting monthly reports for physician productivity and quality metrics to be shared with each physician.

**Employee Engagement**

The Executive team has been working with each of our areas regarding the results of the Employee Engagement Survey, completed in November – December 2020. Most of the feedback we have been getting is around improved communication. We will be starting a monthly newsletter from the Chiefs as well as a Town Hall Meeting. We look forward to improving our communication and getting feedback from employees and providers about these two forums.

**Cerner Transition**

We continue to learn about Cerner, our new EMR. We are still challenged with data transfer from Athena to Cerner but we are excited about our report writing ability. We continue to revise processes and workflows. Again, thanks for being patient with us during our journey.

**Policies for Board Approval**
September, 2021

The following policies have been approved through all appropriate committees and are ready for Board approval:

**Policy Title**

- Non-Retaliation Policy
- Pricing Transparency Policy
- Auditing of Workforce Access to Confidential Information
- Business Associate Agreements Execution and Management
- False Claims Act Employee Training and Prevention Policy
- Safe Patient Handling – Minimal Lift Program
- Warming Cabinet for Blankets/Solutions
- Return to Work Following Illness
- Compliance Program for Northern Inyo Healthcare District
- Subpoena and Legal Summons for Workforce

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**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Non-Retaliation Policy | | |
| Owner: Compliance Officer | Department: Compliance | |
| Scope: District Wide | | |
| Date Last Modified: 08/06/2021 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 02/01/2016 | |

**PURPOSE:**
To provide an effective process for Northern Inyo Healthcare District (NIHD) employees to express problems, concerns or opinions without fear of retaliation or retribution.

**POLICY:**
It is the policy of NIHD to provide and maintain a culture characterized by integrity, responsible behavior and a commitment to the highest legal and ethical standards. NIHD prohibits the taking of any retaliatory action for reporting or inquiring about alleged improper or wrongful activity.

**DEFINITIONS:**
Retaliation: means an adverse action taken against an employee for filing a complaint or supporting another employee's complaint under a variety of laws.

Retribution: means the act of taking revenge.

Good Faith: means honesty; a sincere intention to deal fairly with others.

**ENCOURAGEMENT OF REPORTING**

1. NIHD managers and staff are encouraged to report in good faith all information regarding alleged improper or wrongful activity that may constitute:
   a. Discrimination or harassment;
   b. Fraud;
   c. Unethical or unprofessional business conduct;
   d. Non-compliance with NIHD policies/procedures;
   e. Circumstances of substantial, specific or imminent danger to an employee or the public's health and/or safety;
   f. Violations of local, state or federal laws and regulations; or
   g. Other illegal or improper practices or policies.

**PROTECTION FROM RETALIATION**
Any NIHD staff member who, in good faith, reports such incidents as described above will be protected from retaliation, threats of retaliation, discharge, or other discrimination including but not limited to discrimination in compensation or terms and conditions of employment that are directly related to the disclosure of such information. In addition, no employee may be adversely affected because they refused to carry out a directive which constitutes fraud or is a violation of local, state, federal or other applicable laws and regulations.

**REPORTING PROCEDURE:**

NIHD employees should timely report evidence of alleged improper activity as described above by contacting their immediate supervisor, department director, or senior manager. Any instances of alleged retaliation or retribution should be reported in the same manner. If an employee is not satisfied with the response they receive, or is uncomfortable for any reason addressing such concerns to one of these individuals, the employee may contact the Compliance Office or Human Relations Office. For employees who do not wish to address these issues through the reporting process outlined above, the Compliance Confidential Report Line resource is available at (888)200-9764.

All reports will be handled as promptly and discreetly as possible, with facts made available only to those who need to know to investigate and resolve the matter.

**REFERENCES:**

1. Federal Sentencing Guidelines for Organizations, Guidelines Manual Section 8B2.1(b)(5)(C)
2. NIHD Code of Business Ethics and Conduct
3. HIPAA Administrative Simplification: Enforcement; Final Rule (45 CFR 160.316)

**RECORD RETENTION AND DESTRUCTION:**

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Compliance Program for Northern Inyo Healthcare District
2. Employee Written Formal Complaint Form
3. Equal Employment Opportunity Procedure
4. NIHD Code of Business Ethics and Conduct
5. Practitioner Complaint Resolution Process
6. Professional Conduct, Prohibition or Discriminatory Behavior
7. Harassment by Employees
8. Workplace investigations

| |
|---|
| Supersedes: v.2 Non-Retaliation Policy |

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**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Pricing Transparency Policy | | |
| Owner: Director of Revenue Cycle | Department: Business Office | |
| Scope: Compliance, Fiscal Department | | |
| Date Last Modified: 08/06/2021 | Last Review Date: 08/18/2021 | Version: 1 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: | |

## PURPOSE:

To ensure that Northern Inyo Healthcare District (NIHD) complies with CMS's final rule regarding Price Transparency.

## POLICY:

The Public Health Services Act, Section 2718(e), requires that all hospitals make public a record of gross charges and negotiated rates for all services in the hospital Charge Master Description, as well as a listing of Shoppable Services effective 01/01/2021. The information posted online is in a machine-readable format and in a layout that is easily accessible to a patient without the need for the patient to be identified by a login or establishing an account.

Additionally, a consumer-friendly list of 300 types of standard charges for a limited set of "shoppable services" is required to be posted allowing consumers to compare services across the healthcare setting.

## DEFINITIONS:

1. Public Health Services Act, Section 2718(e): "Bringing Down the Cost of Healthcare Coverage ", was enacted as part of the Affordable Care Act.
2. Northern Inyo Healthcare District (NIHD).
3. Hospital: "An institution in any State in which State or applicable local law provides for the licensing of hospitals and that is: 1) licensed as a hospital pursuant to such law; or 2) approved, by the agency of such State or locality responsible for licensing hospitals, as meeting the standards established for such licensing".
4. Items and Services: Items and services are "all amenities, including individual items and services and/or service packages that could be provided by a hospital to a patient in connection with an Inpatient admission or an Outpatient Department visit for which the hospital has established a standard charge".
5. Third-Party Payer: An "entity that is, by statute, contract or agreement, legally responsible for payment of a claim for a healthcare item or service".
6. Standard Charge: "The regular rate established by the hospital for an item or service provided to a specific group of paying patients".
7. Gross Charges: The amount listed in the hospital's charge master as the charge for an item or service without any discounts.
8. Payer Specific Negotiated Rates: The amount negotiated by the hospital with a specific third party payer for an item or service.

9. Discounted Cash Price: The discounted amount charged to an uninsured patient or to an insured patient who waives their insurance benefits and is treated as self-pay.
10. De-identified Minimum Negotiated Charge: Across all third-party payers, the lowest negotiated amount for an item or service.
11. De-identified Maximum Negotiated Charge: Across all third-party payers, the highest negotiated amount for an item or service.
12. Shoppable Service: A service that can be scheduled by a healthcare consumer in advance and can be a group of related services, when ancillary services are provided alongside the main or primary service.
13. Ancillary Service: An item or service a hospital customarily provides as part of or in conjunction with a shoppable primary service.
14. Charge Description Master (CDM): A tool or listing of codes and prices for hospital (In and Outpatient) providers to communicate medical services to payers and patients.
15. Centers for Medicare and Medicaid Services (CMS): The agency within the U.S. Department of Health and Human Services (HHS) that administers the nation's major healthcare programs.
16. Current Procedural Terminology (CPT): A medical code set used to report medical, surgical and diagnostic procedures and services for physicians, insurance companies and accreditation organizations. The American Medical Association annually publishes the "Physicians' Current Procedural Terminology", or CPT manuals.
17. Fee Schedule: A comprehensive listing of the 'Usual and Customary' fees a physician or group of physician's charge for their services. All of the clinic charges at NIHD live in a Fee Schedule.
18. Centers for Medicare & Medicaid Services (CMS): The agency within the U.S. Department of Health and Human Services (HHS) that administers the nation's major healthcare programs

**PROCEDURE:**

1. Charge Master Requirements
   (a) Machine-Readable Elements
      (i) Description of each item or service
      (ii) List of all standard charges including
         a. Gross charges
         b. Payer-specific negotiated charges
         c. Discounted cash price
         d. Minimum and maximum negotiated charges
      (iii) All codes used by the hospital for purposes of accounting or billing for the item or service
   (b) Format
      (i) Published in a machine-readable file or digital representation of data or information that can be imported or read into a computer system for further processing
      (ii) The information must be available in a single digital file that is of a specific file type; i.e., .XML,. JSON, and .CSV
   (c) Location and accessibility
      (i) The file is displayed prominently and is clearly identifiable on the hospital website using a CMS-specified naming convention
      (ii) The information is easily accessible, without barriers, including that it is accessible free of charge, does not require the user to establish an account, is password free and no personal identifying information is required
      (iii) The file is digitally searchable
      (iv) All information in the file is updated at least annually and clearly displays the last date the file was updated

2. Shoppable Service Requirements
   (a) A display of payer-specific negotiated charges, de-identified minimum and maximum negotiated charges, and discounted cash prices are shown on the hospital website for 300 shoppable services.
      (i) 70 'shoppable services' have been identified by CMS
      (ii) 230 'shoppable services' have been identified by NIHD
      (iii) For every 'shoppable service' of the CMS listing that NIHD does not provide, an additional service must be identified and added to the list, making the posted number 300
      (iv) In the case that the district does not have 300 services to display, then all services within the District must be listed
      (v) The list of 'shoppable services' selected for display by the hospital should include services commonly provided to the hospital's patient population
      (vi) A plain-language description will be used along with all primary codes used by the hospital for proposed accounting or billing
      (vii) A list or groupings of primary 'shoppable services' will include the addition of all ancillary services associated with the procedure, are to be displayed
      (viii) A record of where the 'shoppable service' is provided, Inpatient or Outpatient

   (b) Format
      (i) NIHD has the discretion of format for making public the customer-friendly information
      (ii) The file is displayed prominently and is clearly identifiable on the hospital website using a CMS-specified naming convention
      (iii) The information is easily accessible, without barriers, including that the file is accessible free of charge, does not require the user to establish an account, is password free and no personal identifying information is required
      (iv) The file is digitally searchable
      (v) The file is updated at least annually and clearly displays the last date the file was updated

3. Compliance
   (a) NIHD will meet the requirements of Public Health Services Act, Section 2718(e) by making public standard charges and 'shoppable services for 300 services and, by maintaining an internet-based price estimator tool that can:
      (i) Run estimates for all 300 identified shoppable services
      (ii) Has the information displayed on the hospital's website
      (iii) Is accessible to public without a charge and without needing to register with an account or password
      (iv) Allows consumer access at all times

**REFERENCES:**


1. Healthcare Business Insights, Price Transparency Requirements for 2021, 2019.
2. Healthcare Financial Management Association, Negotiated Rate Posting Requirement CY 2020 OPPS Proposed Rule
3. CMS Medicare Learning Network, CY 2020 Hospital OPPS Policy Changes: Hospital Transparency Requirements, 12/3/2019


**RECORD RETENTION AND DESTRUCTION:**

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Billing for Rehabilitation Services
2. Charge Capture Policy & Procedure
3. Charge Master Procedure for Clinics
4. Charity Care Program
5. COVID Vaccination Financial Policy
6. Outpatient Infusion Charge Description
7. Prompt Pay Discounts
8. Surgery Charges
9. Use off Hospital Issued Notice of Noncoverage (HINN)

| Supersedes: N/A |
|---|

NORTHERN INYO HEALTHCARE DISTRICT
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**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY AND PROCEDURE**

| Title: Auditing of Workforce Access to Confidential Information | | |
|---|---|---|
| Owner: Compliance Officer | Department: Compliance | |
| Scope: Compliance | | |
| Date Last Modified: 08/06/2021 | Last Review Date: No Review Date | Version: 4 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 12/10/2013 | |

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

**Definitions:**

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

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

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

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

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

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

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

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

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

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

**AUDIT TYPES:**

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

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

2. **Audits for Specific Cause –** A request to audit for cause may come from various sources including but not limited to:
    a. Administration
    b. Human Resources
    c. Department Director/Manager
    d. Board of Directors
    e. Quality Assurance/Performance Improvement (QAPI) professionals
    f. Security Officer
    g. Patient or representative
    h. Community member

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

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

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

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

**Audits Investigated and Evaluated**

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

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

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

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

**Audit Record Disposition and Retention**

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

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

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

**Availability and Retention of Documents**

1. Audit documents will be made available to appropriate workforce members, as needed for review, discussion, and appropriate corrective action per NIHD policy and any applicable MOU.
2. Audit documents will be made available to state and federal investigators upon request.
3. Audit documentation shall be maintained for no less than three (3) years.
4. Policy documents will be retained for no less than six (6) years from either the creation date or the last effective date, whichever is longer.

**REFERENCES:**

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

**RECORD RETENTION AND DESTRUCTION:**

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information
2. Minimum Necessary Access, Use and Disclosure of Protected Health Information
3. Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations
4. Workforce Access to His or Her Own Protected Health Information

| Supersedes: v.3 Auditing of Workforce Access to Confidential Information |
|---|

NORTHERN INYO HEALTHCARE DISTRICT
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**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Business Associate Agreements Execution and Management | | |
| Owner: Compliance Officer | Department: Compliance | |
| Scope: District Wide | | |
| Date Last Modified: 08/06/2021 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 12/16/2015 | |

## PURPOSE

To establish guidelines for Northern Inyo Healthcare District to identify those relationships which meet the HIPAA definition of a "business associate" and provide direction on the process by which a business associates agreement will be established.

## DEFINITIONS:

Business Associate (BA): an individual or entity, who is not a member of Northern Inyo Healthcare District's workforce, who performs functions or activities on behalf of, or provides services to, NIHD that involve access by the business associate to PHI

Business Associate Agreement (BAA): a written contract with the business associate that establishes specifically what the business associate has been engaged to do and requires the business associate to comply with the HIPAA Privacy and Security Rules' requirements to protect the privacy and security of protected health information

Covered Entity (CE): health plans, providers of health services, and clearinghouses that transmit any health information in electric form; for the purposes of this policy NIHD is a "provider" CE

Protected Health Information (PHI): information about health status, provision of health care, or payment for health care that is created or collected by a Covered Entity and can be linked to an individual (also called Individually Identifiable Health Information)

## POLICY:

1. Business Associate Agreements will be established with all Business Associates who create, receive, maintain, or transmit PHI on behalf of Northern Inyo Healthcare District.
2. BAAs will meet the applicable requirements of 45 CFR § 164.504(e).
3. BAAs will be revised and re-signed as laws and regulations governing BAAs are updated and implemented by the Federal Government.
4. Departments currently receiving services from the Business Associate will, in collaboration with the Privacy Officer, identify Business Associates.
5. The Privacy Officer or Chief Executive Officer may execute Business Associate Agreements.

## PROCEDURE:

1. For any new contractual agreements to be entered into by the District, District administration will ensure that the Compliance Department is notified to assess the need for a BAA.
2. The Compliance Department will send the BAA to the correct contact for the BA.

3. Once completed, the fully executed BAA will be maintained in the Contract Management Software by the Compliance Department.

**REFERENCES:**

1. 45 CFR § 164 Subpart E
2. 45 CFR § 164.502(e)(1)

**RECORD RETENTION AND DESTRUCTION:**

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Vendor Credentialing

| |
|---|
| Supersedes: v.2 Business Associate Agreements |

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**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY**

| | | |
|---|---|---|
| Title: False Claims Act Employee Training and Prevention Policy | | |
| Owner: Compliance Officer | Department: Compliance | |
| Scope: District Wide | | |
| Date Last Modified: 08/06/2021 | Last Review Date: No Review Date | Version: 4 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 01/14/2014 | |

## PURPOSE:

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

## POLICY:

1. The hospital will provide annual education to all hospital employees, contracted employees, medical staff, and directors on provisions of the State and Federal False Claims Acts (FCA) to comply with the requirements to understand the laws.
2. The hospital will teach all hospital employees (including Management), contracted employees, medical staff and directors detailed information about the False Claims Act established under sections 3729 through 3733 of title 31, administrative remedies for false claims and statements established under chapter 38 of title 31, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (Medi-Cal or Medicare).
3. Up-coding, coding maximization and coding not in compliance with the hospital's Coding Compliance Policy is strictly prohibited and will be prevented by training of coding personnel, requirement for reporting the "illegal, incompetent, or unethical acts of others", and oversight by the hospital's Billing, Coding, and Compliance Committee.
4. The Compliance Officer, Department managers, the Billing and Coding Compliance Committee, and the Director of Revenue Cycle of the hospital will oversee charging and billing practices. Any fraud, waste, or abuse will be prevented or immediately corrected by this oversight.
5. Employees will be given a compliance hotline number to report any suspected fraud, waste, or abuse. The hotline will be monitored by the Compliance Officer and any allegations of fraud, waste, and abuse will be investigated by the Compliance Officer.
6. Any hospital employees (including Management), contracted employees, medical staff or directors who become "qui tam" plaintiffs or report fraud, waste, or abuse (become whistleblowers) shall be protected from any and all retaliation or retribution by any hospital employee (including Management), contracted employee, medical staff or director. Such protection shall include immediate disciplinary action or sanction of the perpetrator of retaliation or retribution in addition to any remedies available under law.
7. Employee education and information available on the hospital intranet site pursuant to this policy shall include, but not be limited to the following facts.

a. The FCA establishes liability for any person who knowingly submits a false claim to the government or causes another to submit a false claim to the government or knowingly makes a false record or statement to get a false claim paid by the government. Section 3729(a)(1)(G) of the FCA is known as the reverse false claims section; it provides liability where one acts improperly – not to get money from the government, but to avoid having to pay money to the government. Section 3729(a)(1)(C) creates liability for those who conspire to violate the FCA.
b. The statute provides that one who is liable must pay a civil penalty of between $11,000 and $21,916 for each false claim (those amounts are adjusted from time to time; the current amounts are $11,000 to $21,916) and treble the amount of the government's damages. Where a person who has violated the FCA reports the violation to the government under certain conditions, the FCA provides that the person shall be liable for not less than double damages.
c. A person does not violate the False Claims Act by submitting a false claim to the government; to violate the FCA a person must have submitted, or caused the submission of, the false claim (or made a false statement or record) with knowledge of the falsity. In § 3729(b)(1), knowledge of false information is defined as being (1) actual knowledge, (2) deliberate ignorance of the truth or falsity of the information, or (3) reckless disregard of the truth or falsity of the information.
d. The FCA also defines what a claim is and says that it is a demand for money or property made directly to the Federal Government or to a contractor, grantee, or other recipient if the money is to be spent on the government's behalf, and if the Federal Government provides any of the money demanded or if the Federal Government will reimburse the contractor or grantee.
e. The FCA states that the statute does not apply to tax claims under the Internal Revenue Code.
f. The FCA allows private persons to file suit for violations of the FCA on behalf of the government (a "*qui tam*" action), and the person bringing the action is referred to as a "relator."
g. The *qui tam* provisions beginning at § 3730(b) of the FCA; § 3730(b)(1) state that a person may file a *qui tam* action. Section 3730(b)(2) provides that a *qui tam* complaint must be filed with the court under seal. The complaint and a written disclosure of all the relevant information known to the relator must be served on the U.S. Attorney for the judicial district where the *qui tam* was filed and on the Attorney General of the United States. The *qui tam* complaint is initially sealed for 60 days. The government is required to investigate the allegations in the complaint; if the government cannot complete its investigation in 60 days, it can seek extensions of the seal period while it continues its investigation. The government must then notify the court that it is proceeding with the action (generally referred to as "intervening" in the action) or declining to take over the action, in which case the relator can proceed with the action. If the government intervenes in the *qui tam* action it has the primary responsibility for prosecuting the action. § 3730(c)(1). It can dismiss the action, even over the objection of the relator, so long as the court gives the relator an opportunity for a hearing (§ 3730(c)(2)(A)) and it can settle the action even if the relator objects so long as the relator is given a hearing and the court determines that the settlement is fair. § 3730(c)(2)(B). If a relator seeks to settle or dismiss a *qui tam* action, it must obtain the consent of the government. § 3730(b)(1). When the case is proceeding, the government (§ 3730(c)(2)(C)) and the defendant (§ 3730(c)(2)(D)) can ask the court to limit the relator's participation in the litigation. d. Award to the relator If the government

intervenes in the *qui tam* action, the relator is entitled to receive between 15 and 25 percent of the amount recovered by the government through the *qui tam* action. If the government declines to intervene in the action, the relator's share is increased to 25 to 30 percent. Under certain circumstances, the relator's share may be reduced to no more than ten percent. If the relator planned and initiated the fraud, the court may reduce the award without limitation. The relator's share is paid to the relator by the government out of the payment received by the government from the defendant. If a *qui tam* action is successful, the relator also is entitled to legal fees and other expenses of the action by the defendant. All of these provisions are in § 3730(d) of the FCA. In §3730(c)(5), the FCA also provides that if the government chooses to obtain a recovery from the defendant in certain types of proceedings other than the relator's FCA suit, this is known as an alternate remedy and the relator is entitled to the same share of the recovery as if the recovery was obtained through the relator's FCA suit. The FCA provides several circumstances in which a relator cannot file or pursue a *qui tam* action:

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

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

**REFERENCE:**

**RECORD RETENTION AND DESTRUCTION:**

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Compliance Program for Northern Inyo Healthcare District
2. NIHD Code of Business Ethics and Conduct

Supersedes: v.3 False Claims Act Employee Training and Prevention Policy

NORTHERN INYO HEALTHCARE DISTRICT
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**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Safe Patient Handling – Minimal Lift Program | | |
| Owner: EMPLOYEE HEALTH INFECT PREV SPEC | Department: Employee Health | |
| Scope: Clinical Staff District Wide | | |
| Date Last Modified: 08/17/2021 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 10/01/2014 | |

## PURPOSE:

NIHD wants to ensure that patients are cared for safely, while maintaining a safe work environment for employees. This document describes the practices at NIHD to ensure employees use safe patient handling and movement techniques for patients in patient care areas.

## POLICY:

1. Patient care areas include all areas of the District where care and treatment of services are rendered directly to the District's patient population and include, but are not limited to Rural Health Clinics, Nursing Services, Diagnostic Imaging Services, Cardiopulmonary, NIA Clinics, Lab and Rehabilitation Services.
2. Direct patient care staff members in all patient care areas will assess all patient handling tasks in advance to determine the safest way to accomplish the tasks.
    a. Mechanical lift aids will be used as appropriate for the patient and all direct patient care employees are expected to assist each other in the execution of safe patient handling matters.
    b. District Leaders are required to ensure that employee have appropriate assistance in implementing this policy on a task by task basis and have trained their staff members on appropriate safe patient handling matters.
3. For patients admitted to the hospital, an RN will serve as the coordinator of care assessing the patient's mobility needs (functional screen in the nursing assessment) and identify in the Plan of Care, the level of assistance required and mechanical device usage.
    a. A referral will be generated to Rehabilitation Services based on the Functional Screen and/or physician order for additional patient assessment and care planning.
4. An inventory of mechanical device equipment for patient care areas will be maintained by the department management.
5. Staff training will be provided on the use of mechanical device equipment as appropriate to the position hired.
6. Mechanical lift devices are to be used on patients requiring assistance. Manual lifting without a mechanical lift device is discouraged.
    a. If some degree of lifting is unavailable, caregivers should seek assistance from other staff members and/or employ mechanical aids whenever possible.
7. Employees who do not utilize proper safe patient handling practices may be subject to corrective action.

In Approval

a. Discipline will not occur with respect to a health care worker who refuses to lift, reposition, or transfer a patient due to concerns about patient or worker safety or lack of equipment or trained lift personnel.

8. Any injury resulting from patient lifting or positioning, including strains, sprains, or any other muscular skeletal injury must be handled according to the Work related Accidents Policy.
9. If a patient is unable to assist the HCW with repositioning or transfers, then the lifting and moving of the patient will be done with minimum of two person assist with or without the use of an assistive device.
10. Transferring patients out of the unit on a gurney or bed to the Radiology Department will be done with a minimum of two-person assistance. If transferring a patient on a gurney, on a flat surface to any inpatient unit or PACU/OR is permissible for 1 person to transport a patient on a gurney.

**DEFINITIONS:**

1. Manual Lifting: Lifting, transferring, repositioning, and moving patients using a caregiver's body strength without the use of lifting equipment/aids that reduce forces on the worker's muscular skeletal structure.
2. Patient Handling Equipment and Aids: Equipment or aids used to decrease the risk of injury from patient handling activities and includes, but is not limited to the following:
    a. **Lifting Equipment** includes portable/floor-based designs and their accompanying slings that function to assist in lifting and transferring patients, ambulating patients, repositioning patients, and other patient handling tasks.
    b. **Lateral Transfer Devices** Provide assistance in moving patients horizontally from one surface to another (e.g., transfers from bed to stretcher).
    c. **Beds** that provide assistance with patient handling tasks such as lateral rotation therapy, transportation, percussion, bringing patients to sitting positions, etc.
    d. **Repositioning Aids** provide assistance in turning patients and pulling patients up to the head of the bed and up in chairs.
    e. **Equipment/bed/wheelchair transport assistive devices** assist caregivers in pushing heavy equipment.
    f. **Patient Handling Aids:** Non-mechanical equipment used to assist in the lift or transfer process. Examples include stand assist aids, sliding boards, and surface friction-reducing devices.
    g. **Powered Height-adjustable exam tables** assist in transfer of patients onto exam tables and in bringing patients to sitting position, and raise the table surface to a more ergonomically safe working level.
3. High Risk Patient Handling Tasks: Patient handling tasks that have a high risk of musculoskeletal injury for staff performing the tasks. These include but are not limited to transferring and lifting tasks, repositioning tasks, bathing patients in bed, making occupied beds, ambulating and dressing patients, turning patients in bed, tasks with long durations, standing for long periods of time bariatric, and other patient handling tasks.
4. Designated Health Care Worker: NIHD staff who have been specifically trained to handle patient lifts, repositioning, and transfers using patient transfer, repositioning, or lifting devices as appropriate for the specific patient. It means staff working together to accomplish these patient related tasks safely.

**PROCEDURE:**

A. Direct Patient Care Employee Responsibility
    1. Take responsibility for their own health and safety, as well as that of their co-workers and their patients during patient handling activities.
    2. Complete initial training and annual training as required.

a. Complete additional training to correct improper use/understanding of safe patient handling and movement.
b. Notify manager of need for re-training in the use of patient handling equipment and aids.

3. Assess patient for condition and ability to cooperate with transfer and appropriate level of patient assist.
   a. Identify and avoid hazardous manual patient handling and movement tasks whenever possible.
4. Use proper techniques, mechanical lifting devices, and other approved equipment and/or aids during performance of high risk patient handling tasks.
5. Promptly report to manager or shift supervisor any injury without fear of negative consequence.
6. Follow procedures for reporting patient handling equipment in need of repair.

B. RN Coordinator of Care Admitted Patients.
   1. To follow initial Nursing Admission Assessment Policy and Procedure.

C. Develop nursing care plan as recommended by EHR documentation for fall risk and mobility scores.
Management of Direct Patient Care Employees.
   1. Be educated and remain up-to-date in the use of mechanical lifts and transfer aids. Be aware of department worker's compensation costs and injury rates and continue to make efforts to reduce the number of incidents in all areas of responsibility.
   2. Through employee observation, documentation review and other means, make sure that all employees are assessing the patient prior to any movement and that all patient handling tasks are completed safely, using mechanical lifting devices and other approved handling aids.
   3. Department inventory of mechanical lifting devices/aids are available in proper working order, maintained regularly and stored readily accessible in the clinical areas.
      a. see Patient Lifting Handling Equipment/Aids per Department reference sheet
   4. Review orientation checklists to make sure that employees complete initial training; ensure employees demonstrate competency; provide re-training when employees are non-compliant with safe patient handling practices; maintain training records for a period of three years.
   5. Refer all staff reporting patient handling injuries to the Shift Supervisor and/or Emergency Department for immediate evaluation and treatment.

D. Rehabilitation Services
   1. Physical Therapy and/or designee will:
      a. Complete training of newly hired staff members on the use of the lift equipment/aids and assist with ongoing training for unit staff members. Provide reference materials with the information needed for troubleshooting.
      b. Training will include use of lifting deices and equipment to handle patient safety and the five areas of body exposure: vertical, lateral, bariatric, repositioning, and ambulation.
   2. PT and/or designee will conduct ergonomic rounds quarterly to assess for patient handling lift training opportunities and to encourage and motivate staff in the use of lifts/transfer devices, report unsafe situations related to the use of the lift equipment and assist with organization and accessibility of equipment.
   3. Remain knowledgeable and current on all lift equipment/transfer aids available to staff members and stay abreast of updates/changes.
   4. Assure equipment and any needed supplies are readily available in departments; communicate supply issues to Manager.

E. Facilities Management:
   1. Biomedical Engineering shall maintain patient care equipment in proper working order.
   2. Consult with equipment manufacturers to provide safe equipment installations.

F. Reporting of Injuries:
   1. Employees are required to follow the Work related Accidents Policy for any patient handling injury event

2. Employees who are non-compliant with the Safe Patient Handling Policy must be re-trained and demonstrate competency in equipment use before returning to work. Continued failure to use proper patient handling practices may result in corrective action up to and including termination.

**REFERENCES:**


1. ANA (2013) Safe Patient Handling and Mobility: Inter-professional National Standards. Nursebooks.org.
2. California Code of Regulations (2013) Safe Patient Handling Bill (AB1136). www.dir.ca.gov/oshsb/safe_patient_handling.htm;


**RECORD RETENTION AND DESTRUCTION:**

Training records will be maintained for a minimum of 1 year per Cal/OSHA requirement (2014 regulation).

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Completing Quality Review Report in Performance Excellence Manual
2. Employee Requests to be Excluded from Patient Care in HR /Employee Handbook
3. TJC (2012) Improving Patient and Worker Safety: Opportunities for Synergy, Collaboration and Innovation. Oakbrook Terrace, Illinois.
4. Work Related Accidents in Human Resources/Employee Handbook
5. Injury and Illness Prevention Program located in Employee Health Manual

| Supersedes: v.2 Safe Patient Handling – Minimal Lift Program |
|---|

in approval

NORTHERN INYO HEALTHCARE DISTRICT
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**NORTHERN INYO HEALTHCARE DISTRICT**
**CLINICAL POLICY AND PROCEDURE**

| | | |
|---|---|---|
| Title: Warming Cabinet for Blankets/Solutions | | |
| Owner: DON Perioperative Services | Department: PACU | |
| Scope: Hospital Clinical Areas | | |
| Date Last Modified: 08/16/2021 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 06/27/2011 | |

**PURPOSE:**

To ensure a safe method of warming textiles/fluids for patient use achieved by circulating air warmed by heaters throughout the heating compartment Warming cabinets are designed to raise the temperature of irrigation, IV solutions and or textiles
(blankets) for patient use.

**POLICY:**

- Temperature will be monitored to ensure it is appropriate for solutions/textiles.
- Adequate room for airflow will be considered when stocking warmer with textiles/solutions.
- Solutions must not come in contact with metal or the heating elements in the warming units.
- Mannitol solutions may not be stored in the warmer.
- Solutions are warmed per manufacture recommendations.

**PROCEDURE:**

- If utilizing unit for both textiles and fluids, place solutions and textiles on shelves as indicated in operator's manual for specific unit. They should be on separate shelves.
- To ensure proper heat distribution, allow airflow space on the top and all sides of textiles. **Do not block air vent.**
- If it is necessary to remove only part of a load from the cabinet, then a FIFO (First in First Out) routine is recommended.
- After setting temperature per manufacture recommendation, the alarm will alert if the temperature exceeds the temperature control setting plus 10°°F.
- Allow temperatures to stabilize after loading the warmer:
  Bottles of solutions: Allow approximately 8 hrs. for temperature to stabilize
  Bags of solutions: Allow approximately 12 hours for temperature to stabilize
  Blankets: Allow approximately 8 hours for temperature to stabilize

BLANKETS

- Textiles (Blankets) can be warmed to a temperature 130° F plus or minus 5°F. Always feel the blanket to assure it is not too warm for patient use prior to placing on patient.
- Rotate textiles when stocking cabinet.
- Blankets must be folded and stacked to allow a 2" to 3" open space between the blankets and the interior walls and door to allow for even heat distribution and proper cabinet operation

In approval

SOLUTIONS FOR INJECTIONS

- Solutions are stocked in the warming cabinet daily as needed. Stock is re-ordered at least twice weekly and is rotated as new solutions are put away.
- Bottled solutions are dated for two months and bag solutions are dated for two weeks when being placed in the warming cabinet per manufacturer recommendation.
- Solutions are checked routinely for outdating and disposed of as needed if the time in the warming cabinet has elapsed.
- Solutions should remain in their overwraps and can remain in the warmer for a period **not longer than 14 days at 104° f.**
- Solutions should not come in contact with metal components within the warming unit.
- Once removed from the warming unit, solutions should be used within 24 hours or discarded and not returned to stock supply.
- Solutions should not be rewarmed.
- Solutions should be dated with REMOVAL DATE when placed in warming unit and the temperature checked daily.

IRRIGATION SOLUTIONS

- Flexible Irrigation solutions (bags) should remain in their overwraps and can remain in the warmer for a period NOT LONGER THAN 14 DAYS. Flexible irrigation containers can be warmed up to a temperature of 150° F according to Solution Manufacture Recommendation.
- Semi- rigid pour bottles may remain in the warming cabinet for up to 60 days at a temperature up to 150° F according to Solution Manufacture Recommendation.
- To ease cap removal for the pour bottles it is recommended that you wait for four minutes after removal of the product from the warming cabinet.
- For both flexible irrigation solutions and rigid pour bottle irrigations, then you must use the lower temperature when warming the solutions which is 104° F.
- When placing solutions in the warmer, the solutions should be dated with date placed into warmer and date of expiration. Preprinted labels are available and should be used. Writing with a pen on the bag should not be done.

**DOCUMENTATION:**

The temperature is monitored electronically by a central temperature monitoring system

**REFERENCES:**

AORN Guidelines for Perioperative Practice, 2018: Environment of Care Part 1, Recommendation V

**RECORD RETENTION AND DESTRUCTION:**

**CROSS REFERENCED POLICIES AND PROCEDURES:**

| |
|---|
| Supersedes: v.2 Warming Cabinet for Blankets/Solutions |

In approval

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**CLINICAL POLICY**

| | | |
|---|---|---|
| Title: 22-03 Return to Work Following Illness | | |
| Owner: EMPLOYEE HEALTH INFECT PREV SPEC | Department: Employee Health | |
| Scope: District Wide | | |
| Date Last Modified: 07/20/2021 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: | |

**POLICY:**

If you have been absent for a period of three (3) or more consecutive work days because of illness or injury, you may be required to provide written authorization from your physician prior to returning to work. In addition, the District may request that you be examined by a District physician.

**REFERENCES:**

**RECORD RETENTION AND DESTRUCTION:**

**CROSS REFERENCED POLICIES AND PROCEDURES:**

| |
|---|
| Supersedes: v.2 22-03 RETURN TO WORK FOLLOWING ILLNESS |

in approval

NORTHERN INYO HEALTHCARE DISTRICT
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# NORTHERN INYO HEALTHCARE DISTRICT

# PLAN

| | | |
|---|---|---|
| Title: Compliance Program for Northern Inyo Healthcare District | | |
| Owner: Compliance Officer | Department: Compliance | |
| Scope: District Wide | | |
| Date Last Modified: 08/12/2021 | Last Review Date: No Review Date | Version: 4 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 11/18/2016 | |

## Contents

## *INTRODUCTION*

It is the fundamental policy of NORTHERN INYO HEALTHCARE DISTRICT (hereinafter "NIHD" or "the District"), that quality patient care and governance is provided by the District, its governing board, medical staff, employees and affiliates, in a manner that fully complies with all applicable state and federal laws, and that all of the District's business and other practices be conducted at all times in compliance with all applicable laws and regulations of the United States, the State of California, all other applicable state and local laws and ordinances, and the ethical standards and practices of the medical profession, the health care industry and this organization.

There is significant concern about "waste, fraud and abuse" in healthcare. In light of this, the Office of the Inspector General (OIG) has issued a document entitled "Compliance Program Guidance for Hospitals." The OIG has recommended that an effective compliance program should contain the following seven elements:

> ***1.*** *The development and distribution of written standards of conduct, as well as written policies and procedures that promote the Company's commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals;*
>
> ***2.*** *The designation of a compliance officer and other appropriate bodies charged with the responsibility of operating and monitoring the compliance program, and who report directly to the CEO and the governing body;*
>
> ***3.*** *The development and implementation of regular, effective education and training programs for all affected employees;*
>
> ***4.*** *The maintenance of a process, such as a hotline, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect complainants from retaliation;*
>
> ***5.*** *The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or federal health care program requirements;*
>
> ***6.*** *The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas; and*
>
> ***7.*** *The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.*

This Compliance Program outlines the process NIHD will utilize to assure that it is in compliance with all the various laws and regulations established by both the Federal government as well as the State of California.

This Compliance Program (the "Program") is intended as a guide to help implement this policy of compliance with all applicable standards. The federal, state, and local laws, regulations, and ethical rules that govern health care are too numerous to list in the Program. Fundamentally, all individuals associated with NIHD by employment, contract or otherwise, are expected to conduct all business activities honestly and fairly. Each employee or contractor is responsible for his or her own conduct in complying with the Program.

The Program provides for the designation of a Compliance Officer who has ultimate responsibility and accountability for directing, monitoring, and reporting on compliance matters. The Compliance Officer shall implement and administer this Program, together with training and education as necessary to affect the full participation of District governing board, medical staff, employees, affiliates, and other agents.

This Program provides a framework for individual or departmental compliance efforts, and applies to all District Personnel and activities. However, each individual employee or agent of the District remains responsible and accountable for his or her own compliance with applicable laws, regulations, standards, policies, and procedures.

The Program identifies those organizational imperatives necessary to prevent accidental and intentional non-compliance with applicable laws. It is further designed to detect non-compliance should it occur. Additionally, it is designed to promote such steps as are necessary to prevent future non-compliance, including education and corrective action.

Northern Inyo Healthcare District is committed to maintaining in the community a positive reputation for conduct in accordance with the highest levels of business ethics. This Program supports that objective. The Program fully supports the NIHD mission: Improving our communities, one life at a time. One team. One goal. Your health!

## *SECTION 1 — COMPLIANCE PROGRAM SUMMARY*

### Definitions of Commonly Used Terms

A list of words that are commonly used in this Compliance Program and their meanings follows:

- **"Affiliate"** means any person or entity controlled by, or under common control with, Northern Inyo Healthcare District.
- **"District"** means Northern Inyo Healthcare District, and all of its subsidiaries and affiliates that are covered by this Compliance Program.
- **"Personnel"** means all members of the governing board, medical staff, employees of the District, and all contractors or others who are required to comply with this Compliance Program. Each of these persons must sign an Acknowledgment of Receipt of District Compliance Program and a Conflict of Interest Questionnaire Form.
- **"Board"** means the Board of Directors of the District.

### Purpose of this Compliance Program

Northern Inyo Healthcare District is committed to ensuring compliance with all applicable statutes, regulations, and policies governing our daily business activities. To that end, the District will have a Compliance Program. The document is to serve as a practical guidebook that can be used by all Personnel to assist them in performing their job functions in a manner that complies with applicable laws and policies. Additionally this Compliance Program is to serve as a mechanism for preventing violations and for reporting any violation in a manner that protects those that identify and report the lack of compliance with those laws.

While this Compliance Program contains policies regarding the business of Northern Inyo Healthcare District, it does not contain every policy that Personnel are expected to follow. For example, this Compliance Program does not cover payroll, vacation and benefits policies. Northern Inyo Healthcare District maintains other policies with which employees are required to comply. If you have questions about which policies apply to you, please ask your supervisor.

It is the policy of the District that:

- All employees are educated about applicable laws and trained in matters of compliance;
- There is periodic auditing, monitoring and oversight of compliance with those laws;
- An atmosphere exists that encourages and enables the reporting of noncompliance without fear of

retribution; and

- Mechanisms exist to investigate and take corrective actions in the event of noncompliance.

## Who is Affected

Everyone employed by Northern Inyo Healthcare District is required to comply with our Compliance Program. Because not all sections will apply to your job function, you will receive training and other materials to explain which portions of this Compliance Program apply to you.

While this is not intended to serve as the compliance program for all of our contractors, it is important that all contractors perform services in a manner that complies with the law. To that end, agreements with contractors may incorporate certain provisions of this Compliance Program.

Please note that compliance requirements are subject to change as a result of new laws and changes to existing laws and regulations. Collectively, we must all keep this Compliance Program current and useful. Therefore, you are encouraged to let the Compliance Officer or your supervisor know when you become aware of changes in law or District policy that might affect this Compliance Program.

## How to Use This Compliance Program

The District has organized this Compliance Program to be understandable and easy to navigate. A brief description of how this manual is organized follows.

1. **Section I – Compliance Program Summary**

2. **Section II – Code of Conduct**

This section contains specific policies related to your personal conduct while performing your job function. The primary objective of these policies is to create a work environment that promotes cooperation, professionalism, and compliance with the law. Compliance with the Code of Conduct is a significant factor in employee performance evaluations. All Personnel will receive training on this section.

3. **Section III – Compliance Program Systems and Processes**

This section explains the roles of the Compliance Officer and the Compliance and Business Ethics Committee. It also contains information about Compliance Program education and training, auditing, and corrective action. Most importantly, this section explains how to report violations anonymously, either in writing or by calling the Compliance Confidential Report Line at 1-888-200-9764 or by emailing the Compliance Officer directly. All Personnel will receive training on this section.

4. **Section IV – Compliance Policies**

The District electronic policy management system houses NIHD Compliance Policies. Some of these policies may not apply to your specific job function, but it is still important that you are aware of their existence and importance. All Personnel will receive training regarding the policies that apply to their job.

Here are some tips on how to use this Compliance Program effectively:

- **Refer to Table of Contents.** The Table of Contents contains a thorough list of topics covered in this Compliance Program. Use the Table of Contents to locate the topic you are looking for quickly.
- **Important Reference Tool.** This Compliance Program should be viewed as an important reference manual that you can refer to on a regular basis to answer questions about how to perform your job. Although it may not contain all of the answers, it will contain many and can save you time.
- **Read it in Context.** The District has created this Compliance Program to incorporate numerous compliance policies, many of which may not apply to you. When reviewing this Compliance

Program and the policies contained in it, keep in mind that the policies are to be applied in the context of your job. If you are uncertain about if or how a policy applies to you, ask your supervisor.

- **Keep it Handy.** Keep this Compliance Program information easily accessible and refer to it on a regular basis.
- **Talk to Your Co-Workers.** Regular dialogue among co-workers and supervisors is a great way to ensure that policies are applied uniformly. While this discussion is encouraged, always remember that the provisions of this Compliance Program should guide you on compliance matters.

## *SECTION II – CODE OF CONDUCT*

### Our Compliance Mission

The mission of Northern Inyo Healthcare District's Compliance Department is to promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law in order to improve our communities, one life at a time.

Northern Inyo Healthcare District believes that dedication to high ethical standards and compliance with all applicable laws and regulations is essential to its mission. This Code of Conduct is a critical component of the overall District Compliance Program. It guides and assists the District in carrying out daily activities in accordance with appropriate ethical and legal standards. These obligations apply to the District's relationship with patients, affiliated physicians, third-party payers, regulatory agencies, subcontractors, contractors, vendors, consultants, and one another. They require that all program participants comply with all applicable federal, state and local laws and regulations. Participants must also comply with all Northern Inyo Healthcare District Standards of Conduct. The absence of a specific guideline practice or instruction covering a particular situation does not relieve an employee from exercising the highest ethical standards applicable to the circumstances.

### Compliance with Laws

It is the policy of the District, its affiliates, contractors, and employees to comply with all applicable laws. When the application of the law is uncertain, the District Chief Executive Officer or Compliance Officer will seek guidance from legal counsel.

### Open Communication

The District encourages open lines of communication among Personnel. If you are aware of an unlawful or unethical situation, there are several ways you can bring this to the District's attention. Your supervisor is the best place to start, but you can also contact the District's Compliance Officer or call the Compliance Confidential Report Line (1-888-200-9764) to express your concerns. All reports of unlawful or unethical conduct will be investigated promptly. The District does not tolerate threats or acts of retaliation or retribution against employees for using these communication channels.

### Your Personal Conduct

The District's reputation for the highest standards of conduct rests not on periodic audits by lawyers and accountants, but on the high measure of mutual trust and responsibility that exists between Personnel and the District. It is based on you, as an individual, exercising good judgment and acting in accordance with this Code of Conduct and the law.

Ethical behavior on the job essentially comes down to honesty, trust, and fairness in dealing with other Personnel and with patients, vendors, competitors, the government and the public. It is no exaggeration to say

that the District's integrity and reputation are in your hands.

The District's basic belief in the importance of respect for the individual has led to a strict regard for the privacy and dignity of Personnel. When management determines that your personal conduct adversely affects your performance, that of other Personnel, or the legitimate interests of the District, the District may be required to take corrective action.

## The Work Environment

The District strives to provide Personnel with a safe and productive work environment. All Personnel must dispose of medical waste, environmentally sensitive materials, and any other hazardous materials correctly. You should immediately address and report to your supervisor any situations that are likely to result in falls, shocks, burns, or other harm to patients, visitors, or Personnel.

The work environment also must be free from discrimination and harassment based on race, color, religion, sex, sexual orientation, age, national origin, disability, veteran status, or other factors that are unrelated to the District's legitimate business interests. The District will not tolerate sexual advances, actions, comments or any other conduct in the workplace that creates an intimidating or otherwise offensive environment. Similarly, the use of racial or religious slurs — or any other remarks, jokes or conduct that encourages or permits an offensive work environment — will not be tolerated.

If you believe that you are subject to such conduct, you should bring such activity to the attention of the District, either by informing your supervisor, the District's Compliance Officer, or by calling the Compliance Confidential Report Line (1-888-200-9764). The District considers all complaints of such conduct to be serious matters, and all complaints will be investigated promptly.

Some other activities that are prohibited because they clearly are not appropriate are:

- Threats;
- Violent behavior;
- The possession of weapons of any type on the premises, except for exempt or authorized Personnel;
- The distribution of offensive jokes or other offensive materials via e-mail or any other manner; and
- The use, distribution, sale, or possession of illegal drugs or any other controlled substances, except to the extent permitted by law for approved medical purposes.

In addition, Personnel may not be on the District premises or in the District work environment if they are under the influence of or affected by illegal drugs, alcohol or controlled substances used other than as prescribed.

## Employee Privacy

The District collects and maintains personal information that relates to your employment, including medical and benefit information. Access to personal information is restricted solely to people with a need to know this information. Personal information is released outside the District or to its agents only with employee approval, except in response to appropriate investigatory or legal requirements, or in accordance with other applicable law. Employees who are responsible for maintaining personal information and those who are provided access to such information must ensure that the information is not disclosed in violation of the District's Personnel policies or practices.

## Use of District Property

District equipment, systems, facilities, corporate charge cards, and supplies must be used only for conducting

District business or for purposes authorized by management.

Personal items, messages, or information that you consider private should not be placed or kept in telephone systems, computer systems, offices, workspaces, desks, credenzas, or file cabinets. Employees should have no expectation of privacy with regard to items or information stored or maintained on District equipment or premises. Management is permitted to access these areas. Employees should not search for or retrieve articles from another employee's workspace without prior approval from that employee or management.

Since supplies of certain everyday items are readily available at District work locations, the question of making personal use of them frequently arises. The answer is clear: employees may not use District supplies for personal use.

## Use of District Computers

The increasing reliance placed on computer systems, internal information, and communications facilities in carrying out District business makes it absolutely essential to ensure their integrity. Like other District assets, these facilities and the information they make available through a wide variety of databases should be used only for conducting District business or for purposes authorized by management. Their unauthorized use, whether or not for personal gain, is a misappropriation of District assets.

While the District conducts audits to help ensure that District systems, networks, and databases are being used properly, it is your responsibility to make sure that each use you make of any District system is authorized and proper.

Personnel are not allowed to load or download software or data onto District computer systems unless it is for business purposes and is approved in advance by the appropriate supervisor. Personnel shall not use District e-mail systems to deliver or forward inappropriate jokes, unauthorized political materials, or any other potentially offensive materials. Personnel are strictly forbidden from using computers to access the Internet for purposes of gambling, viewing pornography or engaging in any illegal activities.

Employees should have no expectation of privacy with regard to items or information stored or maintained on District premises or computer, information, or communication systems.

## Use of Proprietary Information

### Proprietary Information

Proprietary information is generally confidential information that is developed by the District as part of its business and operations. Such information includes, but is not limited to, the business, financial, marketing and contract arrangements associated with District services and products. It also includes computer access passwords, procedures used in producing computer or data processing records, Personnel and medical records, and payroll data. Other proprietary information includes management know-how and processes; District business and product plans with outside vendors; a variety of internal databases; and copyrighted material, such as software.

The value of this proprietary information is well known to many people in the District industry. Besides competitors, they include industry and security analysts, members of the press, and consultants. The District alone is entitled to determine who may possess its proprietary information and what use may be made of it, except for specific legal requirements such as the publication of certain reports.

Personnel often have access to information that the District considers proprietary. Therefore, it is very important not to use or disclose proprietary information except as authorized by the District.

### Inadvertent Disclosure

The unintentional disclosure of proprietary information can be just as harmful as intentional disclosure. To avoid unintentional disclosure, never discuss with any unauthorized person proprietary information that has not been made public by the District. This information includes unannounced products or services, prices, earnings, procurement plans, business volumes, capital requirements, confidential financial information, marketing and service strategies, business plans, and other confidential information. Furthermore, you should not discuss confidential information even with authorized District employees if you are in the presence of others who are not authorized — for example, at a meeting, conference or in a public area. This also applies to discussions with family members or with friends, who might innocently or inadvertently pass the information on to someone else.

**Direct Requests for Information**

If someone outside the District asks you questions about the District or its business activities, either directly or through another person, do not attempt to answer them unless you are certain you are authorized to do so. If you are not authorized, refer the person to the appropriate source within the District. Under no circumstances should you continue contact without guidance and authorization. If you receive a request for information, or to conduct an interview from an attorney, investigator, or any law enforcement officer, and it concerns the District's business, you should refer the request to your supervisor, the office of the District's Chief Executive Officer, or Compliance Officer. Similarly, unless you have been authorized to talk to reporters, or to anyone else writing about or otherwise covering the District or the industry, direct the person to your supervisor.

**Disclosure and Use of District Proprietary Information**

Besides your obligation not to disclose any District proprietary information to anyone outside the District, you are also required to use such information only in connection with the District's business. These obligations apply whether or not you developed the information yourself.

**Proprietary and Competitive Information about Others**

In the normal course of business, it is not unusual to acquire information about many other organizations, including competitors (competitors are other Districts and health facilities). Doing so is a normal business activity and is not unethical in itself. However, there are limits to the ways that information should be acquired and used. Improper solicitation of confidential data about a competitor from a competitor's employees or from District patients is prohibited. The District will not tolerate any form of questionable intelligence gathering.

## Recording and Reporting Information

You should record and report all information accurately and honestly. Every employee records information of some kind and submits it to the District (for example, a time card, an expense account record, or a report). To submit a document that contains false information — an expense report for meals not eaten, miles not driven, or for any other expense not incurred — is dishonest reporting and is prohibited.

Dishonest reporting of information to organizations and people outside the District is also strictly prohibited and could lead to civil or even criminal liability for you and the District. This includes not only reporting information inaccurately, but also organizing it in a way that is intended to mislead or misinform those who receive it. Personnel must ensure that they do not make false or misleading statements in oral or written communications provided to organizations outside of the District.

## Exception

Nothing contained herein is to be construed as prohibiting conduct legally protected by the National Labor Relations Act or other applicable state or federal law.

## Gifts and Entertainment

The District understands that vendors and others doing business with the District may wish to provide gifts,

promotional items, or entertainment to District Personnel as part of such vendors' own marketing activities. The District also understands that there may be occasions where the District may wish to provide reasonable business gifts to promote the District's services. However, the giving and receipt of such items can easily be abused and have unintended consequences; giving and receiving gifts, particularly in the health care industry, can create substantial legal risks.

**General Policy**

It is the general policy of the District that neither you nor any member of your family may solicit, receive, offer or pay any money or gift that is, or could be reasonably construed to be, an inducement in exchange for influence or assistance in conducting District business. It is the intent of the District that this policy be construed broadly such that all business transactions with vendors, contractors, and other third parties are transacted to avoid even the appearance of improper activity. Pharmaceutical samples provided to physicians by manufacturers for patient use are generally allowed. Please discuss any concerns with your supervisor or the Compliance Officer.

**Spending Limits — Gifts, Dining and Entertainment**

The District has developed policies that clearly define the spending limits permitted for items such as gifts, dining, and entertainment. Occasional gifts from vendors, of nominal value (less than $10), that do not influence or appear to influence the objective judgment of personnel, such as sales promotional items (an inexpensive pen), or business related meal or snack for a department are permitted with approval. All Personnel are strictly prohibited from making any expenditure of District or personal funds for gifts, dining or entertainment in any way related to District business, unless such expenditures are made in strict accordance with District policies.

**Marketing and Promotions in Health Care**

As a provider of health care services, the marketing and promotional activities of the District may be subject to anti-kickback and other laws that specifically apply to the health care industry. The District has adopted policies elsewhere in this Compliance Program to specifically address the requirements of such laws.

It is the policy of the District that Personnel are not allowed to solicit, offer or receive any payment, compensation or benefit of any kind (regardless of the value) in exchange for referring, or recommending the referral of, patients or customers to the District.

## Marketing

The District has expended significant efforts and resources in developing its services and reputation for providing high-quality patient care. Parts of those efforts involve advertising, marketing, and other promotional activities. While such activities are important to the success of the District, they are also potential sources of legal liability as a result of health care laws (such as the anti-kickback laws) that regulate the marketing of health care services. Therefore, it is important that the District closely monitor and regulate advertising, marketing and other promotional activities to ensure that all such activities are performed in accordance with District objectives and applicable law.

This Compliance Program contains various policies applicable to specific business activities of the District. In addition to those policies, it is the general policy of the District that no Personnel engage in any advertising, marketing, or other promotional activities on behalf of the District unless such activities are approved in advance by the appropriate District representative. You should ask your supervisor to determine the appropriate District representative to contact. In addition, no advertising, marketing, or other promotional activities targeted at health care providers or potential patients may be conducted unless approved in advance by the District's Chief Executive Officer or Compliance Officer.

All content posted on Internet websites maintained by the District must be approved in advance by the District's Compliance Officer or designee.

## Conflicts of Interest

A conflict of interest is any situation in which financial or other personal considerations may compromise or appear to compromise any Personnel's business judgment, delivery of patient care, or ability of any Personnel to do his or her job or perform his or her responsibilities. A conflict of interest may arise if you engage in any activities or advance any personal interests at the expense of the District's interests.

An actual or potential conflict of interest occurs when any Personnel is in a position to influence a decision that may result in personal gain for that Personnel, a relative or a friend as a result of the District's business dealings. A relative is any person who is related by blood or marriage, or whose relationship with the Personnel is similar to that of persons who are related by blood or marriage, including a domestic partner, and any person residing in the Personnel's household. You must avoid situations in which your loyalty may become divided.

An obvious conflict of interest is providing assistance to an organization that provides services and products in competition with the District's current or potential services or products. You may not, without prior consent, work for such an organization as an employee (including working through a registry or "moonlighting" and picking up shifts at other health care facilities), independent contractor, a consultant, or a member of its Governing Board. Such activities may be prohibited because they divide your loyalty between the District and that organization. While many of these activities are approved with a management plan or Non-Disclosure agreement, failure to obtain prior consent in advance from the District's Compliance Officer may be grounds for corrective action, up to and including termination.

### Outside Employment and Business Interests

You are not permitted to work on any personal business venture on the District premises or while working on District time. In addition, you are not permitted to use District equipment, telephones, computers, materials, resources, or proprietary information for any business unrelated to District business. You must abstain from any decision or discussion affecting the District when serving as a member of an outside organization or board or in public office, except when specific permission to participate has been granted by the District's Compliance Officer or Chief Executive Officer.

### Contracting with the District

You may not contract with the District to be a supplier, to represent a supplier to the District, or to work for a supplier to the District while you are an employee of the District. In addition, you may not accept money or benefits, of any kind, for any advice or services you may provide to a supplier in connection with its business with the District.

### Required Standards

All decisions and transactions undertaken by Personnel in the conduct of the District's business must be made in a manner that promotes the best interests of the District, free from the possible influence of any conflict of interest of such Personnel or the Personnel's family or friends. Personnel have an obligation to address both actual conflicts of interest and the appearance of a conflict of interest. You must always disclose and seek resolution of any actual or potential conflict of interest — whether or not you consider it an actual conflict — before taking a potentially improper action.

No set of principles or standards can cover every type of conflict of interest. The following standards address conduct required of all Personnel and provide some examples of potential conflict of interest situations in addition to those discussed elsewhere in the Compliance Program.

1. Personnel may not make or influence business decisions, including executing purchasing agreements (including but not limited to agreements to purchase or rent equipment, materials, supplies or space) or other types of contracts (including contracts for personal services), from which they, a family member, or a friend may benefit.

2. Personnel must disclose their "significant" (defined below) financial interests in any entity that they know to have current or prospective business, directly or indirectly, with the District. There are two types of significant financial interests:
    a. Receipt of anything of monetary value from a single source. Examples include salary, royalties, gifts and payments for services including consulting fees and honoraria; and
    b. Ownership of an equity interest exceeding 5 percent in any single entity, excluding stocks, bonds and other securities sold on a national exchange; certificates of deposit; mutual funds; and brokerage accounts managed by third parties.
3. Personnel must disclose any activity, relationship, or interest that may be perceived to be a conflict of interest so that these activities, relationships, and interests can be evaluated and managed properly.
4. Personnel must disclose any outside activities that interfere, or may be perceived to interfere, with the individual's capacity to satisfy his or her job or responsibilities at the District. Such outside activities include leadership participation (such as serving as an officer or member of the board of directors) in professional, community, or charitable activities; self-employment; participation in business partnerships; and employment or consulting arrangements with entities other than the District.
5. Personnel may not solicit personal gifts or favors from vendors, contractors, or other third parties that have current or prospective business with the District. Personnel may not accept cash gifts and may not accept non-monetary gifts including meals, transportation, or entertainment from vendors, contractors, or other third parties that have current or prospective business with the District. Questions regarding the gifts should be directed to the District's Compliance Officer.
6. Any involvement by Personnel in a personal business venture shall be conducted outside the District work environment and shall be kept separate and distinct from the District's business in every respect.
7. Personnel should not accept employment or engage in a business that involves, even nominally, any activity during hours of employment with the District, the use of any of the District's equipment, supplies, or property, or any direct relationship with the District's business or operation. Certain emergency situations may require collaboration with suppliers, vendors, or other healthcare organizations. Disclosure and approval by Chief Executive Officer or Compliance Officer at an appropriate time would further clarify compliance; however, nothing in this Program should be interpreted as interfering with the provision of high quality, efficient patient care in a legally compliant manner. Questions should be directed to the District's Compliance Officer.
8. Personnel must guard patient and District information against improper access, disclosure, or use by unauthorized individuals.
9. The District's materials, products, designs, plans, ideas, and data are the property of the District and should never be given to an outside firm or individual, except through normal channels with appropriate prior authorization.
10. Personnel must avoid even the appearance of impropriety when dealing with clinicians and referral sources.
11. All vendors and contractors who have or desire business relationships with the District must abide by this Code of Conduct. Personnel having knowledge of vendors or contractors who violate these standards in their relationship with the District must report these to their supervisor, manager, the District Compliance Officer, or by using the Confidential Compliance Report Line (1-888-200-9764).
12. Personnel shall not sell any merchandise on District premises and shall not sell any merchandise of a medical nature that is of a type or similar to what is sold or furnished by the District, whether on or off District premises, unless prior approval is obtained from the District's Compliance Officer.

13. Personnel shall not request donations for any purpose from other Personnel, patients, vendors, contractors or other third parties, unless prior approval is obtained from the District's Compliance Officer.
14. Personnel may not endorse any product or service without explicit prior approval to do so by the District's Compliance Officer.

## Disclosure of Potential Conflict Situations

You must disclose any activity, relationship, or interest that is or may be perceived to be a conflict of interest and complete the attached Conflict of Interest Questionnaire Form within 90 days of being subject to this Compliance Program (that is, being hired by the District, beginning to volunteer at the District, or assuming any responsibilities at the District). At least annually thereafter, you must review this Compliance Program and Conflict of Interest Questionnaire. You are required to file a Conflict of Interest Questionnaire Form annually, and when there is a change in your circumstances that you have not previously reported. At any time during the year, when an actual, potential, or perceived conflict of interest arises, you must revise your questionnaire form and contact the District's Compliance Officer. It is your responsibility to report promptly any actual or potential conflicts.

All questionnaire forms must be sent to the District's Compliance Officer. The Compliance Officer will review all disclosures and determine which disclosures require further action. The Compliance Officer will consult with the Business Compliance Team if an actual or perceived conflict of interest may exist. The District's Chief Executive Officer or legal counsel may be consulted by the Compliance Officer as needed to determine if further action is required. The outcome of these consultations will result in a written determination stating whether or not an actual conflict of interest exists. If a conflict of interest is determined to exist, the written determination shall set forth a plan to manage the conflict of interest, which may include that:

1. The conflict of interest is not significant and is generally permissible;
2. The activity may represent a potential or perceived conflict of interest, but in many cases would be permitted to go forward after disclosure with a Management Plan or Non-Disclosure Agreement;
3. The conflict of interest will require the Personnel to abstain from participating in certain governance, management or purchasing activities related to the conflict of interest;
4. The activity represents an actual conflict of interest which may be permitted to go forward after disclosure with an appropriate Management Plan or Non-Disclosure Agreement to eliminate the conflict, safeguard against prejudice toward Northern Inyo Healthcare District activities, and provide continuing oversight; or
5. The conflict of interest must be eliminated or, if it involves a proposed role in another organization or entity, must not be undertaken.

The Compliance Officer, or designee, will review any written determination with you and discuss any necessary action you are to take.

## Anti-Competitive Activities

If you work in community relations, sales, or marketing, the District asks you to perform your job not just vigorously and effectively, but fairly, as well. False or misleading statements about a competitor are inappropriate, invite disrespect and complaints, and may violate the law. Be sure that any comparisons you make about competitors' products and services are fair and accurate. (Competitors are other Districts, hospitals, and health facilities.)

## Reporting Violations

The District supports and encourages each employee and contractor to maintain individual responsibility for monitoring and reporting any activity that violates or appears to violate any applicable statutes, regulations, policies, or this Code of Conduct.

The District has established a reporting mechanism that permits anonymous reporting, if the person making the report desires anonymity. Employees who become aware of a violation of the District Compliance Program, including this Code of Conduct, must report the improper conduct to the District's Compliance Officer. That officer, or a designee, will then investigate all reports and ensure that appropriate follow-up actions are taken.

District policy prohibits retaliation against an employee who makes such a report in good faith. In addition, it is the policy of the District that no employee will be punished on the basis that he/she reported what he/she reasonably believed to be improper activity or a violation of this Program.

However, employees are subject to corrective action, if after an investigation the District reasonably concludes that the reporting employee knowingly fabricated, or knowingly distorted, exaggerated or minimized the facts either to cause harm to someone else or to protect or benefit himself or herself.

***Additional, detailed information may be found in the NIHD Code of Business Ethics and Conduct.***

## *SECTION III — COMPLIANCE PROGRAM SYSTEMS AND PROCESSES*

This Compliance Program contains a comprehensive set of policies. In order to effectively implement and maintain these policies, the District has developed various systems and processes. The purpose of this section of the Compliance Program is to explain the various systems and processes that the District has established for the purpose of providing structure and support to the Compliance Program.

### Compliance Officers and Committee

#### Compliance Officer

The District has a Compliance Officer who serves as the primary supervisor of this Compliance Program. The District's Compliance Officer occupies a high-level position within the organization and has authority to carry out all compliance responsibilities described in this Compliance Program. The Compliance Officer is responsible for assuring that the Compliance Program is implemented to ensure that the District at all times maintains business integrity and that all applicable statutes, regulations and policies are followed.

The Compliance Officer provides frequent reports to the Governing Board about the Compliance Program and compliance issues. The Governing Board is ultimately responsible for oversight of the work of the Compliance Officer, and maintaining the standards of conduct set forth in the Compliance Program. The Governing Board oversees all of the District's compliance efforts and takes any appropriate and necessary actions to ensure that the District conducts its activities in compliance with the law and sound business ethics.

The Compliance Officer and Governing Board shall consult with legal counsel as necessary on compliance issues raised by the ongoing compliance review.

*Responsibilities of the Compliance Officer*

The Compliance Officer's responsibilities include the following:

- Overseeing and monitoring the implementation and maintenance of the Compliance Program.
- Reporting on a regular basis to the Governing Board (no less than quarterly) on the progress of implementation and operation of the Compliance Program and assisting the Governing Board in establishing methods to reduce the District's risk of fraud, waste, and abuse.
- Periodically revising the Compliance Program in light of changes in the needs of the District and changes in applicable statutes, regulations, and government policies.

- Reviewing at least annually the implementation and execution of the elements of this Compliance Program. The review includes an assessment of each of the basic elements individually and the overall success of the Program, and a comprehensive review of the compliance department.
- Developing, coordinating and participating in educational and training programs that focus on elements of the Compliance Program with the goal of ensuring that all appropriate Personnel are knowledgeable about, and act in accordance with, this Compliance Program and all pertinent federal and state requirements.
- Ensuring that independent contractors and agents of the District are aware of the requirements of this Compliance Program as they affect the services provided by such contractors and agents.
- Ensuring that employees, independent contractors, and agents of the District have not been excluded from participating in Medicare, Medicaid (Medi-Cal) or any other federal or state heath care program.
- Ensuring that the District does not employ or contract with any individual who has been convicted of a criminal offense related to health care within the previous five years, or who is listed by a federal or state agency as debarred, excluded, or otherwise ineligible for participation in Medicare, Medicaid (Medi-Cal), or any other federal or state health care program.
- Coordinating internal compliance review and monitoring activities.
- Independently investigating and acting on matters related to compliance, including design and coordination of internal investigations and implementation of any corrective action.
- Maintaining a good working relationship with other key operational areas, such as quality improvement, coding, billing and clinical departments.
- Designating work groups or task forces needed to carry out specific missions, such as conducting an investigation or evaluating a proposed enhancement to the Compliance Program.

The Compliance Officer has the authority to review all documents and other information relevant to compliance activities, including, but not limited to, patient records, billing records, records concerning marketing efforts and all arrangements with third parties, including without limitation employees, independent contractors, suppliers, agents and physicians.

The Compliance Officer has direct access to the Governing Board, Chief Executive Officer and other senior management, and to legal counsel.

**Compliance and Business Ethics Committee**

The District has established a Compliance and Business Ethics Committee to advise the Compliance Officer and assist in monitoring this Compliance Program. The Compliance and Business Ethics Committee (CBEC) provides the perspectives of individuals with diverse knowledge and responsibilities within the District.

*Members of the Compliance and Business Ethics Committee*

The Compliance and Business Ethics Committee consists of multiple representatives. The members of the CBEC include those individuals designated below and other members as requested, including representatives of senior management, chosen by the District's Chief Executive Officer in consultation with the Compliance Officer:

- Compliance Officer
- Chief Financial Officer
- Cybersecurity Officer

- Chief Medical Officer
- Chief Nursing Officer
- Chief Executive Officer
- Board of Directors' Representative
- As appropriate, Health Information Management Manager, Revenue Cycle Director, or department designee from Emergency, Human Resources Director Laboratory, Pharmacy, Imaging, Purchasing, and other areas

The Compliance Officer serves as the chairperson of the Compliance and Business Ethics Committee. The CBEC serves in an advisory role and has authority to adopt or implement policies following Board approval. The Compliance Officer will consult with members of the CBEC on a regular basis and may call meetings of all or some members of the CBEC.

The Board of Directors' representative to the CBEC shall be appointed by the full Board of Directors. The Board of Directors' representative shall meet the following qualifications prior to consideration for appointment:

- Completion of ethics and governance training as required by AB1234; and,
- Attended an Association of California Healthcare District (ACHD) Leadership Academy within past two years; and,
- Has completed and filed CA Form 700; and,
- NIHD Conflict of Interest for Members of the Board of Directors has been completed, returned, and reviewed by the Business Compliance Team.

Each member of the CBEC shall sign a Non-Disclosure Agreement (NDA).

*Functions of the Compliance and Business Ethics Committee*
The Compliance and Business Ethics Committee's functions include the following:

- Assessing existing and proposed compliance policies for modification or possible incorporation into the Compliance Program.
- Working with the Compliance Officer to develop standards of conduct and policies to promote compliance.
- Development on Annual Compliance Department Work Plan and Audit Plan, including review and re-prioritizing as necessary
- Recommending and monitoring, in conjunction with the Compliance Officer, the development of internal systems and controls to carry out the standards and policies of this Compliance Program.
- Reviewing and proposing strategies to promote compliance and detection of potential violations.
- Assisting the Compliance Officer in the development and ongoing monitoring of systems to solicit, evaluate, and respond to complaints and problems related to compliance.
- Assisting the Compliance Officer in coordinating compliance training, education and other compliance-related activities in the departments and business units in which the members of the Compliance and Business Ethics Committee work.
- Consulting with vendors of the District on a periodic basis to promote adherence to this Compliance Program as it applies to those vendors and to promote their development of formal

Compliance Programs.

The tasks listed above are not intended to be exhaustive. The CBEC may also address other compliance-related matters as determined by the Compliance Officer.

The CBEC may, from time to time, create one or more sub-committees which shall have that authority specifically designated thereto. Each sub-committee shall answer directly to the respective Compliance and Business Ethics Committee.

The District has established a Billing, Coding, and Compliance Committee (BCCC), which is a sub-committee of the Compliance and Business Ethics Committee, to advise the Compliance Officer and assist in monitoring of billing, coding, and revenue cycle management. The Billing, Coding, and Compliance Committee shall be renamed the Billing and Coding Compliance Subcommittee (BCCS).

The District has established a Business Compliance Team (BCT) to assist the Compliance Officer in appropriate determinations and plans of action for reported, actual, or perceived conflicts of interest. The Business Compliance Team is a subcommittee of the CBEC.

## Compliance as an Element of Performance

The promotion of, and adherence to, the elements of this Compliance Program is a factor in evaluating the performance of all District employees. Personnel will be trained periodically regarding the Compliance Program, and new compliance policies that are adopted. In particular, all managers and supervisors involved in any processes related to the evaluation, preparation, or submission of medical claims must do the following:

- Discuss, as applicable, the compliance policies and legal requirements described in this Compliance Program with all supervised Personnel.
- Inform all supervised Personnel that strict compliance with this Compliance Program is a condition of continued employment.
- Inform all supervised Personnel that disciplinary action will be taken, up to and including termination of employment or contractor status, for violation of this Compliance Program.

Managers and supervisors will be subject to discipline for failure to adequately instruct their subordinates on matters covered by the Compliance Program. Managers and supervisors will also be subject to discipline for failing to detect violations of the Compliance Program where reasonable diligence on the part of the manager or supervisor would have led to the discovery of a problem or violation and thus would have provided the District with the opportunity to take corrective action.

## Training and Education

The District acknowledges that this Compliance Program will be effective only if it is communicated and explained to Personnel on a routine basis and in a manner that clearly explains its requirements. For this reason, the District requires all Personnel to attend specific training programs on a periodic basis. Training requirements and scheduling are established by the District for its departments and affiliates based on the needs and requirements of each department and affiliate. Training programs include appropriate training in federal and state statutes, regulations, guidelines, the policies described in this Compliance Program, and corporate ethics. Training will be conducted by qualified internal or external personnel. New employees are trained early in their employment. Training programs may include sessions highlighting this Compliance Program, summarizing fraud and abuse laws, physician self-referral laws, claims development and submission processes, and related business practices that reflect current legal standards.

All formal training undertaken as part of the Compliance Program is documented. Documentation includes at a minimum the identification of the Personnel participating in the training, the subject matter of the training,

the time and date of the training, the training materials used, and any other relevant information.

The Compliance Officer evaluates the content of the training program at least annually to ensure that the subject content is appropriate and sufficient to cover the range of issues confronting the District's employees. The training program is modified as necessary to keep up-to-date with any changes in federal and state health care program requirements, and to address results of the District's audits and investigations; results from previous training and education programs; trends in Hotline reports; and guidance from applicable federal and state agencies. The appropriateness of the training format is evaluated by reviewing the length of the training sessions; whether training is delivered via live instructors or via computer-based training programs; the frequency of training sessions; and the need for general and specific training sessions.

The Compliance Officer seeks feedback to identify shortcomings in the training program, and administers post-training tests as appropriate to ensure attendees understand and retain the subject matter delivered.

Specific training for appropriate corporate officers, managers, and other employees may include areas such as:

- Restrictions on marketing activities.
- General prohibitions on paying or receiving remuneration to induce referrals.
- Proper claims processing techniques.
- Monitoring of compliance with this Compliance Program.
- Methods for educating and training employees.
- Duty to report misconduct.

The members of the District's Governing Board will be provided with periodic training, not less than annually, on fraud and abuse laws and other compliance matters.

Attendance and participation in compliance training programs is a condition of continued employment. Failure to comply with training requirements will result in disciplinary action, including possible termination.

Adherence with the provisions of this Compliance Program, including training requirements, is a factor in the annual evaluation of each District employee. Where feasible, outside contractors will be afforded the opportunity to participate in, or be encouraged to develop their own, compliance training and educational programs to complement the District's standards of conduct and compliance policies. The Compliance Officer will ensure that records of compliance training, including attendance logs and copies of materials distributed at training sessions, are maintained.

The compliance training described in this program is in addition to any periodic professional education courses that may be required by statute or regulation for certain Personnel. The District expects its employees to comply with applicable education requirements; failure to do so may result in disciplinary action.

## Lines of Communicating and Reporting

### Open Door Policy

The District recognizes that clear and open lines of communication between the Compliance Officer and District Personnel are important to the success of this Compliance Program. The District maintains an open door policy in regards to all Compliance Program related matters. District Personnel are encouraged to seek clarification from the Compliance Officer in the event of any confusion or question about a statute, regulation, or policy discussed in this Compliance Program.

### Submitting Questions or Complaints

The District has established a telephone hotline for use by District Personnel to report concerns or possible wrongdoing regarding compliance issues. We refer to this telephone line as our "Compliance Confidential

Report Line."

The Compliance Confidential Report Line contact number is:

Phone: 1-888-200-9764

Personnel may also submit compliance-related questions or complaints in writing. Letters may be sent anonymously. All such letters should be sent to the Compliance Officer at the following address:

Compliance Officer
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

The Compliance Confidential Report Line number and the Compliance Officer's contact information are posted in conspicuous locations throughout the District's facilities.

All calls to the Compliance Confidential Report Line are treated confidentially and are not traced. The caller need not provide his or her name. The District's Compliance Officer or designee investigates all calls and letters and initiates follow-up actions as appropriate.

Communications via the Compliance Confidential Report Line and letters mailed to the Compliance Officer are treated as privileged to the extent permitted by applicable law; however, it is possible that the identity of a person making a report may become known, or that governmental authorities or a court may compel disclosure of the name of the reporting person.

Matters reported through the Compliance Confidential Report Line or in writing that suggest violations of compliance policies, statutes, or regulations are documented and investigated promptly. A log is maintained by the Compliance Officer of calls or communications, including the nature of any investigation and subsequent results. A summary of this information is included in reports by the Compliance Officer to the District's Governing Board and Chief Executive Officer.

**Non-Retaliation Policy**
It is the District's policy to prohibit retaliatory action against any person for making a report, anonymous or otherwise, regarding compliance. However, District Personnel cannot use complaints to the Compliance Officer to insulate themselves from the consequences of their own wrongdoing or misconduct. False or deceptive reports may be grounds for termination. It will be considered a mitigating factor if a person makes a forthright disclosure of an error or violation of this Compliance Program, or the governing statutes and regulations.

## Enforcing Standards and Policies

**Policies**
It is the policy of the District to use appropriate corrective action with District Personnel who fail to comply with the Code of Conduct or the policies set forth in, or adopted pursuant to, this Compliance Program or any federal or state statutes or regulations.

The guiding principles underlying this policy include the following:

- Intentional or reckless noncompliance will subject Personnel to significant sanctions, which may include oral warnings, suspension, or termination of employment, depending upon the nature and extent of the noncompliance.
- Negligent failure to comply with the policies set forth in this Compliance Program, or with applicable laws, will also result in sanctions.

- Corrective action will be taken where a responsible employee fails to detect a violation, if this failure is attributable to his or her negligence or reckless conduct.
- Internal audit or review may lead to discovering violations and result in corrective action.

Because the District takes compliance seriously, the District will respond to Personnel misconduct.

**Corrective Action Procedures**

Employees found to have violated any provision of this Compliance Program are subject to discipline consistent with the policies set forth herein, including termination of employment if deemed appropriate by the District. Any such discipline is within the sole discretion of the District. Each instance involving disciplinary action shall be thoroughly documented by the employee's supervisor and the Compliance Officer.

Upon determining that an employee of the District or any of its affiliates has committed a violation of this Compliance Program, such employee shall meet with his or her supervisor to review the conduct that resulted in violation of the Compliance Program. The employee and supervisor will contact the Compliance Officer to discuss any actions that may be taken to remedy such violation. All employees are expected to cooperate fully with the Compliance Officer during the investigation of the violation. The Chief of Human Resources, Compliance Officer, or Chief Executive Officer may consult legal counsel prior to final actions or disciplinary measures, as appropriate.

## Auditing and Monitoring

The District conducts periodic monitoring of this Compliance Program. Compliance reports created by this monitoring, including reports of suspected noncompliance, will be reviewed and maintained by the Compliance Officer.

The Compliance Officer will develop and implement an audit plan. The plan will be reviewed at least annually to determine whether it addresses the proper areas of concern, considering, for example, findings from previous years' audits, risk areas identified as part of the annual risk assessment, and high volume services.

Periodic compliance audits are used to promote and ensure compliance. These audits are performed by internal or external auditors who have the appropriate qualifications and expertise in federal and state health care statutes and regulations and federal health care program requirements. The audits will focus on specific programs or departments of the District, including external relationships with third-party contractors. These audits are designed to address, at a minimum, compliance with laws governing kickback arrangements, physician self-referrals, claims development and submission (including an assessment of the District's billing system), reimbursement, and marketing. All Personnel are expected to cooperate fully with auditors during this process by providing information, answering questions, etc. If any employee has concerns regarding the scope or manner of an audit, the employee should discuss this with his or her immediate supervisor.

The District shall conduct periodic reviews, including unscheduled reviews, to determine whether the elements of this Compliance Program have been satisfied. Appropriate modifications to the Compliance Program will be implemented when monitoring discloses that compliance issues have not been detected in a timely manner due to Compliance Program deficiencies.

The periodic review process may include the following techniques:

- Interviews with Personnel involved in management, operations, claim development and submission, and other related activities.
- Questionnaires developed to solicit impressions of the District Personnel.
- Reviews of all billing documentation, including medical and financial records and other source documents, that support claims for reimbursement and claims submissions.

- Presentations of a written report on compliance activities to the Compliance Officer. The report shall specifically identify areas, if any, where corrective actions are needed. In certain cases, subsequent reviews or studies may be conducted to ensure that recommended corrective actions have been successfully implemented.

Error rates shall be evaluated and compared to error rates for prior periods as well as available norms. If the error rates are not decreasing, the District shall conduct a further investigation into other aspects of the Compliance Program in an effort to determine hidden weaknesses and deficiencies.

## Corrective Action

### Violations and Investigations

Violations of this Compliance Program, failure to comply with applicable federal or state laws, and other types of misconduct threaten the District's status as a reliable and honest provider of health care services. Detected but uncorrected misconduct can seriously endanger the District's business and reputation, and can lead to serious sanctions against the District. Consequently, upon reports or reasonable indications of suspected noncompliance, prompt steps to investigate the conduct in question will be initiated under the direction and control of the Compliance Officer to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred. The Compliance Officer may create a response team to review suspected noncompliance including representatives from the compliance, audit and other relevant departments.

If such a violation has occurred, prompt steps will be taken to correct the problem, taking into account the root cause of the problem. As appropriate, such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan, a report to the Office of Inspector General (OIG) or any other appropriate government organization, and/or submission of any overpayments. The specific steps that are appropriate in any given case will be determined after consultation between the Chief Executive Officer or Compliance Officer and legal counsel.

Depending upon the nature of the alleged violations, the Compliance Officer's internal investigation could include interviews with relevant Personnel and a review of relevant documents. Legal counsel, auditors or health care experts may be engaged by the Compliance Officer to assist in an investigation where the Compliance Officer deems such assistance appropriate. Complete records of all investigations will be maintained which contain documentation of the alleged violations, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed, results of the investigation (e.g., any disciplinary action taken), and corrective actions implemented.

If an investigation of an alleged violation is undertaken and the Compliance Officer believes the integrity of the investigation may be at stake because of the presence of employees under investigation, those employees will be removed from their current work activity until the investigation is completed. Where necessary, the Compliance Officer will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

### Reporting

If the Compliance Officer or a management official discovers credible evidence of misconduct from any source and, after reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil, or administrative law, then the misconduct will promptly be reported as appropriate to the OIG or any other appropriate governmental authority or federal and/or state law enforcement agency having jurisdiction over such matter. Such reports will be made by the Compliance Officer on a timely basis.

All overpayments identified by the District shall be promptly disclosed and/or refunded to the appropriate public or private payer or other entity.

## *SECTION IV – COMPLIANCE POLICIES*

The District electronic policy management system houses NIHD Compliance Policies. Some of these policies may not apply to your specific job function, but it is still important that you are aware of their existence and importance. All Personnel will receive training regarding the policies that apply to their job.

**REFERENCES:**

1. Supplemental Compliance Program Guidance for Hospitals (70 Fed. Reg. 4858; January 31, 2005)
2. Compliance Program Guidance for Hospitals (63 Fed. Reg. 8987; February 23, 1998)

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Authority of the Chief Executive Officer for Contracts and Bidding
2. Business Associate Agreements Execution and Management
3. California Public Records Act – Information Requests
4. Communicating Protected Health Information via Electronic Mail (Email)
5. Disclosures of Protected Health Information Over the Telephone
6. Disposal of Equipment
7. Electronic Communication (Email) Acceptable Use Policy
8. False Claims Act Employee Training and Prevention Policy
9. Family Member and Relatives in the Workplace
10. Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information
11. Language Access Services Policy
12. NIHD Code of Business Ethics and Conduct
13. Non-Retaliation Policy
14. Nondiscrimination Policy
15. Patient Rights
16. Pricing Transparency Policy
17. Purchasing Signature Authority
18. Equal Employment Opportunity
19. Sanctions for Breach of Patient Privacy Policies
20. Sending Protected Health Information via Fax
21. Using and Disclosing Protected Health Information for Treatment, Payment and HealthCare Operations
22. Vendor Credentialing
23. Workforce Access to His or Her Own Protected Health Information
24. Workforce Investigations

Supersedes: v.3 Compliance Program for Northern Inyo Healthcare District

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

**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL PROCEDURE**

| | | |
|---|---|---|
| Title: Subpoena and Legal Summons for Workforce | | |
| Owner: Compliance Officer | Department: Compliance | |
| Scope: District Wide | | |
| Date Last Modified: 07/19/2021 | Last Review Date: No Review Date | Version: 1 |
| Final Approval by: Executive Committee | Original Approval Date: | |

## Acceptance of Summons, Complaints and Subpoenas.

District workforce must exercise care when presented with any documents concerning legal actions in which the District or its employees are involved. Only the Office of the Compliance Officer may accept service of summons and complaints on behalf of the District. Subpoenas for District records and/or records of any patient of the District, regardless of the location of those records, must be directed to the Office of the Compliance Officer.

Subpoenas for patient or other non-District records from business affiliates of the District will be handled by the agent designated by the business affiliate and/or pursuant to any policy so adopted by the business affiliate.

Failure to appropriately handle summons, complaints or subpoenas could place the District and the workforce member at risk or disadvantage in legal proceedings. Failure to follow required procedures may be cause for discipline, up to and including termination.

## Definitions.

- **Summons:** A legal document that notifies an individual or entity that a lawsuit has commenced and that the individual or entity served must respond to the complaint.
- **Complaint:** A legal document that sets forth the claims(s) in a lawsuit and the relief being sought by the plaintiff (one who commences a lawsuit to obtain a remedy for an alleged injury to his or her rights).
- **Subpoena:** An order issued by a court or attorney for the production of records or for a person to appear at a deposition (oral testimony under oath) or in court.

## Summons and Complaints.

### A. When the District is a party named in a Summons and Complaint.

If a marshal or other process server attempts to serve a Summons and Complaint on the District to an employee, the process server must be referred to the Office of the Compliance Officer. Only the Office of the Compliance Officer may accept service on behalf of the District.

### B. When both the District and a staff member are named as parties in a Summons and Complaint.

If a marshal or other process server attempts to serve a staff member who is personally named in a complaint along with the District, the workforce member may accept service of the Summons and Complaint only on his or her own behalf. In addition, the workforce member must immediately notify Office of the Compliance Officer.

The process server must be referred to the Office of the Compliance Officer for service of the Summons and Complaint on the District. Only the Office of the Compliance Officer may accept service on behalf of the District. No other District office is authorized to accept service of process on the District's behalf.

**C. When a workforce member and not the District is a party named in a Summons and Complaint.**

**1. A work-related complaint.**

If the complaint, naming only the workforce member, is based on the workforce member's conduct within the course and scope of his or her employment with the District, the workforce member must accept the complaint and contact the Office of the Compliance Officer immediately.

**2. A non-work-related complaint.**

If the complaint naming the workforce member is based on conduct occurring outside the course and scope of his or her employment with the District, the workforce member shall act on his or her own behalf without involving the District. Process servers are not permitted into restricted or patient areas without express permission and an escort by District personnel.

**3. Accepting service on behalf of another workforce member.**

A workforce member asked by the process server to accept service of a Summons and Complaint on behalf of another workforce member should not do so. No workforce member is "apparently in charge" of any office or place of business owned by the District within the meaning of applicable State and/or Federal law. The process server must be referred to the Office of the Compliance Officer for instructions on substitute service of a workforce member in accordance with District policy and applicable law.

**Subpoenas for Records.**

**A. Subpoenas for District records.**

Other than designated personnel, workforce members must not accept subpoenas for District records. Subpoenas for District records, regardless of the location of those records, must be directed to the Office of the Compliance Officer. Thereafter, the Office of the Compliance Officer will transmit the subpoena to the District's proper Custodian of Records. District records do not include the patient or administrative records of business affiliates of the District.

**B. Subpoenas for patient or non-District records from business affiliates.**

Each business affiliate of the District must notify the Office of the Compliance Officer when it accepts subpoenas for patient or non-District records or for District records that may be in the possession, custody or control of the business affiliate. Prior to the production of any District records that may be in the possession, custody or control of a business affiliate, the business affiliate must notify the District.

**Subpoenas for Testimony or for Testimony and Records.**

**A. Subpoena relating to District employment.**

If a workforce member is served with a subpoena in his or her capacity as an employee or agent of the District, he or she must contact the Office of the Compliance Officer prior to accepting service or, if prior contact is not possible, he or she must contact the Office of the Compliance Officer as soon as is possible after accepting service.

**B. Subpoena relating to a business affiliate employment.**

A physician who is served within his or her capacity as an employee or agent of a business affiliate can either accept the subpoena personally or pursuant to the policy for accepting subpoenas set for by the District's business affiliate.

### C. Subpoenas not related to District employment.

Subpoenas for individuals, served in their individual capacity and not as employees or agents of the District, must be personally served on the named individual. For example, the employee witnessed an incident (e.g., a car accident) unrelated to his or her employment and is being subpoenaed to testify as a witness.

| **Summons and Complaint** | |
|---|---|
| **Parties Named in Summons and Complaint** | **Required Action** |
| District only | Refer process server to the Office of the Compliance Officer |
| District and employee | Refer process server to the Office of the Compliance Officer for service on the District. Employee may accept service only on his or her own behalf and must notify the Office of the Compliance Officer immediately. |
| Employee only, work-related | Employee must accept summons and complaint and contact the Office of the Compliance Officer immediately. |
| Employee only, non-work related | Employee must act on his or her own behalf without involving the District. |
| If named employee is absent | Do not accept service on behalf of another employee. Contact the Office of the Compliance Officer for instructions.<br><br>Note: If, after you inform a process server that you are not authorized to accept legal documents on behalf of the District or other workforce members and the process server insists on leaving documents with you, promptly deliver any documents left with you to the Office of the Compliance Officer together with the envelope, any packaging, and an explanation of when and how you came to be in possession of the legal documents. |
| **Subpoena for Records** | |
| **Type of Record** | **Required Action** |
| District records | Employee must not accept subpoena. Direct the process server to Office of the Compliance Officer. Note: District |

in review

| | |
|---|---|
| | records do not include the patient or administrative records of private faculty medical practice plans. |
| Patient or non-District records from District's business affiliate | District's business affiliates must notify the Office of the Compliance Officer regarding who will accept subpoenas for non-District records. |

| **Subpoena for Testimony or for Testimony and Records** | |
|---|---|
| **Type of Testimony or Record** | **Required Action** |
| Employment related | Contact the Office of the Compliance Officer prior to accepting service. |
| Relating to a District's business affiliate | If testimony and/or records subpoenaed are within workforce member's capacity as an employee of a business affiliate, he or she may either accept subpoena or, otherwise, pursuant to the policies of the business affiliate related to accepting service. |
| Non-employment related | Subpoenas for individuals served in their individual capacity and not as employees or agents of the District must be served on the named individual. |

Developed: 6/21 (Legal Counsel)

Supersedes: N/A

in review