# April 20 2022 Regular Board Meeting

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

# *AGENDA*

## NORTHERN INYO HEALTHCARE DISTRICT
## BOARD OF DIRECTORS REGULAR MEETING

## April 20, 2022 at 5:30 p.m.

Northern Inyo Healthcare District invites you to join this meeting:

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

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

The Board is again meeting in person at 2957 Birch Street Bishop, CA 93514. Members of the public will be allowed to attend in person or via zoom. Public comments can be made in person or via zoom:

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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. New Business:
   A. Presentation by Stern Security (*Board will receive this presentation)*
   B. Presentation by Eastern Sierra Cancer Alliance *(Board will receive this presentation)*

C. Northern Inyo Healthcare District Benefit Highlights Presentation (*Board will receive this presentation)*

D. Approval of the District Board Resolution, 22-05 Nondesignated Public Hospital Bridge Loan Program *(Board will consider the adoption of this District Board Resolution)*

E. Approval of the Replacement of the Heating and Air Conditioning Units 1967 Building $80,000.00 (*Board will consider the approval to replace the heating and air conditioning unit 1967 building for $80,000.00)*

F. Northern Inyo Healthcare District 2022 Community Heath Needs Assessment CHNA Update (*Board will receive this update)*

G. Northern Inyo Healthcare District Radiology Services Update (*Board will received this update)*

H. Northern Inyo Healthcare District Workforce Housing Update *(Board will receive this update)*

I. Northern Inyo Healthcare District (NIHD) Governance Committee update and discussion of the NIHD Board of Directors Standing Committees *(Board will receive a this update and consider having this discussion)*

4. Chief of Staff Report, Sierra Bourne MD:

A. Proposed Amendments to Medical Staff Bylaws (*Board will consider the approval to amend these bylaws*)

1. The Active Medical Staff of Northern Inyo Healthcare District has approved the enclosed amendments to the current Medical Staff Bylaws by written ballot and is requesting the Northern Inyo Healthcare District Board of Directors review and consider these amendments for approval. Provided for the Board of Directors review is a document titled "Summary of the Proposed Changes," which provides a high-level overview of the amendments with page citations. Additionally, the full Medical Staff Bylaws text with marked revisions is also included.

B. Policies (*Board will consider the approval of these policies*)

1. *Naloxone (Narcan) Distribution*
2. *Stress Echocardiogram*
3. *Surgery Tissue/Bone Graft "Look Back" Policy*
4. *Interdisciplinary Team – Clinical Screens Built into the Initial Nursing Assessment*
5. *Emergency Management Plan*

C. Medical Executive Committee Meeting Report (*Board will receive this information*)

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***Consent Agenda***

5. Approval of District Board Resolution 22-06, to continue to allow Board meetings to be held virtually *(Board will consider the adoption of this District Board Resolution)*
6. Approval of minutes of the March 16, 2022 Regular Board Meeting *(Board will consider the approval of these minutes)*
7. Financial and Statistical reports as of February 28, 2022 (*Board will consider accepting this report)*
8. Approval of Policies and Procedures *(Board will consider the approval of these Policies and Procedures)*
    A. Forms Development and Control Policy
    B. Nondiscriminatory Policy
    C. Overtime
    D. Smoking/Tobacco Policy
    E. Standby/Callback
    F. Unusual Occurrence Reporting
    G. Paid Time Off
9. Approval of the Northern Inyo Healthcare District Rural Health Clinic- Policies and Procedures & Addendums to the Policies (*Board will consider the approval of these Policies and Procedures & Addendums to the Policies)*
    A. Policies and Procedures
        1. *Regulatory Compliance Policy*
        2. *Formal Corporate or Organization Compliance Plan Policy*
        3. *Organizational Structure and Ownership*
        4. *Organizational Chart Policy*
        5. *Non-Discriminatory Policy*
        6. *RHC Service Area (Location)*
        7. *Advertising, Web-Presence and Social Media Representation*
        8. *Physical Plant Safety: General Policy*
        9. *Preventive and Required Maintenance*
        10. *Building Sanitation and Cleanliness*
        11. *Storage, Handling & Administration of Drugs, Biologicals, and Pharmaceuticals*

12. *Blood Bourne Pathogens: Exposure Control (Including Needle Sticks)*
13. *Infection Control Policy*
14. *Disinfection and Sterilization Policy*
15. *Accidental Needle Sticks*
16. *Medical Waste Handling and Disposal*
17. *Hazardous Materials*
18. *Smoke-Free Workplace*
19. *Fire Safety, Training and Evacuation*
20. *Severe Weather and External Disaster Policy*
21. *Communication During Internal or External Situations*
22. *Visitor Policy*
23. *Animals and Pet Policy*
24. *RHC Provision of Services*
25. *Medical Management Guidelines*
26. *Patient-Provided or 3rd Party Pharmaceuticals*
27. *Referral Policy*
28. *Transitional Care and Continuity of Care Management*
29. *Missed Appointments*
30. *Emergency Care and Treatment*
31. *Discharging/Dismissing a Patient*
32. *After Hours Care*
33. *Medical Records Policy*
34. *Medical Records Integration Policy*
35. *Health Information Technology/IT*
36. *General Employment Policies*
37. *Credentialing and Employment Policy*
38. *COVID-19 Vaccination Policy*
39. *Periodic Performance Evaluation and Clinical Competency*
40. *Program Evaluation Policy*
41. *Quality Assurance and Utilization Review*
42. *Grievance Policy*
43. *Risk Management Policy*

44. *Financial Policies*

B. Addendums to the Policies

1. *Non-Discriminatory Policy- Policy Addendum: Processes and Procedures*
2. *Disinfection and Sterilization Policy- Addendum Policy*
3. *Communication During Internal or External Situations- Addendum Policy*
4. *Medical Management Guidelines- Policy Addendum: Processes and Procedures*
5. *Patient-Provided or 3rd Party Pharmaceuticals- Policy Addendum: Processes and Procedures*

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10. Reports from Board members (*Board will provide this information*).
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**
**REPORT TO THE BOARD OF DIRECTORS**
**FOR INFORMATION**

Date: 3/31/2022

Title: **ANNUAL SECURITY & PENETRATION RESULTS AND FINDINGS.**

Synopsis: This report is the results of our yearly **ANNUAL SECURITY & PENETRATION TESTING / RETESTING**. This testing is required to meet certain areas of compliance.

**What is Penetration testing?** (Pen testing) is a security exercise where a cyber-security expert (Stern Security) attempts to find and exploit vulnerabilities in our network or computer systems. The purpose of this was to simulate an attack to identify any weak spots in our system's defenses which attackers could take advantage of and exploit our users or patients.

Prepared by: Bryan Harper - ITS Director | CISO

Approved by: Kelli Davis
Kelli Davis, Chief Executive Officer

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

# 2021 Penetration Test

# Executive Summary Report

Northern Inyo Healthcare

Assigned Stern Security Team:
Jon Sternstein
Peter Nelson
Kyle Malicoate

Report Date: 12/6/21

Engagement # P210820001

**Information contained in this report is considered confidential**

## Table of Contents

## About Stern Security

Stern Security is a cyber security company headquartered in Raleigh, NC dedicated to customer service and improving the long-term security posture of organizations. Our workforce holds major data security certifications, have won security awards and security competitions, taught security classes, and continuously present at security conferences. Stern Security was a finalist for the 2019 NC TECH Cyber Security Award for the Velocity product and a finalist for the 2018 NC TECH Analytics Award for the Healthcare Breaches Executive Dashboard.

We are deeply involved in the security community. We are members of several groups including ISSA, NCHICA, ISC2, and BSides RDU. Our founder and CEO, Jon Sternstein was the former Security Officer at a large healthcare organization and is the co-author of Security Penetration Testing (The Art of Hacking Series) published by Cisco Press.

Giving Back – At Stern Security, we strongly believe in giving back to the community. A portion of all sales go back into building stronger communities through education and affordable housing programs. Since 2019, we have provided educational resources for 90 youths to become proficient developers and have donated funds that provided thousands of nutritious meals to those in need. Some of our programs that we contribute to include: Tweens & Technology, Bowling for Autism, Habitat for Humanity, and the Food Bank.

# EXECUTIVE SUMMARY

Cyber-attacks are an everyday occurrence for companies across all industries. Stern Security performed the following penetration test on Northern Inyo Healthcare in October and November of 2021. The purpose of the penetration test was to determine the security posture of the organization and discover potential vulnerabilities. Through the penetration test, Stern Security's data security team emulated real world attacks to test the organization's defenses and make staff aware of vulnerabilities before adversaries find them.

There are some good security measures in place at Northern Inyo Healthcare. Solutions such as admin account usage alerts, decoy systems, and Security Information Event Management (SIEM) systems, are more common in much larger organizations with full security teams. There were no discovered exploitable systems on the external network so the most likely attack avenues from the internet are phishing and malware. Implementing 2-factor authentication over the past year greatly increased the external security posture. Some of the top positive security measures include:

1. Proactive Penetration Test
2. 2-factor Authentication on External Portals
3. Security Awareness Training
4. No Exploitable External Systems Discovered
5. Alerting on Admin Account Usage
6. Log Reviews

While there are great security measures in place, security can always be improved, and Stern Security was able to discover high risk vulnerabilities. Stern Security was able to compromise the entire organization through outdated and unpatched internal servers. Some of these unpatched systems are unsupported by Microsoft and need to be either upgraded or decommissioned as they are a high risk of compromise and of ransomware attacks.

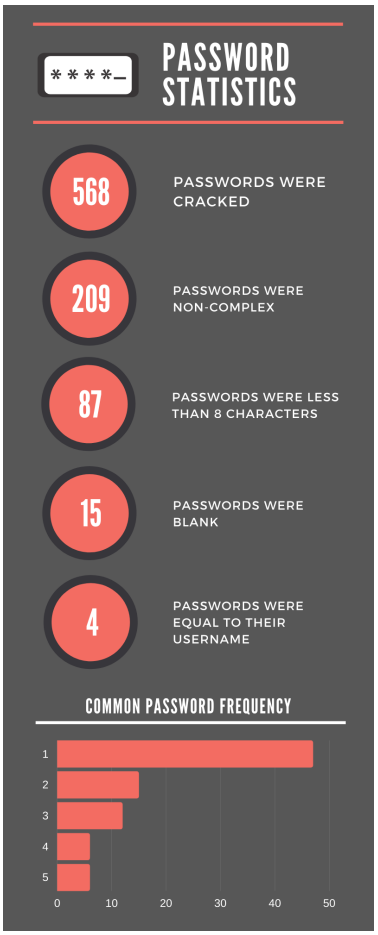
The top vulnerabilities include:

1. Exploitable Systems
2. No Guest Wireless Segmentation (FIXED)
3. Unsupported Systems
4. Unauthenticated Access to PACS
5. Weak Passwords
6. Lenient Access to Sensitive Data

Overall, Northern Inyo Healthcare has a number good security measures in place, but will need to remediate the discovered vulnerabilities to reduce risk. There were no exploitable systems on the external network so the most likely attack avenues from the internet are phishing and malware. Implementing 2-factor authentication over the past year has greatly increased the external security posture. Multiple vulnerabilities that Stern Security discovered pose a high risk to the organization and their remediation efforts should be prioritized. Stern Security has several recommendations to increase the security posture of the organization. Patching or decommissioning exploitable systems, adding authentication to PACS, reviewing network share permissions, and increasing password strength will go a long way to increasing the security posture of the organization.

## Password Statistics

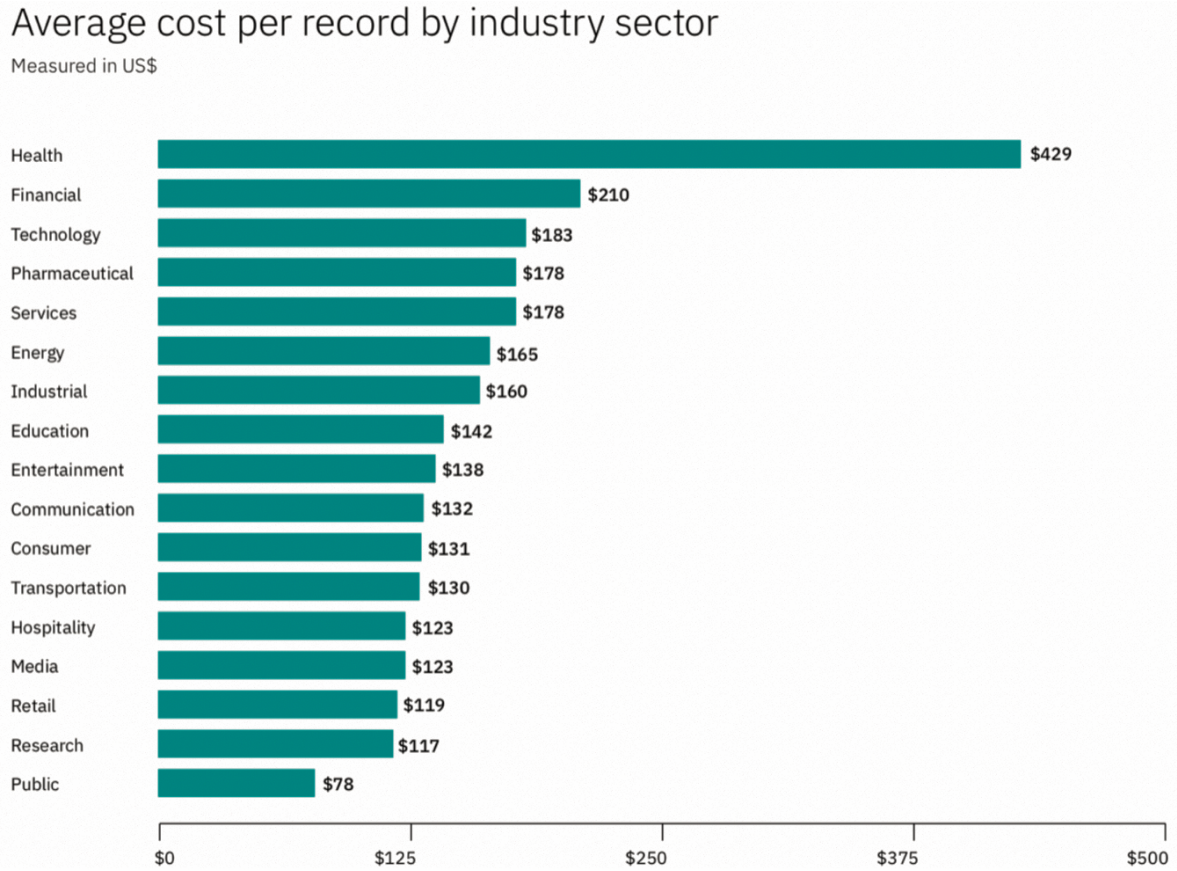
As passwords were one of the top issues, Stern Security performed a deeper dive into the passwords utilized across the organization.



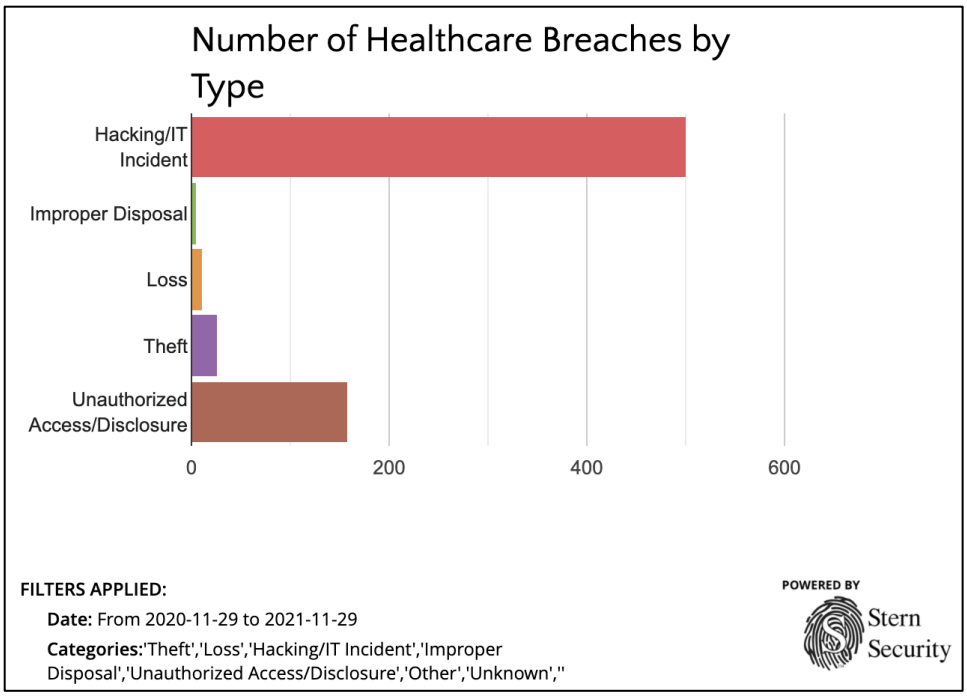
## Risk

Performing a penetration test was imperative to determine the security posture of the Northern Inyo Healthcare, view the environment from the eyes of an attacker, give recommendations to the organization on how to increase their security, and help the Northern Inyo Healthcare protect its data. Penetration testing is becoming increasingly critical, as all sensitive data is available in electronic format.

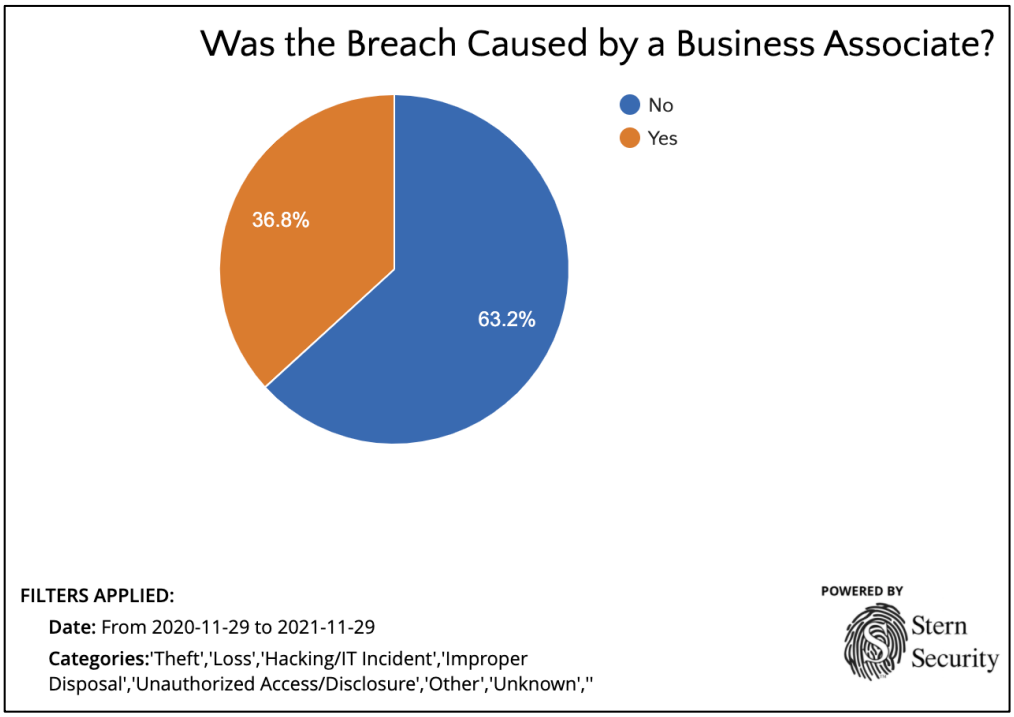
According to the 2019 Ponemon Institute benchmark study, the average cost of a data breach was $429 per compromised account across in the healthcare industry.



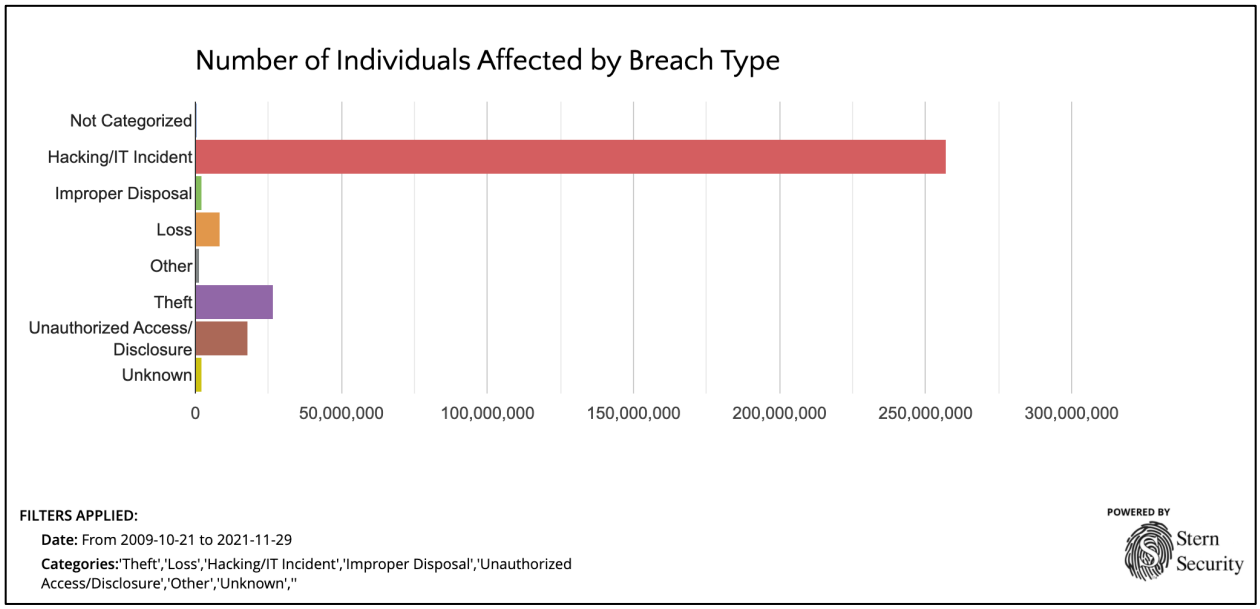

Cost of a Data Breach by industry (Ponemon Institute, 2019)




Hacking is the top cause of data breach within the healthcare industry




36.8% of healthcare breaches over the past 12 months were caused by Business Associates




Hacking has been the cause of most PHI loss in healthcare breaches

To measure the risk, Stern Security gives each discovered vulnerability a rating based on the NIST (National Institute of Standards and Technology) Information Security Guide for Conducting Risk Assessments. The risk is a variation of high, medium, or low rating based on a calculation of the likelihood of a threat event occurrence compounded by the impact of a threat.

**TABLE I-2: ASSESSMENT SCALE – LEVEL OF RISK (COMBINATION OF LIKELIHOOD AND IMPACT)**

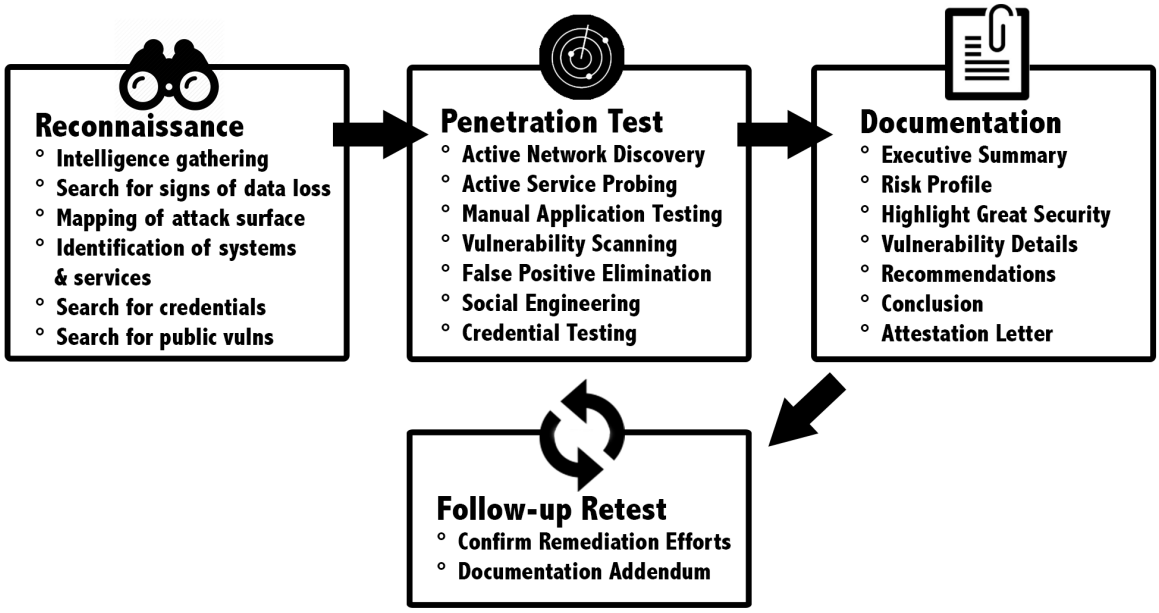
| Likelihood (Threat Event Occurs and Results in Adverse Impact) | Level of Impact | | | | |
|---|---|---|---|---|---|
| | Very Low | Low | Moderate | High | Very High |
| Very High | Very Low | Low | Moderate | High | Very High |
| High | Very Low | Low | Moderate | High | Very High |
| Moderate | Very Low | Low | Moderate | Moderate | High |
| Low | Very Low | Low | Low | Low | Moderate |
| Very Low | Very Low | Very Low | Very Low | Low | Low |

Risk Scale – Overall Risk (NIST, 2012)

# Methodology

Stern Security's methodology follows internally developed data security tactics as well as public penetration testing standards including the Open Web Application Security Project (OWASP) and the Penetration Testing Execution Standard.

The penetration test was divided in to several sections, Reconnaissance, External Penetration Testing, Internal Penetration Testing, Working with Staff, and Reporting.




## Reconnaissance

The first phase of the Penetration Test was the reconnaissance phase. During this stage, Stern Security utilized passive tests to discover information about the client environment. These tests included searching the underground web for information about the organization, reviewing public breaches, social networking sites, and search engines. The results of this examination allowed Stern Security to map the environment with information freely available on the Internet and gave the security team the intelligence they needed to target certain vulnerabilities.

## External Penetration Test

This phase utilized the information discovered within the Reconnaissance phase to actively assess the organization's external hosts in order to access the internal network. In this stage, Stern Security targeted the organization similar to how an external attacker would.

The Penetration Testing team manually assessed the external websites, VPN portals, and other available external services. Stern Security also performed the vulnerability scans during this phase.

### Internal Penetration Test

Stern Security delivered a laptop that was plugged into the internal network. Stern Security performed security tests from the internal network. This showed the organization's exposure from the viewpoint of an attacker or malware that has infiltrated the internal network or compromised an internal system. The security team was given a list of VLANs and hosts to avoid.

### Reporting

The final phase of the penetration test was the Reporting phase. This is where all of the data was combined, recommendations were listed, and this report was delivered to Northern Inyo Healthcare.

# Scope

The penetration test was performed on the network segments belonging to Northern Inyo Healthcare.

## External

Stern Security was given a list of external subnets at the beginning of the engagement. Stern Security performed all external attacks on these addresses. This ensured that the attacks would be limited to the Northern Inyo Healthcare.

| | |
|---|---|
| **External subnets** | 47.176.53.48/29<br>199.26.184.0/26<br>162.252.88.34/32<br>162.252.88.53/32 |
| **Domain** | Nih.org |

See Appendix A for additional details on the discovered external hosts.

## Internal

Stern Security was given an open network port on the 10.71.0.0/24 network.

## Wireless

Four wireless networks were in scope of the penetration test.

| SSID |
|---|
| NIH-Hospital |
| NIH-Guest |
| PACS |
| Clinical Engineering |

# Schedule

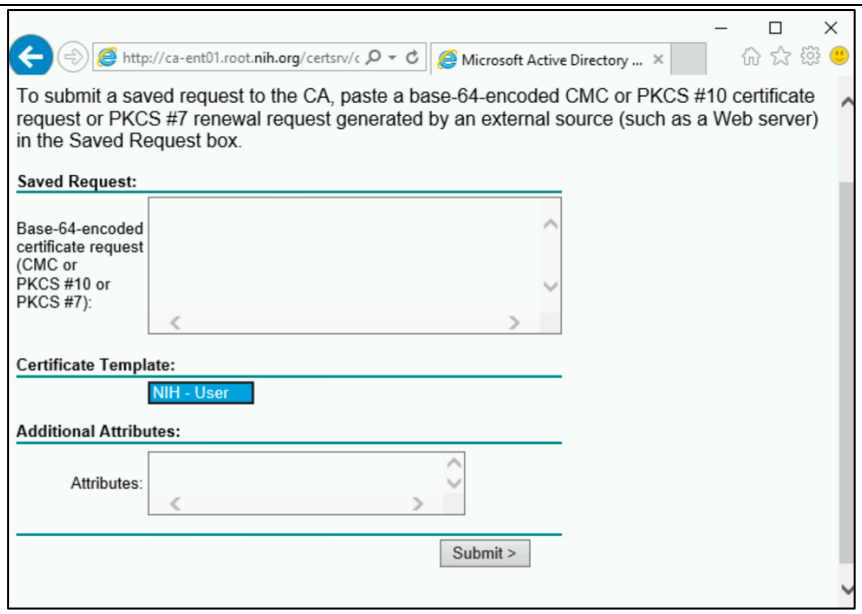
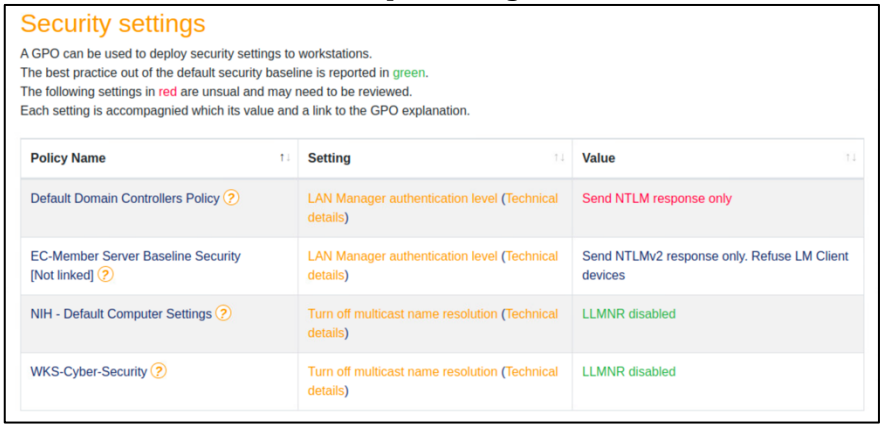
Stern Security kept a strict schedule during the penetration testing engagement.

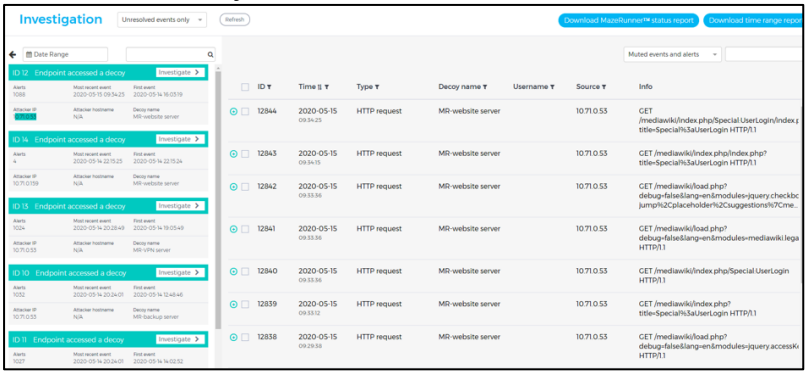
| ID | Pen Test Phase | Date |
|---|---|---|
| **1** | External Penetration Test | October 19th, 2021– October 22nd 2021 |
| **2** | Internal Penetration Test | October 25th,2021 – November 4th, 2021 |

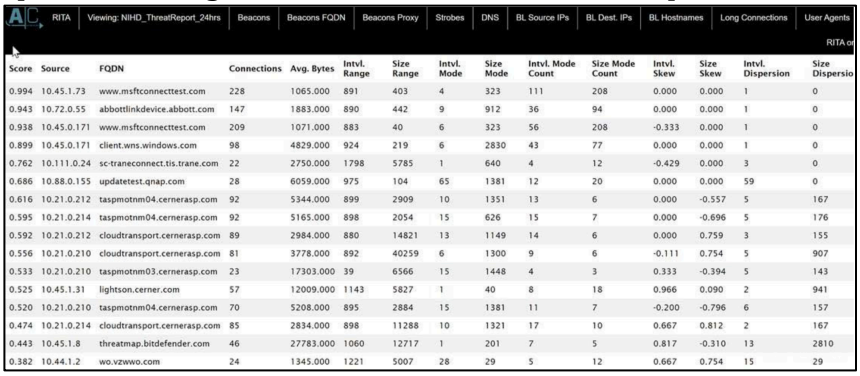
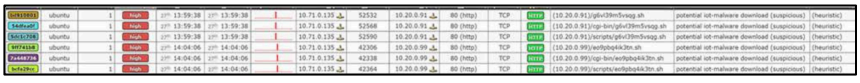
# POSITIVE SECURITY MEASURES

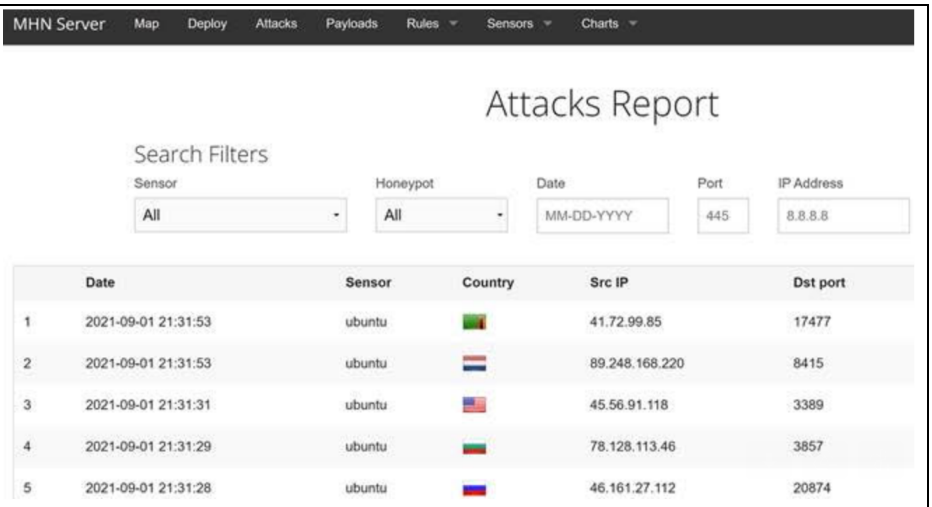
It is important to note some great security measures that are in place at Northern Inyo Healthcare. For an organization of its size, NIH has some great protective measures in place, some of which are more common in much larger organizations.

| ID | Security Measure | Details |
|---|---|---|
| 1 | **Proactive Penetration Test** | Northern Inyo Healthcare hired Stern Security to perform this penetration test. This was a great proactive security measure by Northern Inyo Healthcare to increase their security posture! |
| 2 | **Limited External Hosts** | Very few servers are accessible from the public internet. Only 11 hosts were accessible externally (for the in-scoped devices) and these servers only had a minimum amount of services available. |
| 3 | **DNS Zone Transfer not Allowed** | "DNS Zone Transfers" are not allowed on the DNS servers. |
| 4 | **Security Information Event Management (SIEM) System** | The organization has a SIEM in place to collect, correlate, and analyze logs from various sources. The system is hosted at alienvault.root.nih.org (10.20.0.26). |
| 5 | **Null Session Access Limited on Domain Controllers** | When performing a null session on the domain controllers, group membership could not be viewed. |
| 6 | **Log Reviews** | Staff actively reviews logs and were able to identify some activities performed by Stern Security |
| 7 | **No open shares** | No open shares were found in the VLANs that were scanned. Open Shares are shared folders that are accessible to anyone without credentials. |
| 8 | **2-Factor Authentication on External Login Portals** | The external portals are protected by 2-factor authentication. Imprivata ID is used for Citrix and Fortitokens are used for VPN and webmail. Great job! |
| 9 | **Users can only Issue "User Certificates"** | The certificate templates are limited to "user certificates" for end users. They cannot issue web server certificates. |

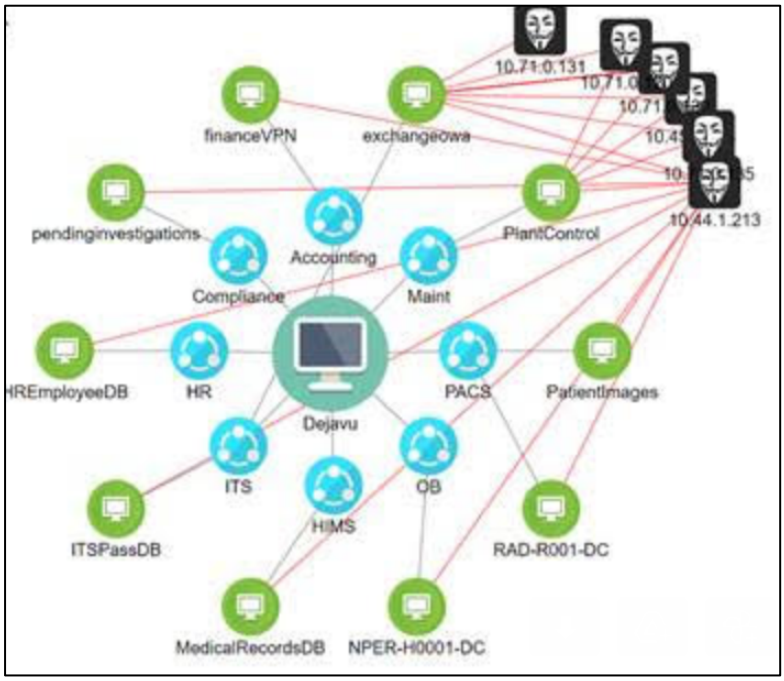
| | | |
|---|---|---|
| | |  |
| 10 | **Vulnerability Scans** | NIH performs vulnerability scans with OpenVAS. |
| 11 | **LLMNR and NetBIOS-NS Disabled** | The organization has disabled LLMNR and NetBIOS-NS protocols to limit certain local network poisoning attacks.<br>  |
| 12 | **Web Filtering** | The organization performs web filtering to block certain categories of websites. |

| | | |
|---|---|---|
| | |  |
| 13 | **Decoy Web Server Alerts** | NIH has deployed decoy web servers which trip alerts when anyone browses to the site. This is a neat way to find systems that are scanning the network for vulnerable devices. The software used for the decoys is MazeRunner. Great work!<br>  |
| 14 | **Current Wireless Encryption Standards** | All of the wireless networks in scope utilized a form a WPA2 encryption. No outdated WEP wireless networks were discovered. |
| 15 | **Security Awareness Training** | NIH performs both ongoing and annual security awareness training for staff. The organization utilizes KnowBe4 for regular phishing exercises and comprehensive annual testing. NIH tracks progress for staff and the organization over time. This staff education greatly helps the security posture of the organization. Excellent work! |

| | | |
|---|---|---|
| | |  |
| 16 | **Monitoring of Outbound Traffic** | NIH utilizes the RITA tool to monitor all outbound traffic for suspicious user agents and other Indicators of Compromise.<br>  |
| 17 | **Monitor VLANS for Malicious Traffic** | All internal VLANs are monitored for malicious traffic utilizing MalTrial.<br>  |
| 18 | **Honeypots** | NIH has deployed honeypots to trick intruders into attacking decoy systems and then the system blocks their IP addresses from reaching any other hospital system. |

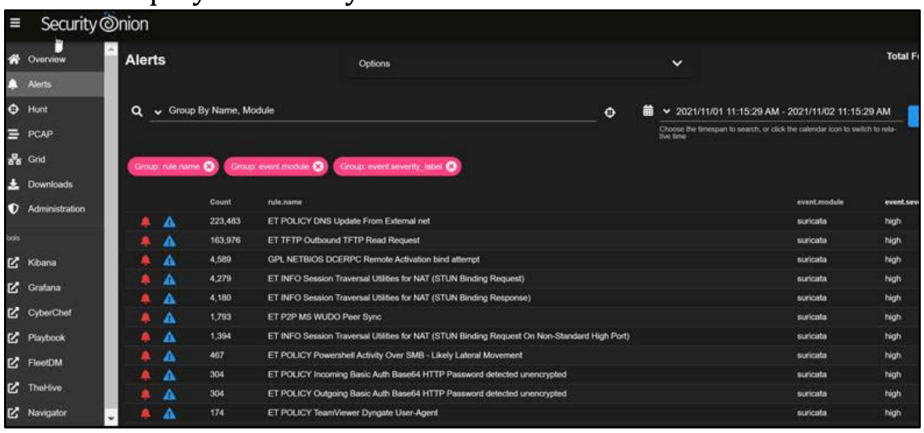
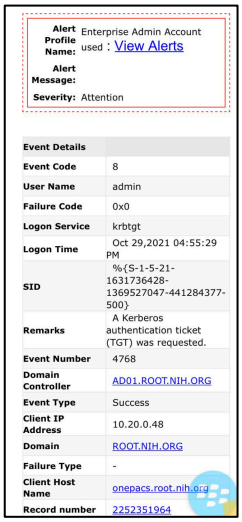



External honeypot




Internal honeypot

| | | |
|---|---|---|
| 19 | **Link Warning for Employees** | NIH has deployed KnowBe4's "Second Chance" tool which prompts staff with a warning if they click on email links. |

| | | |
|---|---|---|
| | |  |
| 20 | **Monitor Traffic with Security Onion** | NIH has deployed Security Onion to monitor traffic for threats.<br>  |
| 21 | **Account Alerts** | When certain administrative accounts are used, alerts are generated.<br>  |

| | | |
|---|---|---|
| 22 | **Account Creation Alerts** | Alerts are generated when accounts are created.<br>  |
| 23 | **No Exploitable Systems Externally** | There were no exploits discovered on the publicly available external systems. |

# Internal Penetration Test Attack Timeline

During the internal portion of the penetration test, Stern Security deployed a laptop on site which was plugged into the internal network. Stern Security mimicked the strategies of an attacker that gained access to the network via account compromise, physical access, or malware.

During the week, Stern Security was able to successfully gain access to all usernames and encrypted passwords, and thousands of sensitive files on the network.

### Details of the Internal Penetration Test attack:

| ID | Summary |
|---|---|
| 1 | Connect to Network |
| 2 | Enumerated Domain Servers using Nmap |
| 3 | Performed Ping Sweep on 10.71.0.0/16, 10.150.0.0/16 and 10.20.0.0/16 subnets. |
| 4 | Performed Nmap port scan for open port 445(SMB) on hosts in the 10.20.0.0/16 range. |
| 5 | Performed EternalBlue scans on the results of the SMB Nmap port scan |
| 6 | Exploited EternalBlue Remote Code Execution vulnerability on 10.20.0.47 (HUGS.root.nih.org) |
| 7 | Tested credentials against ad02.root.nih.org |
| 8 | Performed DCSync on ad02.root.nih.org |
| 9 | Began cracking hashes. |
| 10 | Could Access Sensitive Information |
| 11 | Wireless hacking |
| 12 | Tested Data Exfiltration |

# DISCOVERED VULNERABILITIES

### Vulnerability Summary

| ID | Vulnerability | Phase | Risk Level | Resolution |
|---|---|---|---|---|
| I1-21 | **EternalBlue Vulnerabilities** | Internal Penetration Test | VERY HIGH | Patch, segment or decommission the vulnerable systems. |
| I2-21 | **BlueKeep Vulnerabilities** | Internal Penetration Test | VERY HIGH | Patch, segment or decommission the vulnerable systems. |
| I3-21 | **No Guest Wireless Segmentation** | Internal Penetration Test | VERY HIGH / RESOLVED | Segment the guest wireless network via physical hardware or logically via subnets and ACLs. |
| I4-21 | **Unauthenticated Access to PACS** | Internal Penetration Test | HIGH | Require authentication to access the system.<br>Ensure the system uses HTTPS to communicate with clients. |
| I5-21 | **Access to Sensitive data** | Internal Penetration Test | HIGH | Review ACLs on network shares to ensure Principal of Least Privilege is in use and users only have access to what they need. |
| I6-21 | **Unsupported Software** | Internal Penetration Test | HIGH | Patch or uninstall the software. Migrate applications off unsupported operating systems. |
| I7-21 | **Missing Patches** | Internal Penetration Test | HIGH | Review the Nessus report and patch the affected systems. Develop and implement a patch process to ensure all systems are patched in a timely manner. |
| I8-21 | **Weak Password Policy** | Internal Penetration Test | HIGH | Configure a policy to meet current industry standards. Ensure admin and service accounts have passphrases |

| | | | | |
|---|---|---|---|---|
| | | | | that are at least 15 characters in length. |
| I9-21 | **Weak Password Storage** | Internal Penetration Test | HIGH | Remove GPOs that contain passwords if not needed. Apply patch KB2962486 which prevents credentials from being stored in Group Policy Objects. Change the password on accounts that had their passwords in these files. |
| I10-21 | **Unnecessary Administrators** | Internal Penetration Test | MODERATE | Review the "Domain Admins" group and remove accounts that do not need that level of access. |
| I11-21 | **No Egress Port Filtering** | Internal Penetration Test | MODERATE | Restrict outbound access to only necessary ports. |
| I12-21 | **Minimal Segmentation on the Server Network** | Internal Penetration Test | MODERATE | Place systems on VLANs according to their data classification. Enable VLAN ACLs to limit access between VLANs. |
| I13-21 | **Anonymous FTP allowed** | Internal Penetration Test | MODERATE | Disable Anonymous FTP |
| I14-21 | **Lack of Data Loss Prevention Controls** | Internal Penetration Test | MODERATE | Restrict access to websites that are only necessary for employees and servers. Enable Data Loss Prevention (DLP) controls on the network. |

## CONCLUSION

Northern Inyo Healthcare has some good security measures in place to prevent attacks and the external security posture was greatly increased with the addition of 2-factor authentication. There are several high-risk security vulnerabilities that should be addressed in order to prevent compromise. Outdated and unsupported systems need to be patched, upgraded, isolated, or decommissioned. Password strength needs to be increased, especially on administrator and service accounts. Permissions on network shares should be reviewed to limit access based on role. Stern Security highly recommends that Northern Inyo Healthcare fix the noted vulnerabilities in order to prevent similar attacks in the future.

Stern Security would like to thank the Northern Inyo Healthcare for the opportunity to perform this engagement!

# Works Cited

NIST. (2012). *Guide for Conducting Risk Assessments 800-30.* National Institute of Standards and Technology.

Ponemon Institute. (2019). *2019 Cost of Data Breach Study: Global Analysis.* Ponemon Institute.

# Appendix A – External Northern Inyo Healthcare Hosts

Stern Security used several different methods for discovering the external hosts.

1. Reverse DNS Lookup – Domain Name Servers were queried to discover the host name associated with the IP address.
2. Brute Force Hostnames – Stern Security guessed common hostnames.
3. Google – Stern Security performed Google searches for the domain in order to discover hosts and services.
4. Bing – Stern Security performed Bing searches for the domain in order to discover hosts and services.
5. Shodan – Stern Security performed Shodan searches for the domain.
6. Nmap scans – Hosts were actively scanned to discover services.
7. Certificate Transparency – Reviewing certificate transparency reports which contain issued SSL certificates on the domain.

| Host | IP Address | Ports |
|---|---|---|
| www.nih.org | 34.224.10.110 | 80/tcp, 443/tcp |
| | 47.176.53.52 | 80/tcp, 9200/Elasticsearch, 7547/tcp, 10250/tcp |
| | 47.176.53.53 | 82/Apache 2.4.29 |
| vpn.nih.org | 162.252.88.34 | 4443 |
| msgctr2.nih.org, msgctr.nih.org | 199.26.184.18 | 25/smtp, 8008, 8010, 8015 |
| webmail.nih.org | 199.26.184.19 | 80, 443, 8008, 8010, 8015 |
| | 199.26.184.27 | 2000/tcp, 5060/tcp |
| https://storefront.nih.org/vpn/index.html | 199.26.184.28 | 80, 443,8 008 ,8010, 8015, 8020 |
| https://199.26.184.37/login/?next=/ | 199.26.184.37 | 443 |
| | 199.26.184.58 | 2000/tcp, 5060/tcp/SIP |
| | 199.26.184.59 | 2000/tcp, 5060/tcp/SIP |

# Glossary

| Term | Definition |
|---|---|
| CAPTCHA | A website application that distinguishes humans from machines. |
| Cleartext Authentication | Authentication that is not encrypted. |
| DMZ | Demilitarized zone. A network that is a neutral zone between the trusted and untrusted zones. It is usually a network where organizations place servers that will be providing services to the public Internet. |
| Egress Filtering | Restricting the flow of traffic that is leaving the organization. |
| Exfiltration | Stealing data out of an organization. |
| Multifactor Authentication | A system that requires more than one method of authentication. The different methods of authentication are<br>1. Something you know (e.g. a password or PIN)<br>2. Something you are (e.g. fingerprint or retina scan)<br>3. Something you have (e.g. a card, phone, or key fob) |
| Password Hash | A hash is a one-way function that takes a string such as a password, processes it through an algorithm, and returns a fixed length value called a hash. The password cannot be determined from the hash. The same string always gets the same hash value when processed through the same algorithm. |
| Phishing | Malicious individual poses as a legitimate company and tricks an individual into giving them sensitive information |
| Social Engineering | Manipulating a human to gain access to a system. |
| VPN | Virtual Private Network. A means to securely access internal resources remotely. |

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

# Web Application Retest
# Executive Summary Report

North Inyo Healthcare

Assigned Stern Security Team:
Jon Sternstein
Peter Nelson
Kyle Malicoate

Report Date: 3/29/2022

**Information contained in this report is considered confidential**

## Table of Contents

# EXECUTIVE SUMMARY

Stern Security includes a retest as part of the penetration testing services. The purpose of a retest to validate fixes organizations implement to resolve vulnerabilities. Stern Security performed the penetration test on North Inyo Healthcare from October 19th -November 4th, 2021, and the retest was performed on March 23rd, 2022.

NIH provided a list of ten resolved vulnerabilities for the Stern Security team to verify. The Stern Security team performed the retest over a screenshare meeting with the NIH team. Of the ten reviewed eight were validated as resolved and two are still unresolved.

Upon retesting, two very high, three high, and three moderate findings have been resolved. The remaining reviewed vulnerabilities include one high and one moderate:

1. Unauthenticated Access to PACS
2. No Egress Port Filtering

During testing, the NIH team informed Stern Security they had engaged the OnePACS vendor to resolve the issue. OnePACS stated the issue was resolved but upon verifying the finding during the retest, it was discovered the vulnerability still exists.

The NIH team has done a good job resolving vulnerabilities. Stern Security recommends NIH continues work to resolve the remaining vulnerabilities.

# POSITIVE SECURITY MEASURES

It is important to note some great security measures that are in place at Northern Inyo Healthcare. For an organization of its size, NIH has some great protective measures in place, some of which are more common in much larger organizations.

| ID | Security Measure |
|---|---|
| 1 | **Proactive Penetration Test** |
| 2 | **Limited External Hosts** |
| 3 | **DNS Zone Transfer not Allowed** |
| 4 | **Security Information Event Management (SIEM) System** |
| 5 | **Null Session Access Limited on Domain Controllers** |
| 6 | **Log Reviews** |
| 7 | **No open shares** |
| 8 | **2-Factor Authentication on External Login Portals** |
| 9 | **Users can only Issue "User Certificates"** |
| 10 | **Vulnerability Scans** |
| 11 | **LLMNR and NetBIOS-NS Disabled** |
| 12 | **Web Filtering** |
| 13 | **Decoy Web Server Alerts** |
| 14 | **Current Wireless Encryption Standards** |
| 15 | **Security Awareness Training** |
| 16 | **Monitoring of Outbound Traffic** |
| 17 | **Monitor VLANS for Malicious Traffic** |
| 18 | **Honeypots** |
| 19 | **Link Warning for Employees** |
| 20 | **Monitor Traffic with Security Onion** |
| 21 | **Account Alerts** |
| 22 | **Account Creation Alerts** |
| 23 | **No Exploitable Systems Externally** |
| 24 | **Remediated Vulnerabilities** |

## Retest Vulnerability Summary

| ID | Vulnerability | 2021 Risk Level | Retest Risk Level | Notes |
|---|---|---|---|---|
| I1-21 | **EternalBlue Vulnerabilities** | VERY HIGH | RESOLVED | The NIH team has applied the missing patches for the EternalBlue vulnerabilities. |
| I2-21 | **BlueKeep Vulnerabilities** | VERY HIGH | RESOLVED | The NIH team has applied the missing patches for the BlueKeep vulnerabilities. |
| I4-21 | **Unauthenticated Access to PACS** | HIGH | HIGH | This issue had was previously resolved by the vendor, but during the retest, NIH and Stern Security found unauthenticated access to the PACS was restored. |
| I5-21 | **Access to Sensitive data** | HIGH | RESOLVED | The sensitive data discovered during testing has been removed by the NIH team. |
| I8-21 | **Weak Password Policy** | HIGH | RESOLVED | The password policy has been modified to meet current information security standards. |
| I9-21 | **Weak Password Storage** | HIGH | RESOLVED | The password saved in Group Policies have been removed. |
| I10-21 | **Unnecessary Administrators** | MODERATE | RESOLVED | The users in the Domain Admins group have been reviewed and only the necessary user accounts remain. |
| I11-21 | **No Egress Port Filtering** | MODERATE | MODERATE | The firewall rules have been reviewed and the NIH team has made great progress in implementing port filtering, but there are still more firewall rules to implement or modify. |
| I13-21 | **Anonymous FTP allowed** | MODERATE | RESOLVED | The anonymous login on the FTP server has been disabled and login attempts failed. |
| I14-21 | **Lack of Data Loss Prevention Controls** | MODERATE | RESOLVED | Attachment downloads and uploads have been blocked for email services (Gmail, Yahoo, etc.) |

NORTHERN INYO HEALTHCARE DISTRICT

*One Team. One Goal. Your Health.*

# PENETRATION TEST REVIEW

Presented by

Peter Nelson
Senior Security Engineer

Stern Security

# STERN SECURITY

WE ARE A CYBER SECURITY COMPANY DEDICATED TO CUSTOMER SERVICE AND IMPROVING THE LONG-TERM SECURITY POSTURE OF ORGANIZATIONS.

- PENETRATION TESTING
- DATA SECURITY CONSULTING
- VIRTUAL CISO

velocity™
By Stern Security

Quickly measure Internal and Third-Party Risk.

healthcarebreaches.com

Healthcare breach tracking.

sternsecurity.com

# TESTING METHODOLOGY

- Internally Developed Tactics, Techniques, and Proceedures
- Open Web Application Security Project (OWASP)
- Penetration Testing Execution Standard

# EXTERNAL TESTING

## No Exploitable External Systems Discovered

## Excellent Work!

sternsecurity.com

# INTERNAL TESTING

## Top Vulnerabilities

- Exploitable Systems
- No Guest Wireless Segmentation
  - Issue resolved prior to end of testing
- Unsupported Systems
- Unauthenticated Access to PACS
- Weak Passwords
- Lenient Access to Sensitive Data

## 14 Total Vulnerabilities

- Three Very High Risk
- Six High Risk
- Five Moderate Risk

# VULNERABILITY HIGHLIGHT

## Unauthenticated Access to PACS

Risk Rating: High

- NIH Staff engaged the OnePACS vendor.
- Vulnerability unresolved during retest.
- Vendor identified a system bug.
- Additional vulnerabilities discovered in the OnePACS system.

## Next Steps

- Options are limited for NIH to resolve.
- Continually engage OnePACS.

# WIRELESS TESTING

Four wireless networks were reviewed.

One high vulnerability was discovered and resolved prior to the end of the engagement.

sternsecurity.com

# VULNERABILITY RETEST

During the retest, of the 13 remaining findings 10 were tested to validate the issue is resolved.

## Retest List

2 of 2 Very High Risk Resolved

3 of 4 High Risk Resolved

3 or 4 Moderate Risk Resolved

**9** Findings Resolved

## Remaining Findings

- ZERO Very High Risk
- Three High Risk
- Two Moderate Risk

**5** Remaining

# STAFF KUDOS

It's important to highlight positive security measures in place at NIH. Throughout the penetration test, Stern Security noted 23 great protective measures.

## Top Positive Security Measures

Proactive Penetration Test

2-factor Authentication on External Portals

Security Awareness Training

No Exploitable External Systems Discovered

Alerting on Admin Account Usage

Log Reviews


# CONTACT

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Raleigh, NC

Website

sternsecurity.com

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

Date: March 23, 2022 for April BOD Meeting

Title: **PRESENTATION: EASTERN SIERRA CANCER ALLIANCE**

Synopsis: The Eastern Sierra Cancer Alliance (ESCA) will provide the board with a brief presentation on its mission & history, services, events, and resources. Board members will also recap of its recent Blue Ribbon Run and the importance of the ESCA-NIHD partnership.

Speakers: Andrea Shallcross, Marjee Neer, Michelle Garcia, and Cheryl Underhill

Current ESCA Board members include:

Cheryl Underhill, *President*
Michelle Garcia, *Secretary*
Rosie Graves
Gail Swain
Sarah Fruendt
Kevin Carunchio
Marjee Neer, *Vice President*
Andrea Shallcross, *Treasurer*
Amy Stange
Jim Tyler
Debbie Christensen
Barbara Laughon

Emeritus members:
Patricia Ramirez, *Founder*
Sherry Nostrant, *Resource Center*
Pat Anderson, *Angel Mentors Program*

Prepared by: Barbara Laughon
Barbara Laughon, *Manager*
*Marketing, Communications & Strategy*

Approved by: Kelli Davis
Kelli Davis,
*Chief Executive Officer*

# Eastern Sierra Cancer Alliance

NORTHERN INYO HEALTHCARE DISTRICT BOARD OF DIRECTORS

APRIL 20, 2022

# Meet our Board & Volunteers

**Patricia Ramirez**
Founder & Volunteer

**Cheryl Underhill**
President

**Margee Neer**
Vice- President

**Andrea Shallcross**
Treasurer

**Michelle Garcia**
Secretary

**Rosie Graves**
Member at Large

**Amy Stange**
Member at Large

**Sarah Freundt**
Member at Large

**Debbie Christensen**
Member at Large

**Jim Tyler**
Member at Large

**Kevin Carunchio**
Member at Large

**Barbara Laughon**
Member at Large

**Scot Swan**
Volunteer

**Patricia Anderson**
Volunteer

**Sherry Nostrant**
Volunteer

**Yolanda Hinson**
Volunteer

**Tanya Zaleschuk**
Volunteer

# Mission

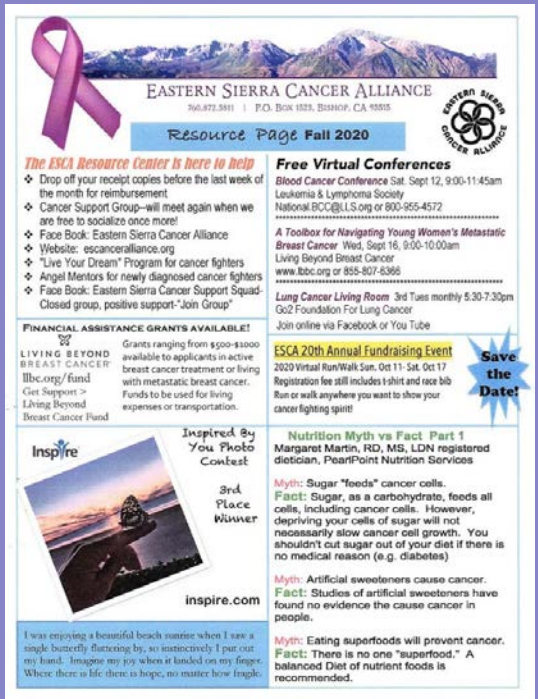
"To offer support to the Inyo and Mono Residents, including families and caregivers, faced with a cancer diagnosis and throughout their cancer journey."

## Goals

- Provide education, emotional support, and financial assistance.
- Collaborate with the Eastern Sierra medical community on directing clients to local and national resources.
- Bring awareness and promote early detection and cancer prevention.

# Services to the Community

- **Resource Center**
- Cancer Support Group
- Angel Mentorship Program
- Financial Assistance- medical, travel, cost of living, etc.



EASTERN SIERRA CANCER ALLIANCE

760.872.3811 | P.O. BOX 1523, BISHOP, CA 93515

Resource Page Fall 2020

**The ESCA Resource Center is here to help**

- Drop off your receipt copies before the last week of the month for reimbursement
- Cancer Support Group--will meet again when we are free to socialize once more!
- Face Book: Eastern Sierra Cancer Alliance
- Website: escanceralliance.org
- "Live Your Dream" Program for cancer fighters
- Angel Mentors for newly diagnosed cancer fighters
- Face Book: Eastern Sierra Cancer Support Squad- Closed group, positive support-"Join Group"

**FINANCIAL ASSISTANCE GRANTS AVAILABLE!**

LIVING BEYOND BREAST CANCER

llbc.org/fund

Get Support > Living Beyond Breast Cancer Fund

Grants ranging from $500-$1000 available to applicants in active breast cancer treatment or living with metastatic breast cancer. Funds to be used for living expenses or transportation.

**Free Virtual Conferences**

*Blood Cancer Conference* Sat. Sept 12, 9:00-11:45am
Leukemia & Lymphoma Society
National.BCC@LLS.org or 800-955-4572

*A Toolbox for Navigating Young Women's Metastatic Breast Cancer* Wed, Sept 16, 9:00-10:00am
Living Beyond Breast Cancer
www.lbbc.org or 855-807-6366

*Lung Cancer Living Room* 3rd Tues monthly 5:30-7:30pm
Go2 Foundation For Lung Cancer
Join online via Facebook or You Tube

**ESCA 20th Annual Fundraising Event**
2020 Virtual Run/Walk Sun. Oct 11- Sat. Oct 17
Registration fee still includes t-shirt and race bib
Run or walk anywhere you want to show your cancer fighting spirit!

Save the Date!

Inspire

Inspired by You Photo Contest

3rd Place Winner

inspire.com

I was enjoying a beautiful beach sunrise when I saw a single butterfly fluttering by, so instinctively I put out my hand. Imagine my joy when it landed on my finger. Where there is life there is hope, no matter how fragile.

**Nutrition Myth vs Fact Part 1**
Margaret Martin, RD, MS, LDN registered dietician, PearlPoint Nutrition Services

Myth: Sugar "feeds" cancer cells.
Fact: Sugar, as a carbohydrate, feeds all cells, including cancer cells. However, depriving your cells of sugar will not necessarily slow cancer cell growth. You shouldn't cut sugar out of your diet if there is no medical reason (e.g. diabetes)

Myth: Artificial sweeteners cause cancer.
Fact: Studies of artificial sweeteners have found no evidence the cause cancer in people.

Myth: Eating superfoods will prevent cancer.
Fact: There is no one "superfood." A balanced Diet of nutrient foods is recommended.

- Face-to-face emotional support to help guide through care or simply listen.
  - Supply Clients with cancer treatment accessories.
  - Assist in completing paperwork or applications for reimbursements.
  - Host the monthly Cancer Support Session.
  - Navigate with medical partners for additional support or resources.

# Services to the Community

- Resource Center
- Cancer Support Group
- Angel Mentorship Program
- **Financial Aid-** medical, travel, cost of living, etc.

# Financial Update

# Services to the Community

- Resource Center
- Cancer Support Group
- **Angel Mentorship Program**
- Financial Aid- medical, travel, cost of living, etc.

- Established in 2019 to provide a one on one mentor for those faced with a cancer diagnosis.
- Mentors are continuously expanding their knowledge through community resources and trainings.
- Clients are matched with a mentor has gone through the cancer journey.
- The relationship develops from mentor to friend.








Thank you Northern Inyo Healthcare District for the years of support and partnership!


# Questions? Thank you!

Eastern Sierra Cancer Alliance

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

Date: March 11, 2022

Title: **NONDESIGNATED PUBLIC HOSPITAL BRIDGE LOAN APPLICATION**

Synopsis: Authorizing the Execution and Delivery of Loan and Security Agreement and Promissory Note.

It is recommended that the Board of Directors approve the resolution of the authorization to execute the loan of $484,877.48 from California Health Facilities Financing Authority to fund the working capital of Northern Inyo Healthcare District and appointing Kelli Davis, Chief Executive Officer, as the Authorized Officer to execute and deliver any and all documents that are necessary for the completion of the loan process.

Prepared by: Dolores Perez, Assistant Controller

Approved by: Vinay Behl, Interim Chief Financial Officer

RESOLUTION NO. 22-05

RESOLUTION OF **NORTHERN INYO HEALTHCARE DISTRICT** AUTHORIZING EXECUTION AND DELIVERY OF A LOAN AND SECURITY AGREEMENT, PROMISSORY NOTE, AND CERTAIN ACTIONS IN CONNECTION THEREWITH FOR THE CALIFORNIA HEALTH FACILITIES FINANCING AUTHORITY NONDESIGNATED PUBLIC HOSPITAL BRIDGE LOAN PROGRAM

**Nondesignated Public Hospital Bridge Loan Program**

WHEREAS, **Northern Inyo Healthcare District** (the "Borrower") is a nondesignated public hospital as defined in Welfare and Institutions Code Section 14165.55, subdivision (l), excluding those affiliated with county health systems pursuant to Chapter 240, Statutes of 2021 (SB 170), Section 25; and

WHEREAS, Borrower has determined that it is in its best interest to borrow an aggregate amount not to exceed **$484,877.48** from the California Health Facilities Financing Authority (the "Lender"), such loan to be funded with the proceeds of the Lender's Nondesignated Public Hospital Bridge Loan Program; and

WHEREAS, the Borrower intends to use the funds solely to fund its working capital needs to support its operations;

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the Borrower as follows:

Section 1. The Board of Directors of Borrower hereby ratifies the submission of the application for a loan from the Nondesignated Public Hospital Bridge Loan Program.

Section 2. **KELLI DAVIS, CHIEF EXECUTIVE OFFICER (**an "Authorized Officer") is hereby authorized and directed, for and on behalf of the Borrower, to do any and all things and to execute and deliver any and all documents that the Authorized Officer(s) deem(s) necessary or advisable in order to consummate the borrowing of moneys from the Lender and otherwise to effectuate the purposes of this Resolution and the transactions contemplated hereby.

Section 3. The proposed form of Loan and Security Agreement (the "Agreement"), which contains the terms of the loan is hereby approved. The loan shall be in a principal amount not to exceed **$484,877.48,** shall not bear interest, and shall mature 24 months from the date of the executed Loan and Security Agreement between the Borrower and the Lender. The Authorized Officer is hereby authorized and directed, for and on behalf of the Borrower, to execute the Agreement in substantially said form that includes the redirection of up to 20% of Medi-Cal reimbursements (checkwrite payments) to Lender in the event of default, with such changes therein as the Authorized Officer(s) may require or approve, such approval to be conclusively evidenced by the execution and delivery thereof.

Section 4. The proposed form of Promissory Note (the "Note") as evidence of the Borrower's obligation to repay the loan is hereby approved. The Authorized Officer(s) is (are) hereby authorized and directed, for and on behalf of the Borrower, to execute the Note in substantially said form, with such changes therein as the Authorized Officer(s) may require or approve, such approval to be conclusively evidenced by the execution and delivery thereof.

Date of Adoption: April 20, 2022

## SECRETARY'S CERTIFICATE

I, Topah Spoonhunter **,** Secretary of **NORTHERN INYO HEALTHCARE DISTRICT,** hereby certify that the foregoing is a full, true and correct copy of a resolution duly adopted at a regular meeting of the Board of Directors of **NORTHERN INYO HEALTHCARE DISTRICT** duly and regularly held at the regular meeting place thereof on the 20TH day of April , 2022 **,** of which meeting all of the members of said Board of Directors had due notice and at which the required quorum was present and voting and the required majority approved said resolution by the following vote at said meeting:

**Ayes:**

**Noes:**

**Absent:**

I further certify that I have carefully compared the same with the original minutes of said meeting on file and of record in my office; that said resolution is a full, true and correct copy of the original resolution adopted at said meeting and entered in said minutes; and that said resolution has not been amended, modified or rescinded since the date of its adoption, and is now in full force and effect.

_____

Topah Spoonhunter, Secretary
Board of Directors

Date: _____

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

Date: April 4, 2022

Title: **NIHD BENEFIT HIGHLIGHTS**

Synopsis: This is a presentation to highlight the benefits that the District provides to an employee and their family members. This will also highlight the value of these benefits from a financial perspective.

Prepared by: _____
Alison Murray
HR Director

Approved by: Kelli Davis
Kelli Davis
Chief Executive Officer

# NORTHERN INYO HEALTHCARE DISTRICT

BENEFIT PACKAGE HIGHLIGHT

APRIL 2022

# Agenda

- NIHD Commitment and Benefit Objectives
- Benefits Highlights
  - Benefit Options
  - Benefit Eligibility
- Value of Benefits for Employees
  - Plan Design
  - Costs & Contributions
  - Employee Examples – Benefit Costs

# Northern Inyo Hospital District's Commitment & Benefit Objectives

- Our greatest asset, and the key to our success, is our employees. You make the difference for the people we care for and the community we serve. That's why we've designed a benefits program to make a difference for you and your family.

<u>BENEFIT OBJECTIVES</u>:

- High quality benefits
- Low out-of-pocket costs
- Competitive employee contributions

# Benefit Options

- Benefit Options:
  - Medical, Dental, and Vision (MDV)
    - **Tier I: Services billed for NIHD will be covered 100%**
  - Prescription Drugs
  - Paid Time Off (PTO)
  - Life/AD&D and Long-Term Disability
  - Flexible Spending Accounts
  - Employee Assistance Program
  - 457 Plan
  - Retirement
    - Defined Contribution/Defined Benefit Plans
- Voluntary Benefits:
  - Supplemental Life and AD&D
  - Trustmark
    - Universal Life with Long-Term Care
    - Universal Life Events with Long-Term Care
    - Critical Illness
    - Accident
    - Short-term Disability
  - Legal Shield and ID Shield

# Benefit Eligibility

- Full-time and Part-time employees
  - 30-40 hours per week
- Begins first of the month after hire date
- Dependents include:
  - Legal married partner
  - Registered Domestic Partner
  - Children to age 26

# Value of MDV Benefits for Employees

- The Total Annual Cost for Benefits at NIHD is around $22,500 per employee and NIHD pays for 90% of those coverage costs.
  - NIHD pays 90% of the total monthly medical & vision premiums
  - 100% of dental coverage is paid by NIHD (Estimated average annual cost of $875+/enrolled EE)
  - The Basic Life/AD&D, Base LTD and EAP coverages are paid by NIHD

# Examples

| Pension Defined Benefit Plan: | Salaries | 72% Pension | 10% PTO | 7.65% FICA | 3% Worker's Comp & Unemployment | 24% Medical Insurance | 4% Dental Vision | Benefits Total | Percent of Salaries | Total Compensation |
|---|---|---|---|---|---|---|---|---|---|---|
| · RN | $122,990 | $88,446 | $12,870 | $9,409 | $4,076 | $29,505 | $4,696 | $149,001 | 121% | $271,992 |
| · NIHD Manager | $112,821 | $81,133 | $11,806 | $8,631 | $3,739 | $27,065 | $4,308 | $136,682 | 121% | $249,503 |
| · Cook | $48,422 | $34,822 | $5,067 | $3,704 | $1,605 | $11,616 | $1,849 | $58,663 | 121% | $107,085 |
| Subtotal | $284,234 | $204,401 | $29,743 | $21,744 | $9,419 | $68,186 | $10,852 | $344,346 | | $628,580 |
| Defined Contribution Plan: | | 7% | | | | | | | | |
| · Pharmacy Tech | $63,935 | $4,475 | $6,690 | $4,891 | $2,119 | $15,337 | $2,441 | $35,954 | 56% | $99,889 |
| · EVS Attendant | $40,706 | $2,849 | $4,260 | $3,114 | $1,349 | $9,765 | $1,554 | $22,891 | 56% | $63,597 |
| · Physical Therapist | $116,735 | $8,171 | $12,216 | $8,930 | $3,868 | $28,004 | $4,457 | $65,646 | 56% | $182,381 |
| · NIHD Director | $207,011 | $14,491 | $21,662 | $15,836 | $6,860 | $49,660 | $7,904 | $116,414 | 56% | $323,425 |
| Subtotal | $428,386 | $29,987 | $44,828 | $32,771 | $14,196 | $102,767 | $16,356 | $240,905 | | $669,291 |
| Grand Total | $712,620 | $234,388 | $74,572 | $54,515 | $23,615 | $170,952 | $27,208 | $585,252 | | $1,297,871 |
| FY 2021 Totals for All | $30,923,375 | $7,517,133 | $3,235,955 | $2,467,505 | $1,024,767 | $8,255,013 | $343,959 | $22,844,331 | | $53,767,706 |
| | | 24% | 10% | 8% | 3% | 27% | 1% | 74% | | |
| DB Pension Expense | $9,300,000 | $6,687,908 | | | | | | | | |
| | | 72% | | | | | | | | |
| DC Pension Expense | $11,846,067 | $829,225 | | | | | | | | |
| | | 7% | | | | | | | | |

# THANK YOU!

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

Date: 3/23/22

Title: **APPROVAL OF REPLACEMENT HEATING AND AIR CONDITIONING UNITS 1967 BUILDING $80,000.00**

Synopsis: The 1967 Building has original heating and air conditioning units supplying it. Unfortunately some of the units have failed beyond repair, because of this we need to replace several units now and plan on replacing two or three each year.

Our solution is to install split condensing units. We are in need of two units at this time each costing $35,000.00 and each will require ~$5000.00 for electrical and other installation work. See the attached map showing the areas that will receive supply from these new units.

We are asking for an approval of $80,000.00.We have reached out to several contractors for formal bids. Once these are received they will be evaluated and the lowest responsible bid will be accepted.

A capital request was put in for this last fiscal year as well as the upcoming budget.

This work needs to be complete prior to the hot summer months to avoid having to relocate people out of areas.

Thank you for your consideration,

Prepared by: Scott Hooker
Director of Facilities

Approved by: Kelli Davis
Kelli Davis, Chief Executive Officer


NORTHERN INYO HOSPITAL
Space Planning

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

Date: April 13, 2022

Title: **2022 COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)**

Synopsis: A Community health needs assessments (CHNAs) is an assessments of the wellness needs within a community. As part of the Accountable Care Act (ACA), the federal government began mandating CHNAs to ensure non-profit hospitals were producing community benefits with the costs saved from certain IRS tax exemptions.

Non-profit hospitals must conduct a CHNA every three years and use that assessment to devise an action/intervention plan. Hospitals must also make those documents publicly available, usually on the hospital website.

The Executive Team has selected QHR, as our vendor of choice, to guide us on the path toward a complete Community Health Needs Assessment (CHNA) for 2022. The CHNA process is anticipated to take about 6 months start to finish.

We had a "Kick-Off" Meeting on April 13, 2022, with QHR and NIHD key representatives in attendance. This was a starting point for the 2022 CHNA process. Much more to come!

Prepared by: _____
Erika Hernandez
Admin Assistant/Board Clerk

Approved by: Kelli Davis
Kelli Davis
CEO

# Evaluating Your Community Health Needs Assessment

QHR™ Health

*Strengthening Independent Community Healthcare*

# Table of Contents

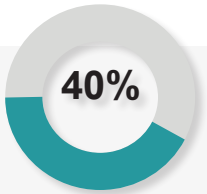
According to a recent QHR study, four out of ten hospitals fail to meet CHNA core requirements. Where does your hospital stand... and what can you do to improve?

The Patient Protection and Affordable Care Act (PPACA or “ACA”) established new federal reporting requirements for not-for-profit 501(c)(3) hospitals beginning in 2013. One chief requirement is to conduct a Community Health Needs Assessment (CHNA) every three years and file a report and detailed findings of the hospital’s improvement implementation strategy both publicly and with the IRS. Failing to provide the required information leaves a hospital at risk for substantive fines and other sanctions.

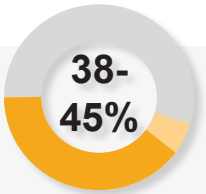
Preparing a CHNA report is a complex undertaking, and there is a high potential of producing deficient CHNA reports. In fact, the original legislation includes provisions requiring hospitals to make self-disclosed report corrections to avoid tax penalties. Additionally, the IRS moved quickly in 2014 to issue further guidance on making corrections. This swift regulatory action can be seen as an early warning indicator of IRS concern.

# How Well Are Hospitals Complying

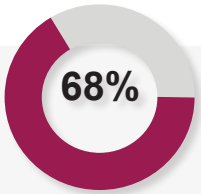
Based on our analysis[1] of 139 not-for-profit hospital reports and web sites, there is justification for the IRS' apparent concerns.[2]



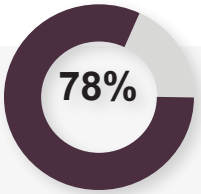

Up to 40% had a deficiency in meeting core CHNA requirements




38 to 45% had a deficiency in meeting core CHNA process steps




68% confronted potential difficulty in measuring progress of CHNA implementation




Up to 78% had a deficiency in documenting at least one detail process step specified in IRS regulatory guidance

In addition, we could not access a widely available CHNA for 15.8% of the hospitals. Up to 78% of the reviewed CHNA reports had a deficiency in documenting at least one detail process step specified in the IRS regulatory guidance.[3]

These findings are worrisome for several reasons. A hospital that fails to make its report widely available or fails to address a core CHNA requirement must self-correct or the hospital risks the IRS imposed excise tax of $50,000. Additional penalties may apply if the IRS determines that the hospital's error was intentional.

# Assessing and Optimizing your CHNA: A Five-Tier Approach

CHNAs must accomplish several tasks. First, a CHNA must follow a prescribed process to identify and establish the priorities of the community needs. Second, the CHNA must create a public document describing how the hospital intends to respond to the identified community needs. Failing to accomplish either of these tasks can result in an IRS special tax or revocation of tax exemption.

The Federal government asks 29 questions to determine if a CHNA meets regulatory requirements. All of the questions relate to specific process and content requirements in the IRS 2012 and 2013 guidance and draft regulations. QHR developed a proprietary assessment framework to help hospitals evaluate the completeness of its CHNA report. This assessment aggregates the regulatory questions into five tiers. The five tiers are sequential; complying with the first tier is more important than complying with the fifth. The tiers help hospitals determine whether its CHNA will trigger IRS action. A potential Federal CHNA compliance evaluation could be as described in the graph on the right:

# Use Caution In Your Guidance Sources

Ever since the 1969 IRS Revenue Ruling first defined community benefit, non-profit hospitals have communicated its efforts in the form of annual community reports, community health status evaluations, cooperative community assessments developed in conjunction with public health and various civic organizations and mission effectiveness reports.

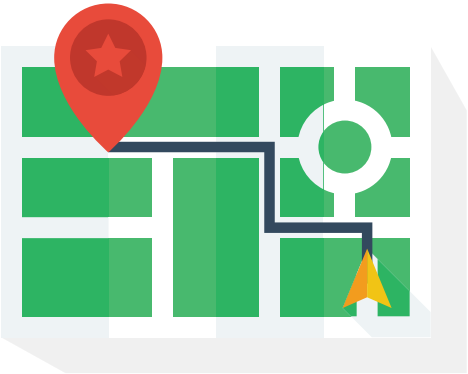
Now, with the passage of PPACA, community benefit reporting standards are codified in IRS regulation. While still in draft stages of regulation, the ACA's CHNA provisions mandate numerous requirements and processes. One step requires obtaining input and participation from public health experts. In addition, the National Association of County and City Health Officials (NACCHO) developed a CHNA compliant guidance tool to help hospitals develop CHNAs.

Hospitals should be aware that most available CHNA resources do not account for the ACA and its regulatory content and process requirements. Hence, if a hospital's report was guided by available resources, it may have inadvertently issued a non-compliant CHNA.

Based on our sampling of CHNAs, hospitals and health systems should:

- Thoroughly review the CHNA regulatory guidance and instructions prior to conducting the effort.
- Know when to be specific. Hospitals that belong to a system can join forces within the system to analyze the market. Each hospital must have its own implementation plan. In our study, several systems produced a combined analytical documentation of the community need but lacked hospital-specific implementation plans.
- Make the report easy to find on your website. Hospitals that fail to post the CHNA reports prominently on their websites are not in compliance.
- Treat the final, corrected report with respect. Prominently post the final report rather than posting an internal document containing directions to view the report correction.

# The Road To The CHNAs



The Medicare and Medicaid enactment in the mid 1960s eroded the reasoning behind not-for-profit hospital tax exemption. The assumption was almost everyone would be able to pay for healthcare due to the Federal and State programs, leaving no need for hospitals to be exempt from tax in order to afford to provide indigent care. In the late 1960s the IRS initiated the concept of “community benefit” to justify continuing to allow hospitals to be tax exempt. Community benefit initially comprised of three components: the provision of free and discounted care for those unable to pay; care to low-income Medicaid and indigent care beneficiaries; and provision of services to improve community healthcare and access.

While the rationale for tax exemption of hospitals has been under scrutiny for some time, the passage of the ACA continues to highlight the need for hospitals to be tax exempt. Again, the community benefit justification for relieving hospitals of the necessity of paying tax was challenged. Medicaid expansion and state Marketplaces established nearly universal health insurance payment ability, thus lessening the demand on hospitals to deliver “charity,” or indigent care. To proactively address this concern, the ACA established several provisions that, if met, would reestablish the tax exemption justification hospitals needed. One tax relief provision said that hospitals needed to document efforts to identify and respond to local health needs. Maintaining justification of being relieved of paying tax is, one of the reasons a hospital needs to develop a compliant CHNA.

## Enabling Compliance Is Just The Start

As one healthcare policy maker put it, “it’s incumbent on hospitals not to think of the new CHNA requirements as an annoyance but rather as an opportunity.”[6] A well-constructed CHNA can have far-reaching benefits in addition to compliance with IRS draft regulations. Hospitals can leverage the information gleaned from the assessment to inform strategic plans, improve stakeholder communications, sharpen marketing efforts and broaden and deepen community involvement.

A hospital should review its CHNA and the answers provided on the IRS 990 tax filing from the perspective of meeting both the spirit and the letter of the IRS draft regulation. If a hospital identifies potential deficiencies, it should self report and correct its report before being contacted by the IRS. Utilizing the assistance of an external organization provides hospitals with CHNA expertise and the objective insight needed to successfully complete a compliant CHNA.

**At your request, QHR will review your CHNA and tell you if gaps exist in your plan that should be disclosed and corrected this year to protect your hospital from unnecessary IRS compliance reviews. Contact us at 615-221-1400 or at QHR.com.**

# Resources

(1) QHR examined a 5% sample (139 valid hospitals ) of the 2,722 CMS listed not-for-proit US hospitals for the existence of a Widely Available CHNA. We excluded hospitals in the sample that had acquired their not-for-profit status on a basis other than a 501 (c) (3) exemption; had converted their status for various reasons; or did not have a web site. We performed a detailed analysis of the available CHNA reports in fifty (50) of the appropriate, randomly chosen not-for-profit hospital web sites.

(2) QHR Strategic Integrated Resources Group wrote or directed the development of 50 CHNA reports in 2013. To eliminate potential bias, QHR excluded any hospital in the sample for which a report was developed the author's guidance.

(3) It is important to note that our analysis did not evaluate quality, i.e. how well or poorly a CHNA complied with the regulation. All we considered was if there was evidence that the report addressed the requirements in some fashion. We also did not form an opinion about whether the report was "conspicuously" posted on a Web site, as is required to meet the "Widely Available" IRS criteria. We counted the report as being in compliance even if the CHNA was found only by using the free text search feature on the hospital's web site.

(4) CHNA reports developed by the author were built to issue evidence offering affrmative compliance with each of the twenty-nine IRS questions.

(5) http://www.naccho.org/topics/infrastructure/mapp/chahealthreform.cfm

(6) Best Practices for Community Health Needs Assessment and Implementation Strategy Development: A Review of Scientific Methods, Current Practices, and Future Potential. The Centers for Disease Control and Prevention. Public Health Institute (2011). http://www.phi.org/uploads/application/les/dz9vh55o3bb2x56lcrzyel83fwfu3mvu24oqqvn5z6qaeiw2u4.pdf

# THE QHR DIFFERENCE

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

Date: April 8, 2022

Title: **RADIOLOGY SERVICES REQUEST FOR PROPOSAL (RFP)**

Synopsis: The current contract for Radiology Services (Radiologist Group) expires in April 2023. As per best practices, NIHD will solicit bids/proposals for a new 3-year contract.
On April 15, 2022, the RFP announcement, including instructions, was posted in prime resources to ensure expanded outreach to interested radiology groups.
The RFP proposal submission window will close on June 30, 2022, at 5:00p.m.
The formal RFP review and selection process for awarding the new contract will begin in early July, with a final selection anticipated in August.
Tahoe Carson Radiology (TCR) Professionals currently holds the multi-year contract. Much appreciation is extended to TCR for their partnership with NIHD and our community over the years.

Prepared by: _____
Erika Hernandez
Admin Assistant/Board Clerk

Approved by: Kelli Davis
Kelli Davis
CEO

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

Date: April 8, 2022

Title: **WORKFORCE HOUSING CONSIDERATIONS**

Synopsis: Housing for current and potential workforce members, and the community as a whole, continues to be a significant barrier. I am currently in discussions with 2 local agencies to secure a number of housing units for the District. This will better enable us to have housing available as need arises. Most often, when securing travel staff, the company representing these candidates cannot find housing, resulting in the travel assignment being cancelled. Additionally, new hires who move to the area, typically cannot find initial housing, and this creates an immediate hardship during the relocation and start time phases. We hope to find ways to minimize or alleviate some of the housing crisis' new workforce members are commonly facing.

Prepared by: _____
Erika Hernandez
Admin Assistant/Board Clerk

Approved by: Kelli Davis
Kelli Davis
CEO

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

Date: April 13, 2022

Title: **NIHD BOARD OF DIRECTORS STANDING COMMITTEES**

Synopsis: Through discussions with the Governance group, it is recommended that discussion and clarification from the Board of Directors take place regarding Board Standing Committees.
NIHD Board Bylaws state:
"The Board of Directors may sit as a Committee of the Whole on any and all matters, or may create such Standing Committees, ad hoc Committees, or task force Committees as are deemed appropriate".
The Bylaws go on to say:
"Standing committees of the Board of Directors as set forth below shall continue in existence until discharged by specific action of the Board of Directors:

1. Quality and Safety – **The Board shall sit as a Committee of the Whole on all quality and safety issues, being advised by the President and Chief Executive Officer, the Medical Executive Committee, the Chief of Staff, and Medical Staff members from time to time.**
2. Finance Committee – **The Board shall sit as a Committee of the Whole on matters pertaining to the finances of the District and its oversight role.**
3. Governance Committee – **Members of this Committee shall include two representatives from the Board of Directors and the Chief Executive Officer. The two members of the Board of Directors shall be the only members of the Committee with voting privileges.**
4. Community Benefit Committee – **The members of this Committee shall be two members of the Board of Directors. The two members of the Board of Directors shall be the only members of the Committee with voting privileges.**

Prepared by: _____
Erika Hernandez
Admin Assistant/Board Clerk

Approved by: Kelli Davis
Kelli Davis
CEO

**NORTHERN INYO HOSPITAL**
*Northern Inyo Healthcare District*
150 Pioneer Lane, Bishop, California 93514

Medical Staff Office
(760) 873-2174 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Sierra Bourne, MD, Chief of Medical Staff
DATE: April 5, 2022
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. Proposed Amendments to Medical Staff Bylaws (*action item*)
    1. The Active Medical Staff of Northern Inyo Healthcare District has approved the enclosed amendments to the current Medical Staff Bylaws by written ballot and is requesting the Northern Inyo Healthcare District Board of Directors review and consider these amendments for approval. Provided for the Board of Directors review is a document titled "Summary of the Proposed Changes," which provides a high-level overview of the amendments with page citations. Additionally, the full Medical Staff Bylaws text with marked revisions is also included.

B. Policies (*action item*)
    1. *Naloxone (Narcan) Distribution*
    2. *Stress Echocardiogram*
    3. *Surgery Tissue/Bone Graft "Look Back" Policy*
    4. *Interdisciplinary Team – Clinical Screens Built into the Initial Nursing Assessment*
    5. *Emergency Management Plan*

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

**Summary of Proposed Bylaws Changes**

(by motion of the Medical Executive Committee)

January 4, 2022

1. Clarification of the CMO vote in medical staff committees. (p.14)

   ***CHIEF MEDICAL OFFICER*** *means an active member of the medical staff appointed by the administrator to provide administrative support for the medical staff, communicate the views of the hospital administration to the medical staff, and serve as a liaison between the medical staff and the administration. The chief medical officer shall serve on medical staff committees without vote unless otherwise specified at the time of appointment.*

2. Addition of the possibility of having up to **two** members-at-large, if two or more individuals run for the position. (p.64)

   *In the election for member-at-large where there are two or more nominees, the two nominees receiving the highest numbers of votes shall be elected to each serve in the role of member-at-large. If there are not two or more nominees on the ballot, only one position of member-at-large need be filled.*

3. Removing the QI committee chair responsibility from the Vice Chief of Staff role, and moving it to the Chief of Staff role. (p.65)

   *The vice chief of staff shall serve a one (1) year term and is selected from among the current department chiefs serving on the medical executive committee. The vice chief of staff shall assume all duties and authority of the chief of staff in the absence of the chief of staff and shall perform such other duties as may be assigned. ~~The vice chief of staff will serve as the chair of the medical staff quality improvement committee and participate in the district quality improvement committees, as described in the district quality plan.~~*

4. Update to numbers of members, voting rights of members and quorum requirements of the Infection Control Committee. Previously, the committee composition consisted of 3 members, the quorum was not specified, and the IP nurse did not have a vote. (p.75)

   *The infection control committee shall be composed of at least two (2) privileged practitioners, at least one (1) of which shall be an active staff member, and the infection prevention nurse (with vote). A quorum shall consist of one (1) privileged practitioner and the infection prevention nurse.*

5. Clarification that the Joint Conference Committee is an ad hoc committee, and therefore not subject to the Brown act (request from the Board, p.78-79)

   *The joint conference committee is an ad hoc committee composed of two (2) members of the board of directors and two (2) members of the medical executive committee, one (1) of which shall be the chief of staff, and the other which shall be appointed by the medical executive committee.*

*The function of the joint conference committee is to serve as a liaison between members of the board of directors, the district administration, and the medical staff on an ad hoc basis.*

6. Addition of the Cardiopulmonary Director to both the Inpatient Medicine and Outpatient Medicine committee compositions. Also, addition of an outpatient representative to inpatient committee and vice versa to promote communication. (p.83-84)

   *Whenever possible, the cardiopulmonary medical director and an outpatient medicine committee representative shall serve on the committee. (Inpatient)*

   *Whenever possible, the cardiopulmonary medical director and an inpatient medicine committee representative shall serve on the committee. (Outpatient)*

7. Update to the meeting frequency language of the medical staff general meeting and giving the Chief of Staff the authority to determine the time/place of meetings.

   *Regular meetings of the medical staff members shall be held ~~each quarter~~ at least quarterly. The date, place and time of the regular meetings shall be determined by the medical executive committee or the chief of staff, and adequate notice shall be given to the members.*

8. Further clarifications of the quorum requirements for non-departmental medical staff committee meetings (credentials, UR, pharm & thxm etc.). (p.87)

   **12.3-2 DEPARTMENT MEETINGS**

   For department committees, a quorum shall consist of all three core members or substitutes as appointed by the departmental chair (in accordance with Section 11.13-1).

   **12.3-3 MEDICAL STAFF COMMITTEE MEETINGS**

   A quorum of fifty percent (50%) of the voting members shall be required for medical executive meetings. For other medical staff committee meetings (e.g., utilization review, pharmacy and therapeutics), the presence of two (2) committee voting members shall constitute a quorum, unless otherwise specified in the committee composition.

# Northern Inyo Healthcare District
# Medical Staff Bylaws

TABLE OF CONTENTS

## ARTICLE I: PURPOSE AND TERMS

### 1.1 PURPOSE OF THE BYLAWS

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

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

(c) The Medical Staff acknowledges that the Board of Directors, in exercising its responsibility to protect the quality of medical care provided by and the competency of the Medical Staff and to ensure the responsible governance of the hospital, possesses administrative oversight authority of the Medical Staff. In exercising its administrative authority, the Board of Directors acknowledges and commits to respecting the rights and functions of a self-governing Medical Staff, as established by statute and through the Medical Staff bylaws. The Medical Staff commits to exercising its rights and responsibilities with diligence and good faith, and acknowledges that if it does not do so, the Board of Directors may act, as delineated in these bylaws, to fulfill the specific responsibility that the Medical Staff has failed to perform.

### 1.2 NAME

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

### 1.3 PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

The medical staff's purposes are:

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

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

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

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

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

The medical staff's responsibilities are:

(a) To provide quality patient care.

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

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

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

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

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

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

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

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

(g) To select and remove medical staff officers.

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

## 1.4 DEFINITIONS

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

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

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

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

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

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

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

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

**CHIEF EXECUTIVE OFFICER** see ADMINISTRATOR.

**CHIEF MEDICAL OFFICER** means an active member of the medical staff appointed by the administrator to provide administrative support for the medical staff, communicate the views of the hospital administration to the medical staff, and serve as a liaison between the medical staff and the administration. The chief medical officer shall serve on medical staff committees without vote unless otherwise specified at the time of appointment.

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

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

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

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

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

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

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

**DAYS** means calendar days, unless otherwise specified.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## ARTICLE II: MEMBERSHIP

### 2.1 NATURE OF MEMBERSHIP

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

### 2.2 QUALIFICATIONS FOR MEMBERSHIP

#### 2.2-1 GENERAL QUALIFICATIONS

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

#### 2.2-2 BASIC QUALIFICATIONS

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

(a) Qualify to practice in California as follows:

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

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

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

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

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

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

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

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

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

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

### 2.2-3 ADDITIONAL QUALIFICATIONS FOR MEMBERSHIP

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

(a) Demonstrate his or her:

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

(2) Current professional competence;

(3) Good judgment; and

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

(b) Be determined to:

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

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

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

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

## 2.3 EFFECT OF OTHER AFFILIATIONS

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

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

### 2.4 NONDISCRIMINATION

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

### 2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## 2.6 CONTRACT PRACTITIONERS

### 2.6-1 MEMBERSHIP AND PRIVILEGES REQUIRED

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

### 2.6-2 EFFECT OF SPECIFIED CLINICAL SERVICES CONTRACT TERMINATION

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

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

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

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

### 2.6-3 MEDICAL STAFF ROLE IN SPECIFIED CLINICAL SERVICES CONTRACTING

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

## 2.7 ADMINISTRATIVE PRACTITIONERS

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

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

## ARTICLE III: CATEGORIES OF MEMBERSHIP

### 3.1 CATEGORIES

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

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

### 3.2 MODIFICATION OF MEMBERSHIP

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

### 3.3 ACTIVE STAFF

#### 3.3-1 QUALIFICATIONS

The active staff shall consist of members who:

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

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

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

#### 3.3-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

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

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

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

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

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

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

### 3.3-3 TRANSFER OF ACTIVE STAFF MEMBER

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

## 3.4 COURTESY STAFF

### 3.4-1 QUALIFICATIONS

The courtesy staff shall consist of members who:

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

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

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

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

### 3.4-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

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

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

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

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

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

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

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

### 3.4-3 LIMITATIONS

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

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

## 3.5 CONSULTING STAFF

### 3.5-1 QUALIFICATIONS

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

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

(b) possess adequate clinical and professional expertise;

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

### 3.5-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

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

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

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

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

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

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

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

## 3.6 HONORARY STAFF

### 3.6-1 QUALIFICATIONS

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

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

#### 3.6-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

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

### 3.7 GENERAL EXCEPTIONS TO PREROGATIVES

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

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

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

### 3.8 TABLE OF PREROGATIVES BY MEDICAL STAFF CATEGORY

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

## ARTICLE IV: CLINICAL PRIVILEGES

### 4.1 EXERCISE OF PRIVILEGES

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

### 4.2 PRIVILEGE REQUESTS

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

### 4.3 LAPSE OF APPLICATION

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

### 4.4 BASIS FOR PRIVILEGE DETERMINATION

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

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

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

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

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

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

## 4.6 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

### 4.6-1 FPPE FOR INITIAL PRIVILEGES

(a) General Provisions:

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

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

(b) Failure to Complete FPPE:

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

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

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

### 4.6-2 FPPE ARISING FROM CONCERNS

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

## 4.7 CONDITIONS FOR PRIVILEGES OF PRACTITIONERS

### 4.7-1 ADMISSIONS

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

(1) Physicians (MDs or DOs)

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

(1) Dentists (non-MD)

(2) Podiatrists

(3) Certified Nurse Midwives

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

(1) Physician Assistants

(2) Nurse Practitioners

### 4.7-2 RESPONSIBILITY FOR CARE OF PATIENTS

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

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

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

#### 4.7-3 SURGERY

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

### 4.8 TEMPORARY CLINICAL PRIVILEGES

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

#### 4.8-1 PATIENT CARE NEEDS

(a) Care of Specific Patient

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

(b) Locum Tenens

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

(c) Other Important Patient Care Needs

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

#### 4.8-2 PENDING APPLICATION FOR MEDICAL STAFF MEMBERSHIP OR PRIVILEGES

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

#### 4.8-3 PROCESS FOR GRANTING TEMPORARY CLINICAL PRIVILEGES

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

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

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

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

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

(e) The following has been completed:

(1) Verification of current California licensure;

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

(3) Verification of relevant training and experience;

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

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

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

(1) The applicable clinical department chief;

(2) The credentials committee chairperson; and

(3) The chief of staff.

### 4.8-4 GENERAL CONDITIONS OF TEMPORARY PRIVILEGES

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

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

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

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

## 4.9 TELEMEDICINE PRIVILEGES

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

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

### 4.9-1 TELEMEDICINE CREDENTIALING

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

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

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

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

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

### 4.9-2 RELIANCE ON DISTANT-SITE ENTITIES

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

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

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

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

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

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

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

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

### 4.10 ADVANCED PRACTICE PROVIDERS

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

### 4.11 EMERGENCY PRIVILEGES

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

## 4.12 DISASTER PRIVILEGES

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

(a) the chief of staff;

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

(c) any department chief;

(d) any active medical staff member; or

(e) designee of any of the above.

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

## ARTICLE V: APPLICATION PROCEDURES FOR PRIVILEGES

### 5.1 GENERAL

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

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

### 5.2 BURDEN OF PRODUCING INFORMATION

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

### 5.3 APPOINTMENT AND AUTHORITY

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

### 5.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

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

### 5.5 APPLICATION FOR INITIAL APPOINTMENT, REAPPOINTMENT, AND PRIVILEGES

#### 5.5-1 APPLICATION FORM

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

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

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

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

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

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

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

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

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

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

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

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

**5.5-2 EFFECT OF APPLICATION**

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

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

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

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

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

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

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

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

(h) agrees to provide quality care for patients;

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

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

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

### 5.5-3 VERIFICATION OF INFORMATION

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

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

### 5.5-4 DETERMINE IF APPLICATION IS COMPLETE

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

### 5.5-5 DEPARTMENT ACTION

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

### 5.5-6 CREDENTIALS COMMITTEE ACTION

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

### 5.5-7 MEDICAL EXECUTIVE COMMITTEE ACTION

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

### 5.5-8 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

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

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

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

### 5.5-9 BOARD OF DIRECTORS ACTION

On favorable recommendation of the medical executive committee:

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

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

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

On adverse recommendation of the medical executive committee:

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

### 5.5-10 NOTICE OF FINAL DECISION

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

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

### 5.5-11 REAPPLICATION AFTER ADVERSE OR UNFAVORABLE ACTION

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

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

### 5.5-12 TIMELY PROCESSING OF APPLICATIONS

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

## 5.6 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

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

### 5.6-1 REAPPLICATION DEADLINE AND CONTENT

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

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

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

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

### 5.6-2 FAILURE TO FILE REAPPOINTMENT APPLICATION

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

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

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

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

## 5.7 LEAVE OF ABSENCE

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

### 5.7-1 ROUTINE LEAVE OF ABSENCE

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

### 5.7-2 MEDICAL LEAVE OF ABSENCE

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

### 5.7-3 MILITARY LEAVE OF ABSENCE

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

### 5.7-4 OBLIGATION UNDER LEAVE OF ABSENCE

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

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

### 5.7-5 REQUEST FOR REINSTATEMENT

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

### 5.7-6 FAILURE TO REQUEST REINSTATEMENT

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

### 5.7-7 EXPIRATION OF APPOINTMENT WHILE ON LEAVE

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

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

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

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

## ARTICLE VI: PEER REVIEW AND CORRECTIVE ACTION

### 6.1 MONITORING AND PEER REVIEW

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

### 6.2 CORRECTIVE ACTION

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

#### 6.2-1 CRITERIA FOR INITIATION

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

#### 6.2-2 INITIATION

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

#### 6.2-3 INVESTIGATION

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

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

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

(b) review the practitioner's file.

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

### 6.2-4 EXECUTIVE COMMITTEE ACTION

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

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

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

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

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

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

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

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

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

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

### 6.2-5 SUBSEQUENT ACTION

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

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

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

### 6.2-6 INITIATION BY BOARD OF DIRECTORS

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

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

## 6.3 SUMMARY RESTRICTION OR SUSPENSION

### 6.3-1 CRITERIA FOR INITIATION

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

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

### 6.3-2 NOTICE OF SUMMARY SUSPENSION

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

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

### 6.3-3 MEDICAL EXECUTIVE COMMITTEE ACTION

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

### 6.3-4 PROCEDURAL RIGHTS

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

### 6.3-5 INITIATION BY BOARD OF DIRECTORS

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

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

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

## 6.4 AUTOMATIC SUSPENSION OR LIMITATION

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

### 6.4-1 LICENSURE

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

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

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

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

### 6.4-2 DRUG ENFORCEMENT ADMINISTRATION (DEA) CERTIFICATE

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

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

### 6.4-3 MEDICAL RECORDS

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

### 6.4-4 PROFESSIONAL LIABILITY INSURANCE

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

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

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

### 6.4-6 FELONY CONVICTION OR PLEA

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

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

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

### 6.4-7 EXCLUSION FROM GOVERNMENTAL PROGRAM

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

### 6.4-8 NOTICE OF AUTOMATIC ACTION

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

### 6.4-9 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

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

## ARTICLE VII: HEARINGS AND APPELLATE REVIEWS

### 7.1 GENERAL PROVISIONS

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

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

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

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

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

#### 7.1-3 DUTY TO EXHAUST INTERNAL REMEDIES

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

#### 7.1-4 TIMELY COMPLETION OF PROCESS

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

#### 7.1-5 FINAL ACTION

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

## 7.2 GROUNDS FOR HEARING

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

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

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

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

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

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

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

## 7.3 REQUESTS FOR HEARING

### 7.3-1 NOTICE OF ACTION OR PROPOSED ACTION

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

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

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

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

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

### 7.3-2 HEARINGS PROMPTED BY BOARD OF DIRECTORS ACTION

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

### 7.3-3 REQUEST FOR HEARING

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

### 7.3-4 TIME AND PLACE FOR HEARING

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

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

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

### 7.3-6 JUDICIAL REVIEW COMMITTEE

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

### 7.3-7 FAILURE TO APPEAR OR PROCEED

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

### 7.3-8 POSTPONEMENTS AND EXTENSIONS

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

## 7.4 HEARING PROCEDURE

### 7.4-1 PREHEARING PROCEDURE

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

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

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

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

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

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

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

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

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

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

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

### 7.4-2 REPRESENTATION

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

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

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

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

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

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

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

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

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

### 7.4-3 THE HEARING OFFICER

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

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

### 7.4-4 RECORD OF THE HEARING

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

### 7.4-5 RIGHTS OF THE PARTIES

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

### 7.4-6 MISCELLANEOUS RULES

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

### 7.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

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

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

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

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

### 7.4-8 ADJOURNMENT AND CONCLUSION

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

### 7.4-9 BASIS FOR DECISION

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

### 7.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

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

## 7.5 APPEAL

### 7.5-1 TIME FOR APPEAL

Within ten (10) days after receipt of the decision of the judicial review committee, either the practitioner or the medical executive committee may request an appellate review. A written request for such review shall be delivered to the chief of staff, the administrator, the chief medical officer, the other party in the hearing, and a copy provided to the board of directors. If a request for appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the medical staff.

### 7.5-2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

(a) substantial non-compliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice;

(b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5-5; or

(c) the judicial review committee failed to sustain an action or recommendation from the medical executive committee that, based on the evidence in the hearing record was reasonable and warranted.

### 7.5-3 APPEAL BOARD

The board of directors may sit as the appeal board, or it may delegate that function to an appeal board which shall be composed of not less than three (3) individuals designated by the board of directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the board of directors shall be neither the attorney firm that represented either party at the hearing before the judicial review committee nor the attorney who assisted the hearing panel or served as hearing officer.

### 7.5-4 TIME, PLACE AND NOTICE

The appeal board shall, within thirty (30) days after receipt of request for appellate review, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The appellate review shall commence within sixty (60) days from the date of such request for appellate review, provided however, that when a request for appellate review concerns a practitioner who is under suspension which is then in effect, the appellate review should commence within forty-five (45) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the appeal board for good cause.

### 7.5-5 APPEAL PROCEDURE

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the judicial review committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the judicial review committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal board may remand the matter to the judicial review committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence

of the appellant and respondent and their representatives. The appeal board shall present to the board of directors its written recommendations as to whether the board of directors should affirm, modify, or reverse the judicial review committee decision consistent with the standard set forth in Section 7.5-6, or remand the matter to the judicial review committee for further review and decision.

### 7.5-6 DECISION

(a) Except as provided in Section 7.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the board of directors shall render a final decision. The board of directors may affirm, modify, reverse the decision or remand the matter for further review by the judicial review committee or any other body designated by the board of directors for reconsideration stating the purpose for the referral. The board of directors shall give great weight to the judicial review committee findings and shall not act arbitrarily or capriciously. The board of directors may, however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision was reasonable and warranted, and whether any bylaw or policy relied upon by the judicial review committee is unreasonable and unwarranted. The decision shall be in writing, shall specify the reasons for the action taken, and shall provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from those of the judicial review committee. If the board of directors determines that the practitioner was not afforded a fair hearing in compliance with the bylaws, the board of directors shall remand the matter.

(b) If the matter is remanded to the judicial review committee or other body designated by the board of directors for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the board of directors. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the board of directors and the judicial review committee.

(c) The appeal board's decision shall constitute the final decision of the district. Any recommendation affirmed by the appeal board shall become effective immediately. The decision reached shall be forwarded to the chief of staff, the medical executive and credentials committees, the subject of the hearing, the chief medical officer and the administrator.

### 7.5-7 RIGHT TO ONE HEARING

Except in circumstances where a new hearing is ordered by the board of directors or a court because of procedural irregularities or otherwise for reasons not the fault of the practitioner, no practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

## 7.6 EXCEPTION TO HEARING RIGHTS

### 7.6-1 AUTOMATIC ACTION BASED UPON ACTIONS TAKEN BY ANOTHER PEER REVIEW BODY

(a) The medical executive committee shall be empowered to:

(1) use as a basis for disqualification from membership and/or privileges, or

(2) automatically impose

any adverse action that has been taken within the preceding thirty-six (36) months by another peer review body (as that term is used in the federal or California laws) after that action is considered final and the action was taken in conformance with California Business & Professions Code section 809 et seq. For purposes of this Section, an action shall be considered final when the practitioner has completed the hearing, appeal and judicial proceedings related to the action.

(b) The practitioner shall not be entitled to any hearing or appeal unless the medical executive committee takes an action that is more restrictive than the final action taken by the original peer review body. Any hearing and appeal that is requested by the practitioner shall not address the merits of the action taken by the original peer review body, which were already reviewed at the original peer review body's hearing, and shall be limited to only the question of whether the automatic action is more restrictive than the original peer review body's action.

(c) Nothing in this Section shall preclude the medical staff or board of directors from taking a more restrictive action than another peer review body based upon the same facts or circumstances.

## ARTICLE VIII: ADVANCED PRACTICE PROVIDERS

### 8.1 QUALIFICATIONS OF ADVANCED PRACTICE PROVIDERS

Advanced Practice Providers (APPs) are non-physician practitioners who are eligible to apply for privileges at Northern Inyo Healthcare District. APPs are not eligible for medical staff membership as described in California state law. They may be granted practice privileges if they hold a license, certificate or other credentials in a category of APPs that the board of directors (after securing medical executive committee recommendation) has identified as eligible to apply for practice privileges, and only if the APPs are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the medical staff bylaws as demonstrated by the medical staff ongoing and focused professional practice evaluation process.

### 8.2 CATEGORIES

The board of directors may determine, based upon recommendation of the medical executive committee and such other information as it has before it, those categories of APPs that shall be eligible to exercise privileges at Northern Inyo Healthcare District. Such APPs shall be subject to the supervision requirements developed and approved by the interdisciplinary practice committee, the medical executive committee, and the board of directors.

### 8.3 PRIVILEGES

(a) APPs may exercise only those setting-specific privileges granted to them by the board of directors. The range of privileges for which each APP may apply, and any special limitations or conditions to the exercise of such privileges, shall be based on recommendations of the interdisciplinary practice committee, subject to approval by the credentials committee, the medical executive committee and the board of directors.

(b) An APP must apply and qualify for practice privileges. Applications for initial granting of practice privileges and biennial renewal thereof shall be submitted and processed in a similar manner to that provided for medical staff members, unless otherwise specified in medical staff policies.

(c) Each APP shall be subject to terms and conditions similar to those specified for medical staff members as they may logically be applied to APPs and appropriately tailored to the particular APP.

### 8.4 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

The prerogatives which may be extended to an APP shall be defined in medical staff and/or district policies. Such prerogatives may include:

(a) Provision of specified patient care services; which services may be provided independently or under the supervision or direction of a medical staff member and consistent with the practice privileges granted to the APP and within the scope of the APP's licensure or certification.

(b) Participation in the open session of general meetings of the medical staff in a non-voting role.

(c) Being a voting participant at departmental committees appropriate to their specialty, which vote shall be limited to the following:

(1) Departmental policies, procedures, or other matters specific to the APP's line of practice; and

(2) Election of department chief.

(d) Attendance at district and medical staff education programs.

Additionally, each APP shall:

(a) Meet those responsibilities required by applicable policies and as specified in the bylaws, Section 2.5, and as they may be logically applied to reflect the scope of practice of the APP.

(b) Retain appropriate responsibility within the APPs area of professional competence for the care and supervision of each patient in the district for whom the APP is providing services.

(c) Participate in peer review of other APPs as appropriate, participate in quality improvement and discharge such other functions as may be required from time to time.

## 8.5 PROCEDURAL RIGHTS OF ADVANCED PRACTICE PROVIDERS

### 8.5-1 GRIEVANCE RIGHTS AFTER ADVERSE ACTIONS

Except as otherwise provided in this Section with respect to automatic termination or other matters, an APP shall have the right to utilize the grievance hearing process set forth in this Section in order to challenge any action that, if taken against a medical staff member, would be an adverse action constituting grounds for a procedural rights hearing pursuant to these bylaws. However, nothing contained in these bylaws shall be interpreted to entitle an APP to procedural rights, including, but not limited to, a procedural rights hearing or appellate review to which a medical staff member may be entitled.

An APP may challenge such adverse action by filing a written grievance with the medical executive committee no later than fifteen (15) days after such action. Upon receipt of such a grievance, the medical executive committee or its designee shall conduct an investigation that shall afford the APP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a "hearing" pursuant to the bylaws and shall not be conducted according to the procedural rules applicable to such hearings as set forth in Article VII. Before the interview, the APP shall be informed of the general nature and circumstances giving rise to the action, and the APP may present information relevant thereto at the interview. A record of the interview shall be made. The medical executive committee or its designee shall make a decision and recommendation for final action based on the interview and all other information available to it, and shall submit a written report of its recommendation, decision, and statement of basis for it to the board of directors. After receipt of the medical executive committee report, the board of directors shall take final action on the matter.

### 8.5-2 EMPLOYMENT BY THE DISTRICT

If the APP is an employee of Northern Inyo Healthcare District, disciplinary actions related to the terms and conditions of employment of the APP shall be governed by applicable human resources policies.

### 8.5-3 AUTOMATIC TERMINATION

(a) Notwithstanding the provisions of Section 8.5-1, an APP's privileges shall automatically terminate without review if the APP's certification or license expires, is revoked, or is suspended.

(b) Notwithstanding the provisions of Section 8.5-1, an APP's privileges may be subject to termination following review by the interdisciplinary practice committee and medical executive committee if no appropriate supervising practitioner is available because:

(1) The medical staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary and no other member is able or willing to function as the supervising practitioner; or

(2) The supervising practitioner no longer agrees to act as the supervising practitioner for any reason, or the relationship between the APP and the supervising practitioner is otherwise terminated, regardless of the reason thereof and no other member is able or willing to function as the supervising practitioner.

(c) Additionally, APPs are subject to the automatic action provisions of Section 6.4 of these bylaws.

### 8.5-4 REVIEW OF CATEGORY DECISIONS

The grievance rights afforded by this Section shall not apply to any decision regarding whether a category of APP shall or shall not be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the board of directors, which has the discretion to decline to review the request or to review it using any procedure the board of directors deems appropriate.

## ARTICLE IX: OFFICERS

### 9.1 OFFICERS OF THE MEDICAL STAFF

#### 9.1-1 IDENTIFICATION

The officers of the medical staff shall be the chief of staff, vice chief of staff, immediate past chief of staff, and member(s)-at-large. In addition, the medical staff's department chiefs shall be deemed medical staff officers within the meaning of California law.

#### 9.1-2 QUALIFICATIONS

Officers must be members of the active medical staff at the time of their nomination and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

The chief medical officer will not be eligible to hold medical staff office during employment by the District. Should a medical staff officer accept a position as chief medical officer they will resign from their medical staff position and a replacement shall be determined per the process outlined in these bylaws. The chief medical officer will retain voting privileges to which they are eligible to participate based on their rights as an active medical staff member.

Additionally, if possible, the chief of staff must have previously served on the medical executive committee in some capacity for at least one term.

#### 9.1-3 NOMINATIONS

(a) The medical staff election year shall be every two years.

(b) The medical executive committee shall nominate one or more nominees for the office of chief of staff and may nominate one or more nominees for member-at-large to be filled at the time of elections. The medical executive committee shall give notice of the nominations to members eligible to vote on the officers no later than thirty (30) days prior to the election.

(c) Nominations may also be made by any member entitled to vote by submitting a written nomination to the medical staff office. A member may also nominate him- or herself, provided that he or she qualifies for such office.

(d) All nominees for election shall disclose in writing to the medical staff those current or impending personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the district, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.

#### 9.1-4 ELECTIONS

The chief of staff and member(s)-at-large shall be elected by written ballot sent to eligible members prior to the end of the medical staff year during which an election is held. Whenever feasible, the

election shall be held three (3) to six (6) months prior to the end of the medical staff year so as to give the newly elected officer the opportunity to begin transitioning into the role. Voting shall be by written ballot submitted to the medical staff office or via electronic vote.

A nominee for chief of staff shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the medical executive committee shall decide the election by written ballot at its next meeting or a special meeting called for that purpose.

In the election for member-at-large where there are two or more nominees, the two nominees receiving the highest numbers of votes shall be elected to each serve in the role of member-at-large. If there are not two or more nominees on the ballot, only one position of member-at-large need be filled.

#### 9.1-5 TERM OF ELECTED OFFICE

The chief of staff shall serve a two (2) year term, commencing on the first day of the medical staff year following the election. The chief of staff shall be eligible to serve consecutive terms.

The vice chief of staff, immediate past chief of staff, and member(s)-at-large shall serve a one (1) year term. The vice chief of staff and member(s)-at-large shall be eligible to serve consecutive terms.

Each officer shall serve until the end of that officer's term, unless that officer resigns or is removed from office.

#### 9.1-6 RECALL OF OFFICERS

Any medical staff officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a medical staff officer may be initiated by the medical executive committee or by a petition signed by at least one-third of the members of the active medical staff presented to the medical executive committee or chief of staff. Recall shall require a majority vote of the medical executive committee. A special meeting may be called for this purpose.

At least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the medical executive committee prior to a vote on removal. This provision does not include actions such as summary suspension where such timeline may not be feasible.

#### 9.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies shall be filled by appointment by the chief of staff with consultation with the medical executive committee until the next regular election, except for the member-at-large, which may remain vacant.

### 9.2 DUTIES OF OFFICERS

#### 9.2-1 CHIEF OF STAFF

The chief of staff shall serve as the chief officer of the medical staff. With the assistance of the medical executive committee where appropriate, the duties required of the chief of staff (or designee, as allowed by the bylaws) shall include, but not be limited to:

(a) enforcing the medical staff bylaws and policies, implementing sanctions where indicated in consultation with the medical executive committee, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

(b) calling, presiding at, and being responsible for the agenda of all general meetings of the medical staff;

(c) serving as chair of the medical executive committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

(d) in the interim between medical executive committee meetings, performing those responsibilities of the committee that, in the chief of staff's opinion, must be performed prior to the next regular or special meeting of the committee;

(e) serving as an ex-officio member of all other staff committees without vote, unless chief of staff membership in a particular committee is required by these bylaws;

(f) interacting with the administrator, chief medical officer and board of directors in all matters of mutual concern within the district;

(g) representing the views and policies of the medical staff to the board of directors, the administrator or designee, and chairing the joint conference committee as indicated in these bylaws;

(h) regularly reporting to the board of directors on the performance of medical staff functions and communicating to the medical staff any concerns expressed by the district board;

(i) being a spokesperson for the medical staff in external professional and public relations;

(j) serving on liaison committees with the board of directors and administration, as well as outside licensing or accreditation agencies;

(k) performing such other functions as may be assigned to the chief of staff by the bylaws, the medical staff, or the medical executive committee.

### 9.2-2 VICE CHIEF OF STAFF

The vice chief of staff shall serve a one (1) year term and is selected from among the current department chiefs serving on the medical executive committee. The vice chief of staff shall assume all duties and authority of the chief of staff in the absence of the chief of staff and shall perform such other duties as may be assigned. ~~The vice chief of staff will serve as chair of the medical staff quality improvement committee and participate in the district quality improvement committees, as described in the district quality plan.~~

### 9.2-3 IMMEDIATE PAST CHIEF OF STAFF

The immediate past chief of staff will remain a member of the medical executive committee for one (1) year, and shall attend at least the first three (3) consecutive months of their term to assure a smooth transition with the change in leadership and longer as deemed necessary. The immediate past chief of staff shall perform such other duties as may be assigned.

### 9.2-4 MEMBER-AT-LARGE

There may be one or two officers with the title member-at-large. The member(s)-at-large shall be ~~a~~ members of the medical executive committee and shall perform duties as may be assigned.

## ARTICLE X: CLINICAL DEPARTMENTS

### 10.1 ORGANIZATION OF CLINICAL DEPARTMENTS

The active medical staff shall be organized into clinical departments. Each department shall be organized as a separate component of the medical staff and shall have a chief selected and entrusted with the authority, duties, and responsibilities specified in this Article. When appropriate, or at the recommendation of the departmental committee, the medical executive committee may approve the creation, elimination, modification, or combination of departments.

Department committees, as described in Article XI, may represent a single clinical department or a combination of clinical departments as appropriate.

Additional medical or surgical specialties not currently listed as a department will be assigned to an existing department through the credentialing and privileging process.

### 10.2 DEPARTMENTS

The clinical departments under these bylaws are:

(a) Anesthesia

(b) Emergency Medicine

(c) Surgery (including Pathology)

(d) Inpatient Medicine

(e) Obstetrics & Gynecology

(f) Orthopedic Surgery (including Podiatry)

(g) Outpatient Medicine

(h) Pediatrics

(i) Radiology

### 10.3 ASSIGNMENT TO DEPARTMENTS

Each privileged practitioner shall be assigned membership based on specialty or board certification in at least one department, but may also be granted membership and/or clinical privileges in other departments consistent with practice privileges granted.

### 10.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

(a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department, as per the medical staff's policy on ongoing and focused professional practice evaluation.

(b) Recommending to the medical executive committee guidelines for the granting of clinical privileges and the performance of specified services within the department.

(c) Evaluating and making appropriate recommendations to the credentials committee and the medical executive committee regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department.

(d) Reviewing and evaluating departmental adherence to: (1) medical staff and district policies and procedures, (2) sound principles of clinical practice, and (3) quality improvement.

(e) Coordinating with nursing and ancillary staff in regards to patient care provided by the department's members with nursing and ancillary patient care services.

(f) Reporting to the departmental committee concerning: (1) the activities of the department, and (2) recommendations for maintaining and improving the quality of care provided in the department and the district.

(g) Meeting regularly for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions.

(h) Taking appropriate action when problems in patient care and clinical performance or opportunities to improve care are identified.

(i) Formulating departmental policies/procedures as reasonably necessary for the proper discharge of its responsibilities subject to the approval by the medical executive committee.

## 10.5 DEPARTMENT CHIEFS

### 10.5-1 QUALIFICATIONS

Each department shall have a chief who shall be a member of the active staff and shall be qualified by licensure, training, experience and demonstrated ability in at least one of the clinical areas covered by the department. If required by applicable California regulations or other law, the department chief must be certified by an appropriate specialty board or eligible for certification by an appropriate specialty board. Otherwise, the department chief shall possess comparable competence as affirmatively established through the peer review process.

### 10.5-2 SELECTION

The department chief shall be elected by the voting members of their department. In the event of a tie vote, the chief will be appointed by vote of the medical executive committee. Departments with a single member will automatically have the single member designated as chief. Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt.

The medical director of the department may be eligible to serve as the department chief, if so elected. If after election, the department chief becomes the administratively-appointed medical director of his or her department, a re-election will be held at the next departmental meeting.

### 10.5-3 TERM OF OFFICE

Each department chief shall serve a one (1) year term which coincides with the medical staff year or until his or her successor is chosen, unless he or she shall sooner resign, be removed from office, or lose his or her medical staff membership or clinical privileges in that department. Department chiefs shall be eligible to serve consecutive terms.

### 10.5-4 REMOVAL

Removal of department chiefs from office may occur for cause by a two-thirds vote of the department members. The medical executive committee may remove department chiefs in the course of a corrective action proceeding as indicated.

### 10.5-5 DUTIES

Each chief shall have the following authority, duties and responsibilities, and shall otherwise perform such duties as may be assigned:

(a) oversee the quality of patient care, professional performance and behaviors rendered by practitioners with clinical privileges in the department and designate proctors as necessary;

(b) assign a member of the medical staff to assume responsibility for duties and/or the care of another member's patients in the event the member is unable to fulfill their obligations due to termination of privileges, illness, or similar extenuating circumstances;

(c) enforce the medical staff bylaws and medical staff and district policies within the department;

(d) implement within the department appropriate actions taken by the medical executive committee;

(e) coordinate with district administration, department medical director (if any), and nursing services in matters relevant to the department;

(f) perform such other duties commensurate with the office as may from time to time be reasonably requested by the chief of staff or the medical executive committee.

## ARTICLE XI: COMMITTEES

### 11.1 DESIGNATION

The medical executive committee and the other committees described in these bylaws shall be the standing committees of the medical staff. Special or ad hoc committees may be created by the medical executive committee or the chief of staff to perform specified tasks. Any committee that is carrying out all or any portion of a function or activity required by these bylaws is deemed a duly-appointed and authorized committee of the medical staff.

### 11.2 GENERAL PROVISIONS

#### 11.2-1 APPOINTMENT OF COMMITTEE MEMBERS AND CHAIRS

The chair and members of committees shall be designated as per the bylaws. If not specified in the bylaws, the chair and members of committees shall be appointed by and may be removed by the chief of staff, subject to consultation with the medical executive committee. Medical staff committees shall be responsible to the medical executive committee. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

The administrator, or his or her designee, shall appoint any non-medical staff committee members who are not otherwise designated by title in the provision or resolution creating the committee.

The removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

#### 11.2-2 COMMITTEE COMPOSITION

Except as otherwise provided in the bylaws, committees established to perform medical staff functions required by these bylaws may include any category of: medical staff members; advanced practice providers; representatives from district services such as administration, nursing services, or medical records; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each active medical staff member and advanced practice provider who serves on a committee participates with vote unless the statement of committee composition provides for designation of the position as non-voting.

#### 11.2-3 REPRESENTATION ON DISTRICT COMMITTEES AND PARTICIPATION IN DELIBERATIONS

The medical staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing medical staff representation on district committees established to perform such functions. The medical executive committee will be responsible for providing a medical staff or APP representative on district committees when requested by the board or administration.

### 11.2-4 EX-OFFICIO MEMBERS

The chief of staff and the administrator or designee are ex-officio members of all standing and special committees of the medical staff. They and all other persons designated to serve as ex-officio committee members shall serve without vote unless provided otherwise in the provision or resolution creating the committee.

### 11.2-5 ACTION THROUGH SUBCOMMITTEES

Any medical staff standing committee may establish subcommittees to assist in carrying out its duties, in addition to any such subcommittees established by the medical executive committee or expressly designated in the bylaws. A subcommittee shall be composed of one or more voting members of the standing committee. The medical executive committee shall be informed when a subcommittee is established. The committee chair may also appoint individuals to serve as non-voting subcommittee members, after consulting with, and subject to the approval of, the chief of staff regarding medical staff members, and the administrator or designee regarding district personnel. An ad hoc committee is not considered a subcommittee.

### 11.2-6 TERM OF COMMITTEE MEMBERS

The term of committee members shall be as designated in the bylaws. If not specified, a committee member shall be appointed for a term of one year, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee.

### 11.2-7 COMMITTEE VACANCIES

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

### 11.2-8 LIMITATION OF ATTENDANCE AT COMMITTEE MEETINGS

Unless otherwise specified in the bylaws, any privileged practitioner who is in good standing may be permitted to attend any portion of a medical staff committee's meeting dealing with a matter of importance to that practitioner even though the practitioner is not a member of the committee. However, the committee chair or the chief of staff shall have the discretion to deny entry to the meeting to such practitioner, or to request any nonmember to leave the meeting. Any such nonmember who attends shall abide by all bylaws applicable to that committee.

In addition, during any portion of a committee meeting when the committee is in closed session or conducting peer review and chart review functions with respect to specific medical staff members, applicants, or other practitioners or advanced practice providers, attendance at the committee's meeting shall be restricted to (a) privileged practitioners who are members of the committee through assignment or election by the medical staff, and (b) any medical staff member or other person whom the committee has invited or requested to attend to assist in the functions (but only for the portion of the meeting designated by the committee or the committee chair).

The committee chair, after consulting with the chief of staff and administrator, may call on outside consultants or other special advisors to assist the committee in fulfilling its duties and allow such special

advisors to attend committee meetings related to the assistance they are providing, but such advisors shall not be deemed members of the committee.

Any nonmember who attends a committee meeting shall be deemed to have agreed, by his or her presence at the meeting, to maintain the confidentiality of and to refrain from any unauthorized disclosure to other persons of the committee's records, deliberations, and proceedings.

#### 11.2-9 ACCOUNTABILITY

All medical staff committees shall be accountable to the medical executive committee.

## 11.3 MEDICAL EXECUTIVE COMMITTEE

#### 11.3-1 COMPOSITION

The medical executive committee shall be composed of the chief of staff, vice chief of staff, immediate past chief of staff, department committee chairs, and up to two~~a~~ member~~s~~-at-large, if elected. The chief of staff shall chair and preside over the medical executive committee. The administrator or designee and the chief nursing officer shall be a non-voting ex-officio members.

#### 11.3-2 DUTIES

With the assistance of the chief of staff and/or the use of ad hoc committees as appropriate, the medical executive committee shall:

(a) represent and act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws;

(b) ensure the medical staff fulfills its responsibilities to the district board as per the district bylaws;

(c) monitor, evaluate, and supervise the performance of all medical staff functions, including conducting an annual review of medical staff policies;

(d) review, evaluate, or take other appropriate action for matters related to the competence and other qualifications of privileged practitioners or practitioners applying for privileges;

(e) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all privileged practitioners and when indicated, initiate and/or pursue disciplinary or corrective actions affecting privileged practitioners, as provided in the bylaws;

(f) ensure medical staff's knowledge of and compliance with the medical staff bylaws and policies; the district's bylaws, rules, and policies; state and federal laws and regulations; and other accreditation requirements;

(g) oversee the development of medical staff policies, approve (or disapprove) all such policies, and oversee the dissemination and implementation of all such policies following their approval by the medical staff;

(h) implement, as they relate to the medical staff, the approved policies, procedures, standards, and rules of the district, including, without limitation, the Compliance program (which

program relates to Medicare and Medi-Cal fraud and abuse matters); the district confidentiality policies and procedures related to compliance with applicable law, including but not limited to the federal Health Insurance Portability and Accountability Act ("HIPAA") and the California Medical Information Act; and the district medical error reporting program, including without limitation, applicable disclosure and reporting protocols.

(i) provide liaison between the medical staff, the administrator and the district board by regularly reporting to the district board and to the medical staff;

(j) make recommendations to the district board regarding medical staff structure, membership and privileges requirements, application, disciplinary, and hearing procedures, peer review and quality assessment and improvement activities, and other aspects of medical staff affairs addressed in the medical staff bylaws;

(k) make recommendations to administration in the selection of and assignment of responsibilities to department medical directors, the chief medical officer, or other practitioners contracted by the district to provide administrative services;

(l) review and make recommendations to the chief medical officer regarding quality of care issues related to specified clinical services contract arrangements for professional medical services;

(m) participate and provide information when requested in district proceedings involved with making specified clinical services contracting decisions;

(n) establish, as needed, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the medical executive committee;

(o) appoint committee members for all standing committees, all special medical staff, liaison, or multi-disciplinary committees, and designating the chairs of these committees, except where otherwise provided by these bylaws; and

(p) recommend the amount of annual dues for each medical staff membership category, subject to medical staff approval, and recommend the manner of expenditure of dues funds, subject to the committee's acknowledgment that such expenditures must be consistent with applicable law regarding such expenditures.

#### 11.3-3 MEETINGS

The medical executive committee should be scheduled to meet on a monthly basis and shall meet at least ten (10) times during the medical staff year.

### 11.4 QUALITY IMPROVEMENT COMMITTEE

#### 11.4-1 COMPOSITION

The quality improvement committee shall consist of the members of the medical executive committee. The administrator or designee and the chief nursing officer shall be ex-officio non-voting members. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity. The chair shall be the ~~vice~~ chief of staff.

### 11.4-2 DUTIES

The quality improvement committee shall be responsible for overall supervision of patient care services quality monitoring, assessment, and improvement activities and accordingly shall:

(a) in collaboration with the district, oversee the development and implementation of a district-wide quality improvement plan and perform an annual review and recommend revisions as needed;

(b) carry out the duties as described in the district quality improvement plan;

(c) review quality improvement reports from department chiefs, committees, and other medical staff patient care review activities; and

(d) refer problems for assessment and corrective action to appropriate departments or committees.

### 11.4-3 MEETINGS AND REPORTS

The medical staff quality improvement committee should be scheduled to meet on a monthly basis and shall meet at least ten (10) times during the medical staff year.

## 11.5 BYLAWS COMMITTEE

### 11.5-1 COMPOSITION

The bylaws committee shall be composed of at least three (3) active staff members.

### 11.5-2 DUTIES

The bylaws committee shall make reasonable efforts to assure that the medical staff bylaws and policies adequately and accurately reflect the current structure and practices of the medical staff and comply with applicable legal requirements by:

(a) conducting an annual review of the bylaws;

(b) developing and submitting proposals for bylaws changes to the medical executive committee and to the medical staff in accordance with bylaws procedures;

(c) receiving, evaluating, and making recommendations with respect to bylaws or policies proposals made by the executive committee, department chiefs, member petition or other sources; and

(d) engaging in such other activities as reasonably appropriate for fulfilling these and other functions as specified in the bylaws or policies.

### 11.5-3 MEETINGS AND REPORTS

The bylaws committee will meet at least annually and otherwise as requested by the bylaws committee chair or chief of staff. The committee shall report its activities and recommendations at least annually to the medical executive committee.

## 11.6 CREDENTIALS COMMITTEE

### 11.6-1 COMPOSITION

The credentials committee shall be composed of at least five (5) active staff members, selected on a basis that will ensure insofar as feasible, representation of the clinical departments and the major clinical specialties which are routinely practiced by privileged practitioners at Northern Inyo Healthcare District.

### 11.6-2 DUTIES

The credentials committee shall evaluate and make recommendations with respect to the qualifications of all applicants for medical staff appointment, reappointment, privileges, and changes in staff categories, and fulfill other functions as specified in the bylaws or policies.

### 11.6-3 MEETINGS AND REPORTS

The credentials committee shall meet at least quarterly, or as often as necessary as determined and called by the committee chair, the chief of staff, or the medical staff office. The committee shall report its activities and recommendations with respect to applicants as specified in the bylaws and shall otherwise report the status of pending applications and its activities to the medical executive committee.

## 11.7 INFECTION CONTROL COMMITTEE

### 11.7-1 COMPOSITION

The infection control committee shall be composed of at least ~~three (3)~~two (2) privileged practitioners, at least ~~two (2)~~one (1) of which shall be an active staff member~~s~~, and the infection prevention nurse (with vote). A quorum shall consist of one (1) privileged practitioner and the infection prevention nurse.

Ex-officio members serving without vote shall include ~~the infection prevention nurse,~~ the administrator (or the administrator's designee), and a representative from the clinical laboratory (bacteriology). In addition, representatives from areas such as, but not limited to, the employee health, dietary, respiratory therapy, and environmental service departments may be invited to attend and participate in discussion without vote. The chair of the infection control committee shall be required to complete the necessary infection control training as mandated per state regulations.

### 11.7-2 DUTIES

The duties of the infection control committee shall include assisting the district in:

(a) developing a hospital-wide infection control program and maintaining surveillance over the program;

(b) developing a system for reporting, identifying and analyzing the incidence and cause of healthcare-associated infections, including assignment of responsibility for the ongoing collection and analytic review of such data;

(c) monitoring implementation of corrective actions for healthcare-associated infections, and making recommendations to eliminate future such infections;

(d) developing and implementing a preventative and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

(e) developing written policies defining special indications for isolation requirements;

(f) coordinating actions on findings from the medical staff's review of the clinical use of antibiotics;

(g) taking such actions as reasonably necessary to assure infection control compliance with regulatory agencies and with established guidelines such as those of the Center for Disease Control and APIC (Association for Professionals in Infection Control and Epidemiology); and

(h) reviewing sensitivities of organisms specific to the facility.

### 11.7-3 MEETINGS

The infection control committee shall meet at least quarterly. The committee, or a representative of the committee, shall provide to the medical executive committee and the quality improvement regular reports of the committee's activities.

## 11.8 INTERDISCIPLINARY PRACTICE COMMITTEE

### 11.8-1 COMPOSITION

The interdisciplinary practice committee (IDPC) shall be composed of:

(a) an equal number of medical staff members who are physicians and nursing staff who are registered nurses;

(b) the lead advanced practice provider;

(c) the chief nursing officer; and

(d) the administrator (or the administrator's designee, who may not be a registered nurse or a physician medical staff member).

The medical executive committee shall appoint the physician members and designate one of them as the chairperson. The chief nursing officer shall appoint the nursing staff members. In addition, representatives in the categories of advanced practice providers granted privileges in the district may serve as consultants on an as-needed basis, and shall participate, when requested and feasible, in the committee proceedings when a member of the same APP category is applying for privileges.

### 11.8-2 DUTIES

The IDPC functions to establish, implement, monitor, and evaluate policies and procedures for interdisciplinary medical practice pursuant to Title 22, California Code of Regulations, Sections 70706 and 70706.2, other applicable law, and the bylaws. IDPC duties shall include, but not necessarily be limited to, the standardized procedures and credentialing duties as set forth below in this Section.

(a) **STANDARDIZED PROCEDURE DUTIES:**

(1) The IDPC shall develop and review standardized procedures that apply to nurses or APPs, identify functions that are appropriate for standardized procedures, initiate such procedures, and review and approve standardized procedures in accordance with applicable licensure regulations, such as Title 22, California Code of Regulations, Sections 70706 and 70706.2, other applicable law, and the bylaws.

(2) Request for development of standardized procedures may be initiated by the administrator, the chief medical officer, the chief nursing officer, the medical executive committee, the chief of staff, the appropriate department chiefs, the affected registered nurses or APPs, or supervising practitioners.

(3) Prior to approval of new or amended standardized procedures, the IDPC shall obtain consultation and recommendations from the department chief(s), other appropriate medical staff members, and nonmedical staff members who practice in the clinical field or medical or nursing specialties under review as subject of the proposed standardized procedures.

(4) Standardized procedures shall be reviewed and approved by the IDPC, the medical executive committee, the administrator, and the board of directors in order to become effective.

(5) The IDPC may approve standardized procedures only by affirmative vote of the following IDPC members: the administrator (or the administrator's designee), a majority of the physician members, and a majority of the registered nurse members (including the chief nursing officer).

(6) The IDPC is responsible for assuring that standardized procedures are a collaborative effort among administrators and health professionals, including physicians and nurses. Each standardized procedure shall:

i. Be in writing and show the date or dates of each required approval, including approval by the IDPC;

ii. Specify which standardized procedure functions which registered nurses are authorize to perform and under what circumstances;

iii. State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure;

iv. Specify any experience, training, and/or special education requirements for performance of the standardized procedure functions;

v. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform the standardized procedure functions;

vi. Provide for a method of maintaining a written record of those persons authorized to perform the standardized procedure functions;

vii. Specify the nature and scope of review and/or supervision required for performance of the standardized procedure functions. For example, if the function is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated;

viii. Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition;

ix. State the limitations on settings or departments within the facility where the standardized procedure functions may be performed;

x. Specify any special requirements for procedures relating to patient recordkeeping; and

xi. Provide for a method of periodic review of the standardized procedure.

(b) **CREDENTIALING ADVANCED PRACTICE PROVIDERS DUTIES:**

(1) Upon request by the medical executive committee or the board of directors, or at its own initiative, the IDPC shall make recommendations regarding APP category eligibility, delineation of APP practice privileges, supervision requirements, and other such matters related to APP practice at the district.

(2) The IDPC shall review and evaluate APP applications and requests for privileges and forward its written report and recommendations to the appropriate department chief or credentials committee.

(3) The IDPC shall serve as liaison between APPs and the medical staff.

### 11.8-3 MEETINGS

The IDPC shall meet as often as needed, but at least annually. The committee shall report its activities and recommendations with respect to applicants as specified in the bylaws to the credentials committee.

## 11.9 JOINT CONFERENCE COMMITTEE

### 11.9-1 COMPOSITION

The joint conference committee is an ad hoc committee ~~shall be~~ composed of two (2) members of the board of directors and two (2) members of the medical executive committee, one (1) of which shall be the chief of staff, and the other which shall be appointed by the medical executive committee. The administrator, or designee, shall be a non-voting, ex-officio member. The chair of the committee should alternate yearly between the board of directors and the medical staff; odd-numbered years will be the board of directors, and even-numbered years will be the medical staff.

### 11.9-2 DUTIES

The function of the joint conference committee is to serve as ~~an official means of~~a liaison between members of the board of directors, the district administration, and the medical staff on an ad hoc basis. The joint conference committee shall act in an advisory function and provide a forum for:

(a) maintenance of effective communications to keep the board, medical staff, and the administrator cognizant of any pertinent actions taken or contemplated;

(b) planning for growth and development of the district and the medical staff;

(c) discussion of matters of district and medical staff policy, practice, and planning not related to peer review; and

(d) interaction between the board of directors and the medical staff on such matters as may be referred by the medical executive committee or the board of directors.

The joint conference committee ~~shall~~ may also meet on an ad hoc basis to act as a deliberative body as described below for:

(a) the resolution of conflicts or disputes between the medical staff and the board of directors or administration; and

(b) the resolution of any dispute related to the medical staff's rights or self-governance or discharge of medical staff responsibilities.

### 11.9-3 DISPUTE RESOLUTION PROCESS

All disputes between administration or the board of directors and the medical staff that have not been resolved by prior informal meetings and discussions shall be addressed to and mediated by the joint conference committee.

(a) Following written notice of a dispute needing mediation, the committee shall convene within fourteen (14) days after the next regularly scheduled district board meeting.
(b) The committee shall meet and confer in good faith to formulate a recommendation for mediation of the dispute.
(c) If the committee cannot reach a consensus, the committee may appoint an outside professional mediator as a member of the committee, and the mediator shall serve as the chair of the committee but shall have no vote. The parties shall cooperate to select the mediator from a list of candidates provided by services such as the Judicial Arbitration and Mediation Service or the American Arbitration Association. The cost of the mediator shall be covered by the district.

### 11.9-4 MEETINGS AND REPORTS

The committee shall ~~meet at least semi-annually, but may also~~ meet as needed on an ad-hoc basis as described above. The chief of staff, or designee, shall report the committee's activities or discussions to the medical executive committee and to the medical staff via email or at the next regularly scheduled

meetings, as appropriate for the subject matter. Minutes shall be kept during meetings as appropriate and a copy maintained ~~at the district office and~~ in the medical staff office.

## 11.10 PHARMACY AND THERAPEUTICS COMMITTEE

### 11.10-1 COMPOSITION

The pharmacy and therapeutics committee shall be composed of at least three (3) active staff members, the pharmacy director (with vote), and the chief nursing officer or other nurse designated by the chief nursing officer (with vote). Ex-officio members serving without vote shall include the administrator, or the administrator's designee, and a representative from clinical informatics. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

### 11.10-2 DUTIES

The duties of the pharmacy and therapeutics committee shall include:

(a) assisting in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage;

(b) advising the medical staff and the pharmaceutical service on matters pertaining to the choice of available drugs;

(c) making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(d) periodically reviewing and maintaining formulary or drug list for use in the hospital;

(e) evaluating clinical data concerning new drugs or preparations requested for use in the hospital;

(f) establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

(g) maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the medical executive committee concerning those activities; and

(h) reviewing untoward drug reactions.

### 11.10-3 MEETINGS

The pharmacy and therapeutics committee shall meet at least quarterly. The committee shall report a summary of its activities or findings to the medical executive committee and the quality improvement committee on a regular basis.

## 11.11 PHYSICIAN WELLNESS COMMITTEE

### 11.11-1 COMPOSITION

The physician wellness committee shall be composed of at least three (3) medical staff members, one (1) of whom should be a psychiatrist whenever feasible. Insofar as feasible, members of this committee shall not actively participate on other peer review, corrective action ad hoc committee, or quality improvement committees while serving on this committee.

Additionally, in order to facilitate open communication about provider wellness, meetings of the physician wellness committee will be limited to the medical staff members of that committee and other participants will be included by invitation of the chair of the committee only.

**11.11-2 DUTIES**

The committee shall:

(a) Consider general matters related to the health and well-being of medical staff members and, with the approval of the medical executive committee or chief of staff, develop educational programs or staff events for promoting well-being.

(b) Educate staff on illness and impairment recognition issues specific to physicians.

(c) Review, evaluate, and make recommendations as appropriate or otherwise required by the bylaws:

(1) Voluntary disclosures to the committee by members or other practitioners regarding their health status;

(2) Health status referrals or reports from the chief of staff or other medical staff officer or committee regarding a member; and

(3) Responses from applicants concerning physical or mental disabilities.

(d) Investigate any applicant, member, or other practitioner who has or may have physical or mental disability that may affect the practitioner's capability to exercise the privileges applied for and/or held by the practitioner in a manner that meets the patient care quality standards of the district and the medical staff. An investigation may include any or all of the following steps:

(1) Ascertain the health status of the practitioner through committee interview;

(2) Medical examination by an appropriate healthcare professional to evaluate whether the practitioner has a physical or mental disability or other health problem that may affect patient care;

(3) Evaluate the effects of the health status on the practitioner's capability to exercise privileges applied for or held by the practitioner, and when relevant with respect to a qualified physical or mental disability under applicable law, assess if and how reasonable accommodations can be made;

(4) Provide advice, counseling, or referrals as appropriate.

The activities of the physician wellness committee shall be confidential. However, if the committee receives information that demonstrates that the health or impairment of a practitioner may pose a risk

of harm to patients, self or others, that information shall be referred to the chief of staff or the medical executive committee. This committee is not disciplinary in nature and does not preclude other review mechanisms as set forth in these bylaws.

### 11.11-3 MEETINGS, REPORTING AND MINUTES

The physician wellness committee shall meet as often as necessary, but at least quarterly. It shall maintain only such records of its proceedings as it deems advisable and consistent with confidentiality concerns, and shall routinely report on its activities to the medical executive committee.

## 11.12 UTILIZATION REVIEW AND MEDICAL RECORDS COMMITTEE

### 11.12-1 COMPOSITION

The utilization review and medical records committee shall consist of at least three (3) medical staff members. Representatives from quality, utilization review, nursing, billing, medical records, and social services shall be invited as non-voting members.

### 11.12-2 DUTIES

The utilization review and medical records committee shall perform the following functions:

(a) Delineate the scope of utilization review provided within the district;

(b) Develop critical indicators to be used as screening devices in reviewing the utilization of district services;

(c) After cases have been isolated using the critical indicators, evaluate utilization of services administered and identify areas for improvement, if necessary;

(d) Review patient care services to ascertain if utilization of services within the standards of the district and medical staff are being provided in the most cost-effective manner, address overutilization, underutilization, and inefficient scheduling of care and resources;

(e) Review diagnoses, problems, procedures and the practices of practitioners that appear to have utilization-related problems, and examine relevant quality assurance findings and interface with the practitioners as deemed necessary or appropriate;

(f) Determine appropriate action to be taken with respect to identified utilization and other patient care problems, and report such matters to the medical executive committee and the quality improvement committee;

(g) Refer problems which cannot reasonably be resolved at the committee level to the appropriate committee;

(h) Develop, implement, and maintain such Utilization Review Plan as approved by the medical executive committee and district board; and

(i) Comply with applicable federal and state regulations.

### 11.12-3 MEETINGS

The utilization review and medical records committee shall meet at least quarterly. The committee shall report a summary of its activities or findings to the medical executive committee on a regular basis. The committee shall also give notification to the medical executive committee promptly after the committee receives notice of any matter for which a practitioner is required to give notice to the medical staff pursuant to these bylaws, if not already reported.

## 11.13 DEPARTMENTAL COMMITTEES

### 11.13-1 COMPOSITION

The departmental committees can represent a single clinical department or a combination of clinical departments. The departmental committees shall be composed of at least three (3) practitioners from the represented departments that are designated as core committee members. The majority of core committee members must be physicians. The chair may also be a core committee member.

Core committee members will be designated by the chair of the departmental committee following consultation with the committee members. Core committee members have the duty to attend all meetings of the department, unless excused for good reason by the chair of the committee.

Additional committee members may be assigned as needed to represent all disciplines of the department at regularly scheduled meetings. All practitioners are encouraged to attend their departmental committees, even if not designated as a core member of the committee.

(a) Emergency Services Committee

The emergency services committee shall represent all medical services provided in the emergency department. In addition, the emergency room nurse manager and the administrator (or designee) shall be ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(b) Inpatient Medicine Committee

The inpatient medicine committee represents the adult medical services provided in the medical/surgical and intensive care unit departments. At least one core member of the committee shall be a hospitalist. Whenever possible, the cardiopulmonary medical director and an outpatient medicine committee representative shall serve on the committee. The medical/surgical nurse manager and the administrator (or designee), as well as representatives from the respiratory therapy, physical therapy, dietary, and pharmacy departments shall be non-voting ex-officio members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(c) Outpatient Medicine Committee

The outpatient medicine committee represents the outpatient services including family medicine, internal medicine, outpatient infusion department, and other outpatient medicine departments not represented by other committees. Whenever possible, the

cardiopulmonary medical director and an inpatient medicine committee representative shall serve on the committee. The clinical nurse manager, a representative from the outpatient infusion department, and the administrator (or designee) shall be non-voting ex-officio members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(d) Perinatal/Pediatrics Committee

The perinatal/pediatrics committee shall represent the pediatric and obstetrical departments. The nurse managers of the perinatal and pediatrics units and the administrator (or designee) shall be ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(e) Radiology Services Committee

The radiology committee represents the radiology services. The director of diagnostic services and the administrator (or designee) shall be non-voting ex officio members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(f) Surgery/Tissue/Transfusion/Anesthesia Committee

The surgery, tissue, transfusion and anesthesia (STTA) committee represents all surgical, anesthesia, and pathology services. The director of perioperative nursing and the administrator (or designee) shall serve as ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

**11.13-2 DUTIES**

The medical staff departmental committees listed in Section 11.13-1 are responsible for overseeing the quality and appropriateness of patient care rendered in the department by, without limitation:

(a) Using critical indicators to conduct concurrent and retrospective peer review of medical records with referral for committee review as indicated;

(b) Monitoring and evaluating clinical performance of all privileged practitioners attending patients or administering care in the department;

(c) Periodically reviewing and evaluating the medical services provided;

(d) Making recommendations concerning matters for which the committee is responsible to the medical executive committee, the quality improvement committee and the administrator or chief medical officer as appropriate;

(e) Reviewing applicants for privileges when requested by the department chief;

(f) Electing annually the departmental committee chair, who presides over the meetings and attends the medical executive committee meetings. This departmental committee chair may or may not be the chief of the department; and

(g) Receiving reports from other committees as appropriate.

**11.13-3 MEETINGS AND REPORTS**

The medical staff departmental committees shall meet at least quarterly. The committees shall report a summary of their activities or findings to the medical executive committee and quality improvement committee on a regular basis. The committees shall also give notification to the medical executive committee promptly after the committees receive notice of any matter for which a practitioner is required to give notice to the medical staff pursuant to these bylaws, if not already reported.

## ARTICLE XII: MEETINGS

### 12.1 GENERAL MEDICAL STAFF MEETINGS

#### 12.1-1 REGULAR MEETINGS

Regular meetings of the medical staff members shall be held ~~each~~ at least quarterly. The date, place and time of the regular meetings shall be determined by the medical executive committee or the chief of staff, and adequate notice shall be given to the members.

#### 12.1-2 AGENDA

The order of business at a meeting of the medical staff shall be determined by the chief of staff and medical executive committee. The agenda shall include, as applicable:

(a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) administrative reports from the chief of staff, departments, and committees, chair of the quality improvement committee, and the administrator or designee;

(c) election of officers when required by these bylaws;

(d) old business; and

(e) new business.

#### 12.1-3 SPECIAL MEETINGS

Special meetings of the medical staff may be called at any time by the chief of staff or the medical executive committee, or shall be called upon the written request of ten percent (10%) of the members of the active medical staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled as soon as reasonably possible, but within thirty (30) days after receipt of such request. Notice shall be given to the members of the staff with as much advance notice as possible, which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

### 12.2 COMMITTEE AND DEPARTMENT MEETINGS

#### 12.2-1 REGULAR MEETINGS

Except as otherwise specified in these bylaws, the chairs of medical staff and departmental committees may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

#### 12.2-2 SPECIAL MEETINGS

A special meeting of any medical staff committee or department may be called by the chair thereof, the medical executive committee, or the chief of staff.

## 12.3 QUORUM

### 12.3-1 GENERAL MEDICAL STAFF MEETINGS

The presence of fifty percent (50%) of the total members of the active medical staff at any regular or special meeting in person or through written (electronic) ballot shall constitute a quorum for the purpose of the election or removal of medical staff officers, or other special votes as determined by the chief of staff. The presence of twenty-five percent (25%) of members shall constitute a quorum for all other actions.

### 12.3-2 DEPARTMENT ~~AND COMMITTEE~~ MEETINGS

~~A quorum of fifty percent (50%) of the voting members shall be required for medical executive and credentials committee meetings.~~ For ~~all other medical staff and~~ department committees, a quorum shall consist of all three core members or substitutes as appointed by the departmental chair (in accordance with Section 11.13-1).

### 12.3-3 MEDICAL STAFF COMMITTEE MEETINGS

A quorum of fifty percent (50%) of the voting members shall be required for medical executive ~~and credentials committee~~ meetings. For other medical staff committee meetings (e.g., utilization review, pharmacy and therapeutics), the presence of two (2) committee voting members shall constitute a quorum, unless otherwise specified in the committee composition.

## 12.4 VOTING AND MANNER OF ACTION

### 12.4-1 VOTING

Unless otherwise specified in these bylaws, only members of the active medical staff may vote in medical staff general meetings and elections. All members of the medical staff and APP staff are entitled to vote at committee and department meetings appropriate to their specialty as described at time of appointment.

### 12.4-2 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. A meeting in which a quorum is not initially present may be started, though no action may be taken until a quorum is present. Committee and medical staff action may be conducted by telephone conference or other electronic communication. Votes collected by electronic means require a majority vote to be valid.

## 12.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters.

## 12.6 ATTENDANCE REQUIREMENTS

### 12.6-1 REGULAR ATTENDANCE

Members are expected to attend all meetings of the medical staff and of the department or committee to which assigned. Attendance via telephone conference or other electronic communication shall be accepted. Each member of the consulting or courtesy staff shall be required to attend such meetings as may be determined by the medical executive committee.

### 12.6-2 ABSENCE FROM MEETINGS

Any member who is compelled to be absent from any medical staff, department, or committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence. Unless excused for good cause by the presiding officer of the department or committee, or the medical staff office for medical staff meetings, failure to attend may be included in the practitioner's ongoing professional practice evaluation, reviewed by the medical executive committee, and may be grounds for removal from such committee or for corrective action.

### 12.6-3 SPECIAL ATTENDANCE

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting to which notice was given, unless excused by the medical executive committee upon a showing of good cause, shall be a basis for corrective action.

## 12.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

## 12.8 EXECUTIVE SESSION

The chairperson of any standing, special, or ad hoc committee of the medical staff, including departments, may call an executive session meeting. Only members of the active medical staff holding voting privileges on the committee shall attend the executive session meeting. The chairperson, at his or her discretion, may request other individuals to attend the meeting in an informational capacity. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

## ARTICLE XIII: CONFIDENTIALITY, IMMUNITY AND RELEASES

### 13.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within Northern Inyo Healthcare District, an applicant:

(a) authorizes representatives of the district and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

(b) authorizes persons and organizations to provide information concerning such practitioner to the medical staff;

(c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the medical staff or the district who would be immune from liability under Section 13.3 of this Article; and

(d) acknowledges that the provisions of this Article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at this district.

### 13.2 CONFIDENTIALITY OF INFORMATION

#### 13.2-1 GENERAL

The minutes, files, records and proceedings of the medical staff and all departments and standing or ad hoc committees, including information regarding any applicant, member or other individual exercising clinical privileges or practice privileges, shall be considered medical staff minutes or records and, to the fullest extent permitted by law, shall be confidential and protected from discovery pursuant to California Evidence Code Section 1157 and any other applicable peer review or other policy or privilege. This information shall become part of the medical staff committee files and shall not become part of any patient files, general district records, or any member's personal or office files.

Dissemination of such information and records shall only be made where expressly required by law, as authorized by these bylaws, or pursuant to officially adopted policies of the medical staff or, where no officially adopted policy exists, only with the express approval of the chief of staff and the administrator.

#### 13.2-2 BREACH OF CONFIDENTIALITY

As effective peer review and consideration of the qualifications of medical staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of medical staff departments or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this medical staff, violates the medical staff bylaws, and will be deemed disruptive to the operations of the district. If it is determined that such a breach has occurred, the medical executive committee may undertake such corrective action as it deems appropriate.

### 13.2-3 ACCESS TO AND RELEASE OF CONFIDENTIAL INFORMATION

All requests for access to medical staff records, including confidential committee records and credential files, shall be presented to an authorized representative. Authorized representatives include the authorized medical staff office personnel and medical staff officers.

(a) Access for Official Purposes

(1) The following individuals may access medical staff records, including confidential committee records and credentials files, to the extent described:

i. Committee members and their authorized representatives, for the purpose of conducting authorized committee functions.

ii. Medical staff and department officials, and their authorized representatives, for the purpose of fulfilling any authorized function of such official.

iii. The administrator, the board of directors, and their authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities. Information which is disclosed to the board of directors or its appointed representatives shall be maintained as confidential.

iv. Consultants or attorneys engaged by the district may be granted access to credential files that are necessary to enable them to perform their functions, if an authorized medical staff representative agrees.

v. Representatives of licensure agencies, accreditation agencies, or auditors from Medicare or Medicaid, if an authorized representative is with them.

(2) All subpoenas pertaining to medical staff records, including confidential committee records and credentials files, shall be referred to the medical staff office, who shall first consult with the administrator, the chief of staff, and legal counsel regarding appropriate response.

(b) Limits on Access to Practitioner's Credentials File

(1) A practitioner can view the contents of his or her credentials file, as described below, during normal business hours upon reasonable prior request to the chief of staff or medical staff officer. The individual only has the right to review and receive a copy of documents provided by or addressed personally to the individual practitioner. The medical staff has discretion to disclose other documents to a member, but in no case shall copies of confidential letters of reference, hospital verifications or other confidential correspondence be disclosed. An individual practitioner may review the above identified parts of his or her credentials file under the following circumstances:

i. Review of the credentials file is accomplished in the presence of one of the following: authorized medical staff office personnel, officer of the medical staff, a member of the credentials committee, or department chief.

ii. The practitioner understands that he or she may not remove any items from the credentials file.

iii. The practitioner understand that, subject to review by the chief of staff, he or she may add an explanatory note or other document to the file.

iv. The practitioner understands that he or she may not review confidential letters of reference, hospital verifications or other confidential correspondence received by the district or the medical staff.

v. Documents provided by the practitioner for inclusion in the credentials file (e.g., Curriculum Vitae, licenses, insurance policy, continuing medical education) may be photocopied. No other items may be photocopied without the express permission of the credentials chair.

(c) Medical Staff Committee Files and Minutes

(1) Any member shall be allowed access to minutes or other medical staff records which describe meetings or activities of the medical staff committees that they were entitled to attend (e.g. their department committees of which they are members). This does not include minutes or records of meeting or activities from which the practitioner was specifically excluded.

## 13.3 IMMUNITY FROM LIABILITY

### 13.3-1 FOR ACTION TAKEN

Each representative of the medical staff and district shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the medical staff or district.

### 13.3-2 FOR PROVIDING INFORMATION

Each representative of the medical staff and district and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the medical staff or district concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this district.

## 13.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

(a) application for appointment, reappointment, or clinical privileges;

(b) corrective action;

(c) hearings and appellate reviews;

(d) utilization reviews;

(e) other department, committee or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

(f) queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

**13.5 RELEASES**

Each applicant or member shall, upon request of the medical staff or district, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

**13.6 INDEMNIFICATION**

Northern Inyo Healthcare District shall indemnify, defend and hold harmless the medical staff, its individual members, and its appointed representatives (e.g. expert witnesses, lay committee members, hearing officers) from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review, quality assessment, or activities related to establishing standards, policies and/or procedures pursuant to the self-governing medical staff provisions, including, but not limited to:

(a) as a member of or witness for a medical staff department, service, committee or hearing panel;

(b) as a member of or witness for the district board or any district task force, group, or committee, and;

(c) as a person providing information to any medical staff or hospital group, officer, board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a medical staff member or applicant.

The medical staff or member may seek indemnification for such losses and expenses under this bylaws provision, statutory and case law, any available liability insurance or otherwise as the medical staff or member sees fit, and concurrently or in such sequence as the medical staff or member may choose. Payment of any losses or expenses by the medical staff or member is not a condition precedent to the district's indemnification obligations hereunder. In no event will the district indemnify an indemnitee for acts or omissions taken in bad faith or in pursuit of the indemnitee's private economic interests.

## ARTICLE XIV: GENERAL PROVISIONS

### 14.1 DUES OR ASSESSMENTS

The medical executive committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of medical staff membership, subject to the approval of the medical staff, and to determine the manner of expenditure of such funds received.

Failure of a member to pay dues or assessments, without good cause as determined by the medical executive committee, will be included in the member's ongoing professional practice evaluation and may be grounds for corrective action.

### 14.2 AUTHORITY TO ACT

Any member or members who act in the name of this medical staff without proper authority shall be subject to such disciplinary action as the medical executive committee may deem appropriate.

### 14.3 DIVISION OF FEES

Any division of fees by members of the medical staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the medical staff.

### 14.4 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the medical staff or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee
Name of department or committee
*[c/o medical staff office, chief of staff]*
Hospital name
Street address
City, State, Zip code

Mailed notices to a member, applicant or other party shall be to the addressee at the address as it last appears in the official records of the medical staff or district.

### 14.5 DISCLOSURE OF INTEREST

All nominees for election or appointment to medical staff offices, department chief, or the medical executive committee shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the medical executive committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff. Further information on conflict of interest may be found in Northern Inyo Healthcare District's compliance program.

### 14.6 RETALIATION PROHIBITED

Neither the medical staff, its members, committees or department heads, the board of directors, its chief executive officer, or any other employee or agent of the district or medical staff, may engage in any punitive or retaliatory action against any member of the medical staff because that member claims a right or privilege afforded by, or seeks implementation of any provision of, these medical staff bylaws.

## ARTICLE XV: ADOPTION AND AMENDMENT OF BYLAWS AND POLICIES

### 15.1 BYLAWS

#### 15.1-1 PROCEDURE FOR PROPOSALS

Proposals to adopt, amend or repeal the bylaws may be initiated by either of the following methods:

(a) The medical executive committee, with the recommendation of the bylaws committee, or on its own motion, may recommend adoption, amendment or repeal of the bylaws to the voting members of the medical staff as provided in this Article.

(b) The members of the active staff, by a written petition signed by at least twenty percent (20%) of the active staff members, may petition the medical executive committee to initiate a proposal to adopt, amend or repeal the bylaws. Such petition shall identify exact language to be added, changed or deleted. If the medical executive committee agrees with the proposed change, it may recommend the change as provided in subsection (a), above.

#### 15.1-2 APPROVAL BY THE ACTIVE STAFF

If a proposal is initiated as provided above, the chief of staff shall inform the members of the active staff, by mail or by electronic means, of the proposed change. Not less than thirty (30) days and not more than ninety (90) days from the date of such notice, the chief of staff shall either call a special meeting of the medical staff or add it to the agenda of a regular meeting to consider the proposed change.

To be adopted, a proposed change must be approved by a majority of the members of the active staff voting in person or by written ballot. If a written ballot is used, the ballots shall be opened and counted at the meeting and the results shall be announced.

#### 15.1-3 APPROVAL BY THE DISTRICT BOARD

Upon action by the active staff as provided above, the proposed change shall be submitted to the board of directors for approval. The board of board of directors may not unreasonably withhold its approval from the active staff's recommended change. If the board of directors votes to disapprove any part of the recommended change, the board of directors shall give the chief of staff written notice of the reasons for non-approval within ten (10) business days from the board of directors' action. At the request of the medical executive committee, the board of directors' disapproval shall be submitted to the Joint Conference Committee for resolution.

### 15.2 MEDICAL STAFF POLICIES

#### 15.2-1 PROCEDURE FOR PROPOSALS

Proposals to adopt, amend or repeal the medical staff policies may be initiated by any active medical staff member or medical staff committee.

### 15.2-2 APPROVAL

(a) Approval by the appropriate medical staff committee(s), as applicable;

(b) Approval by the medical executive committee;

(c) Approval by the active medical staff; and

(d) Submission to the board of directors for approval. If the board of directors disapproves the policy, it will be referred back to the appropriate committee(s).

## 15.3 TECHNICAL AND EDITORIAL AMENDMENTS

Notwithstanding any other provision of the bylaws to the contrary, the medical executive committee shall have authority on behalf of the medical staff to approve such amendments to the bylaws or policies as the medical executive committee deems to be necessary or appropriate to correct or clarify punctuation, spelling, grammatical or expression errors or ambiguities; cross references; numbering or organization; names or titles of committees, officers, practitioner categories, or other such identifiers. The medical executive committee shall give notice of such amendments to the medical staff members, the administrator, and the district board. Such amendments shall become effective upon approval by the district board.

## 15.4 DISTRIBUTION OF APPROVED PROPOSALS

Promptly after approval, and if reasonably practical, prior to the proposal's effective date, a copy of an approved proposal for bylaws or policies changes shall be distributed to all members, applicants, and other privileged practitioners and APPs who hold any type of privileges pursuant to the bylaws.

ADOPTED by the medical staff on

_____, 20_____
Date

_____
Chief of Staff

_____
Vice Chief of Staff

APPROVED by the board of directors on

_____, 20_____
Date

_____
President

_____
Secretary

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

| | | |
|---|---|---|
| Title: Naloxone (Narcan) Distribution | | |
| Owner: Care Coordinator Manager | Department: Clinics - Primary Care | |
| Scope: Emergency Department, Rural Health Clinic | | |
| Date Last Modified: 12/07/2021 | Last Review Date: No Review Date | Version: 2 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 03/18/2020 | |

## PURPOSE:

Northern Inyo Health Care District (NIHD) volunteers/staff/peers (excluding non-clinic RN staff) who are trained in overdose prevention education, pursuant to the Standing Order to dispense naloxone issued by the prescribing practitioner, will register and train opioid overdose responders to administer naloxone to individuals experiencing an opioid overdose. Naloxone is an opioid antagonist, which is used to reverse the effects of an opioid overdose.

## POLICY:

NIHD is an organization that provides harm reduction education, safe drug consumption supplies and disposal services, and health and social service referrals to individuals. NIHD aims to engage, empower and increase access to essential services for Inyo County's underserved and hard to reach populations. Core direct services include comprehensive harm reduction services (education and supplies), overdose prevention education and naloxone distribution and hygiene supply distribution. Referrals for substance use disorder treatment, primary care services, Hepatitis C treatment, benefits enrollment, and Social Service assistance are also offered to participants.

NIHD Recovery Support Navigator (RSN): An NIHD employee who is responsible for coordinating the Overdose Prevention and Naloxone Distribution Program, including training Overdose Prevention Educators and monitoring naloxone inventory. The RSN is educated to conduct Opioid Overdose Responder trainings. Overdose Prevention Educators can be peers, volunteers, staff, or anyone else working with the program who is in a position to reach people who use drugs and other potential bystanders.

Prescribing Practitioner: A practitioner licensed the State of California and who holds a valid DEA license who is issuing the standing order to dispense naloxone and is supporting the purchase of naloxone for NIHD. *See Attached Standing Order*

Opioid Overdose Responder: A person who participates in an overdose response training with a NIHD Overdose Prevention Educator.

**Responsibilities of Prescribing Practitioner:**

1. When indicated, the naloxone will be ordered by NIHD, under the license of the Prescribing Practitioner. The Prescribing Practitioner will provide their license and DEA number to pharmaceutical companies/distributors that NIHD (Medication Assisted Treatment (MAT) program purchases naloxone from. The naloxone will be shipped to NIHD, stored there, and distributed with a syringe exchange program.
2. The Prescribing Practitioner shall be responsible for writing all necessary standing orders for the distribution, possession and administration of the naloxone for the successful implementation of this program.
3. The Prescribing Practitioner will advise the NIHD MAT program related to any medical questions that may arise. The Prescribing Practitioner will not provide direct clinical care.

**PROCEDURE:**

**Training of NIHD MAT Overdose Prevention Educators:**

All Overdose Prevention Educators who will be distributing naloxone will receive training by the RSN Overdose Prevention Coordinator in the following:

At a minimum, the training curriculum shall address:

- Risk factors for opioid overdose
- Prevention strategies
- Recognizing overdose
- Signs of an overdose
- Calling 911
- Rescue breathing
- Administering naloxone
- Completion of proper documentation
- Proper storage of naloxone
- Post-overdose care
- Refill procedure

**Quality Assurance:**

- All NIHD MAT Overdose Prevention Educators will attend a mandatory training with a RSN Overdose Prevention Coordinator that cover the above topics before distributing naloxone.
- The RSN will observe all NIHD MAT Educators providing an overdose prevention education training and will provide feedback if needed.
- Any clinical issues related to the dispensing of naloxone and other adverse events reported by participants will be referred immediately to the Prescribing Practitioner.

**Training of the Opioid Overdose Responders (people who use drugs/other layperson bystanders):**

1. NIHD MAT Overdose Prevention Educators shall be responsible for training Responders using the training curriculum.
2. Trainings may be conducted in a variety of settings, including on the street or in a more conventional private indoor setting. The trainings may be in small groups or conducted one-on-one. The duration of the training shall depend on the number of responders in the class and their familiarity with naloxone

administration and overdose. 1:1 training can be as short as 5-10 minutes, and group trainings should not exceed one hour.
3. Responders shall be given a naloxone kit during 1:1 training or at the end of the group training.

**Distribution of Naloxone Kits:**

1. The contents of the naloxone kits shall be assembled in accordance with the Prescribing Practitioner's standing order. The RSN may distribute multiple forms of naloxone depending on cost and availability.
2. Naloxone kit refills shall be made available to anyone who has previously completed the training.
3. Registered Nurses are outside of their scope of practice should they dispense any medication, including Naloxone, EXCEPT when the RN is employed and working in the clinic setting and has a medical provider order to dispense.

**Data Collection and Record Keeping:**

1. NIHD MAT program and the RSN will complete data collection requirements as outlined by funders.

**Safe Storage of Naloxone Supplies and Program Records:**

1. The RSN Overdose Prevention Coordinator shall ensure that all naloxone kits are securely stored at each program site at room temperature (59-77F degrees, with exposure up to 104F without product failure) and protected from light.
2. The naloxone inventory shall be regularly assessed to ensure that it is not expired or close to expiration.

**REFERENCES:**


1. California Code, Civil Code - CIV § 1714.22
2. California Hospital Record and Data retention schedule (2018).


**RECORD RETENTION AND DESTRUCTION:** Competency validation document for staff distributing Narcan will be maintained in the HR file for the duration of employment plus 6 years.

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Naloxone (Narcan) Distribution
2. Naloxone (Narcan) Distribution

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| Supersedes: v.1 Naloxone (Narcan) Distribution |

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

| | | |
|---|---|---|
| Title: Stress Echocardiogram | | |
| Owner: Cardiopulmonary Manager | Department: EKG | |
| Scope: Cardiopulmonary Department | | |
| Date Last Modified: 12/22/2021 | Last Review Date: No Review Date | Version: 2 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 05/13/2015 | |

**PURPOSE:**
To define Stress Treadmill Echocardiogram (STE) test policies and procedures.

**POLICY: Pretest Policies:**

1. The Physician, Medical Office, or Clinic will send an order; after it is placed in the electronic health record (EHR) or scanned into the Cardiopulmonary bucket and authorization is verified, the EKG Department will print the order and place it in a folder for the Echocardiographer to review.
2. The EKG Department will contact the patient and collect pertinent information needed for the test. If the patient has Chronic Obstructive Pulmonary Disease (COPD) or weighs over two hundred and fifty pounds, the patient will be asked to come in for a pre-screening Echocardiogram.
3. The EKG Technician will give the patient pre-test instructions and obtain a list of patient's medications and ascertain allergy history.
4. The EKG Department will schedule the patient for the test.
5. The patient will check in at the Diagnostic Imaging Department.
6. The EKG Technician will obtain written consent.
7. The Echocardiographer will scan the patient to insure a readable study.
8. The EKG Technician will prep the patient for a stress test that allows for the Echocardiographer to obtain images.
9. The appropriate stress testing protocol will be selected prior to the start of the test.
10. The Echocardiographer will acquire resting images.
11. Once the patient is prepared, the supervising Physician will be notified and they will be present before and during the test, and during the recovery period.
12. The stress test will be performed in the standard way using the stress test procedure.
13. When the patient has reached predicted maximal heart rate or as close to it as possible, the patient will be removed immediately from the treadmill and the Echocardiographer will obtain post exercise images.
14. When the test has been completed, the Physician will generate a report and the Echocardiographer will send the echocardiogram study via electronic transmission to the Cardiologist who will do the interpretation.

**PROCEDURE:**

1. Arrange patient on their left side and place foam block behind their back for comfort during the study.
2. Tape and acquire 10-15 beats of 2D apical 4 chamber images.
3. Tape and acquire 10-15 beats of 2D apical 2 chamber images.
4. Tape and acquire 10-15 beats of 2D apical long axis images.

5. Tape and acquire 10-15 beats of 2D parasternal short axis images.
6. Tape and acquire 10-15 beats of 2D parasternal long axis images.
7. Record resting electrocardiogram (EKG), and blood pressure.
8. Record sitting EKG, and blood pressure.
9. Record standing EKG, and blood pressure.
10. Patient will stand on the treadmill and be instructed on how to walk and to report any signs or symptoms of chest pain, lightheadedness or shortness of breath.
11. At 1 minute and 30 seconds, a blood pressure will be taken and the patient will be instructed that the speed and elevation of the treadmill will increase.
12. Patient will continue exercising until one of the following occurs:
    a) Patient reaches a target heart rate between 85 and 100% of their predicted maximum (220 minus age).
    b) Patient states that they can no longer continue.
    c) Blood pressure exceeds the safety range of Systolic >220mmHg or Diastolic > 110mmHg.
    d) Patient has chest pain with corresponding EKG changes and the Physician stops the test.
13. Once the treadmill has been stopped, the patient is quickly removed from the treadmill and placed on the bed and repositioned on their left side for image acquisition.
14. Start continuous digital acquisition and attain all 4 previous views within 90 seconds.
15. Monitor patient until heart rate and blood pressure have returned to normal and any symptoms have abated.
16. Select representative images of 1 cardiac cycle for each of the 4 post stress acquisition for paging comparison and record side by side pre and post stress images.
17. Release patient and compose preliminary report for Cardiologist to interrupt.

**EQUIPMENT:**

1. Treadmill
2. 12 lead ECG machine and electrodes
3. Razor
4. BP cuff, Stethoscope and Oximeter
5. Oxygen and cannula or mask
6. Echocardiography machine (and operator)
7. Crash cart

**CONTRAINDICATIONS:**

1. Acute myocardial infarction.
2. Unstable angina.
3. Life-threatening arrhythmia.
4. Congestive heart failure.
5. Significant uncontrolled hypertension.
6. Ventricular aneurysm.
7. Dissecting aortic aneurysm.
8. Pericarditis.
9. Myocarditis.
10. Severe anemia.
11. Unwilling patient or patient unable to give informed consent.

12. Weight limit of 350 pounds (treadmill weight limit).
13. Unable to obtain readable images.

**RECORD RETENTION AND DESTRUCTION:**
Documentation is contained within the medical record, which is managed by the Medical Records Department at Northern Inyo Healthcare District.

**CROSS REFERENCED POLICIES AND PROCEDURES:**
1. Cardiopulmonary Department Cardiac Stress Test

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| Supersedes: v.1 Stress Echo |

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

| | | |
|---|---|---|
| Title: Surgery Tissue / Bone Graft "Look Back" Policy" | | |
| Owner: DON Perioperative Services | Department: Surgery | |
| Scope: Surgery, Laboratory, Infection Prevention | | |
| Date Last Modified: 02/25/2022 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 4/2015 | |

**PURPOSE:**

- To ensure that tissue or bone graft recipients are notified in the event that the hospital is notified that a particular lot of tissue or bone was potentially contaminated with Human Immunodeficiency Virus (HIV), Human T-Lymphotropic Virus I-II (HTLV I-II), Viral hepatitis or other infectious agents known to be transmitted through bone/tissue.
- To ensure that recipients are provided with information regarding testing, treatment and counseling.
- To ensure that recipients are provided with information regarding the potential for transmission of infection to others.

**POLICY:**

If a patient has an infection or other identified health problem that could potentially be related to a bone/tissue implant, the Infection Control Officer/Chief Medical Officer (CMO) will be notified. An Unusual Occurrence Report and Look Back Report will be completed and the appropriate bone/tissue bank will be notified of the nature of the problem, the type of bone/tissue used and the specific identification number associated with the bone/tissue. The Bone/Tissue Bank log will be reviewed for any additional bone/tissue from the same donor and it will be quarantined until appropriate investigative measures have approved its release or return to the appropriate bone/tissue bank.

If an individual has received potentially infectious tissue/bone from a donor who has tested positive for HIV or HCV since the time of donation, Northern Inyo Hospital (NIHD) will initiate the “Look Back” policy, as soon as notified of the fact.

**PROCEDURE:**

Upon notification by fax and/or letter by the Bone/Tissue Bank to the Pathology Director and or Perioperative Manager that a potentially infectious tissue/bone product was issued to the NIHD Tissue/Bone Bank, the Pathology Director and or Perioperative Manager or their designee will immediately determine the disposition of the tissue/bone product.

1. If the product is present in the Surgery Bone/Tissue inventory, the assigned investigator will:
    A. Isolate the product and return it to Bone/Tissue Bank.
    B. Document the return in the Disposition Log.
    C. Complete a Look Back Report and an Unusual Occurrence Report (UOR) and have both documents signed by the Perioperative Manager and or Pathologist.
    D. File one copy of the Look Back report in the Laboratory and give one copy to the CMO.
2. If the product has been implanted, the assigned investigator will:

A. Complete the Look Back Report and Unusual Occurrence Report and will have both documents signed by the Perioperative Manager and/or Pathologist.
B. File one copy of the of the Look Back report in the Perioperative Department, one copy with the Laboratory Manager, and give one copy to the CMO.

3. Upon notification, the Director of Infection Control or CMO will:
    A. Make at least three attempts by a notification letter sent via certified mail to notify the attending physician and request that the physician immediately notify the individual of the need for testing, treatment and/or counseling.
    B. If the physician is unable to notify the client, the Director of Infection Control will make three attempts to notify the client of the need for testing, treatment and/or counseling by letter sent via certified mail.
    C. Notification attempts will be documented on the Look Back report that was filed in the Laboratory.
    D. If the hospital is notified that a state court has declared the recipient legally incompetent, notice must be given to the legal representative of the client.

4. The timeframe for notification is as follows:
    A. HIV Look Back – complete within eight weeks
    B. HCV Look Back - complete within twelve weeks

**REFERENCES:**

- TJC (TS.03.03.01)
- CAH Functional Chapter: Tissue

**RECORD RETENTION AND DESTRUCTION:**

Look Back Reports will be retained for at least ten years from the date of notification and will be accessible for retrieval within five working days.

The Look Back Report form is kept in the back of the Tissue / Bone Bank binder in Surgery.

**CROSS REFERENCED POLICIES AND PROCEDURES:**

- Medical Device Tracking
- Medical Device Implantation
- Bone Graft Tissue Bank

| Supersedes: v.2 Surgery Tissue / Bone Graft "Look Back" Policy* |
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**NORTHERN INYO HEALTHCARE DISTRICT**

**CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Interdisciplinary Team – Clinical Screens Built into the Initial Nursing Assessment | | |
| Owner: Manager Acute/Subacute ICU | Department: Acute/Subacute Unit | |
| Scope: Registered Nurses in Hospital | | |
| Date Last Modified: 03/01/2022 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 03/16/2016 | |

**PURPOSE:** To identify clinical screens that are part of the Initial Nursing Assessment to trigger referrals to members of the Interdisciplinary Team. The Interdisciplinary Team may include, but is not limited to, Case Manager, Licensed Clinical Social Worker, Physical Therapist, Speech Language Pathologist, Occupational Therapist, Respiratory Therapist or Registered Dietitian.

**POLICY:**

1. As part of the Initial Nursing Assessment, the interdisciplinary team identifies screens that the RN will complete through interview or assessment.
    a. The screens contain risk factor information that triggers a referral to the Interdisciplinary Team member.
    b. More in depth assessment will then be completed by the Interdisciplinary Team based on the risk factors.

2. Referral from screening that meets criteria generates further assessment by specific service line; this service line screen is more in-depth and does not require a medical provider order. Treatment orders do require a medical provider order. Interdisciplinary screens that are contained within the Initial Nursing Assessment include:
    a. Nutritional Screen
    b. Functional Screen (Rehabilitation Services)
    c. Case Management Screen
    d. Respiratory Therapy Screen

**PROCEDURE:**

1. The Interdisciplinary Team develops Initial Nursing Assessment Clinical Screens (interview or physical assessment) that will initiate a referral to that discipline.

2. The referred discipline will then complete a more thorough assessment which may include Medical Staff Practitioner Orders, Plan of Care with goals and/or further referral.

3. The goals from the Health Care Team are incorporated into the Interdisciplinary Plan of Care that are monitored for patient progress.

**REFERENCES:**

1. TJC Comprehensive Accreditation Manual of Hospital Functional Chapter Provision of Care. PC.01.02.03 EP-7, EP-8, Oakbrook Terrance, Illinois.

**RECORD RETENTION AND DESTRUCTION:**

Screens are documented within the patient's medical record, which is managed and maintained by the Northern Inyo Healthcare District Medical Records Department.

**CROSS REFERENLCED POLICIES AND PROCEDURES:**

1. Rehabilitation Services Functional Screen
2. Nutritional Services Screen
3. Case Management Services Screen

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|---|
| Supersedes: v.2 Interdisciplinary Team – Clinical Screens Built into the Initial Nursing Assessment* |

**NORTHERN INYO HEALTHCARE DISTRICT**

**PLAN**

| | | |
|---|---|---|
| Title: Emergency Management Plan | | |
| Owner: Manager of ED and Disaster Planning | Department: Emergency Department | |
| Scope: District Wide | | |
| Date Last Modified: 03/15/2022 | Last Review Date: No Review Date | Version: 5 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 08/01/2008 | |

## POLICY:

Northern Inyo Healthcare District Emergency Operations Plan (EOP) follows the Hospital Incident Command System (HICS) format. Northern Inyo Healthcare District (NIHD) will manage all emergency incidents, exercises and preplanned (reoccurring/special) events in accordance with the incident command system (ICS) design of the HICS. HICS provides for an "All Hazards" approach to manage emergencies. HICS has a defined organization and job action sheets to accommodate as many positions as needed, depending on the disaster. NIHD has identified nine leadership positions that may be activated when activate HICS plan. These include Incident Commander, Liaison, Safety Officer, Public Information officer (PIO), Medical Tech/Specialist, Operations Section Chief, Planning, Logistics and Finance Administrator. These positions will be filled with most appropriate staff member on duty when Hospital Incident Command System (HICS) is activated. These people will be relieved when senior healthcare district staff becomes available.

HICS materials including job action sheets, vests (found only on Disaster Cart), and organization chart and documentation forms are located in the Disaster Manual and Disaster Cart and brought to the Incident Command Center (ICC) upon activation of Code Triage.

An emergency incident is defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization's buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods, explosions; or, the impact on patient care and treatment activities due to such things as the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization's ability to provide care.

This Emergency Operations Plan (EOP) is designed to outline the basic infrastructure and operating procedures utilized to mitigate, prepare for, respond to, and recover from emergency situations that tax the routine operating capabilities of the healthcare district. NIHD has adopted the National Incident Management System (NIMS) at an organization level. NIMS uses a system approach to integrate the best of existing processes and methods for a unified national framework for incident management. NIHD has incorporated the 17 elements of NIMS compliance into this Emergency Operations Plan.

NIHD has established mutual-aid agreements with Mammoth Hospital, Southern Inyo Healthcare District and Toiyabe Indian Health Clinic. NIHD works in conjunction with hazardous materials response teams, local fire department, local law enforcement, area pharmacies and/or medical supply vendors. Established

Memorandums of Understanding (MOU) and/or Agreement (MOA) will be shared with local emergency management prior to an incident occurring.

NIHD will participate in local, regional, and or state multidiscipline and multi-agency drills twice per year. Exercise activities will address internal and external communications, receiving, triage, treatment, and transfer of mass casualties, progression of causalities through the healthcare district system, resource management, security procedures, specialty lab testing, and or site/facility safety. Exercise will be conducted through drills, tabletop, functional, and or full scale exercises.

**SCOPE:**

The Emergency Operations Plan is designed to assure appropriate, effective response to a variety of emergency situations that could affect the safety of patients, staff, and visitors, or the environment of NIHD, or adversely impact upon the healthcare district's ability to provide healthcare services to the community based upon the Hazard Vulnerability Analysis. The Program is also designed to assure compliance with applicable codes and regulations.

This plan covers all healthcare district facilities (Main and All outbuildings and clinics) and its implementation is the responsibility of all personnel.

**GOALS:**

1. Adhere to the NIHD's mission statement.
2. Prevent or lessen the impact that an emergency may have on the institution and the community (mitigation).
3. Identify resources essential to emergency response and recovery and facilitate their access and utilization (preparedness).
4. Prepare staff to respond effectively to emergency situations that affect the environment of care response and test response mechanisms.
5. Plan processes for reestablishing operations after the incident (recovery).

**OBJECTIVES:**

**EM 01.01.01**

The critical access hospital engages in planning activities prior to developing its written Emergency Operations Plan. Note: An emergency is an unexpected or sudden event that significantly disrupts the organization's ability to provide care, or the environment of care itself, or that results in a sudden, significantly changed or increased demand for the organization's services. Emergencies can be either human-made or natural (such as an electrical system failure or a tornado), or a combination of both, and they exist on a continuum of severity. A disaster is a type of emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions

**EM 02.01.01**

The critical access hospital has an Emergency Operations Plan. This "all hazards" approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the plan's response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.

**EM. 02.02.01**

As part of its Emergency Operations Plan, the hospital has a plan for how it will communicate during emergencies

**EM. 02.02.03**

As part of its Emergency Operations Plan, the healthcare district prepares for how it will manage resources and assets during emergencies.

**EM. 02.02.05**

As part of its Emergency Operations Plan, the critical access hospital prepares for how it will manage security and safety of staff, patients, visitors, volunteers and other individuals during an emergency.

**EM. 02.02.07**

As part of its Emergency Operations Plan, the critical access hospital prepares for how it will manage staff during an emergency

**EM.02.02.09**

As part of its Emergency Operations Plan, the critical access hospital prepares for how it will manage utilities during an emergency.

**EM.02.02.11**

As part of its Emergency Operations Plan, the critical access hospital prepares for how it will manage patients during emergencies.

**EM.02.02.13**

During disasters, the critical access hospital may grant disaster privileges to volunteer licensed independent practitioners. Note: A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

**EM.02.02.15**

During disasters, the critical access hospital may assign disaster responsibilities to volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification, or registration. Note: While this standard allows for a method to streamline the process for verifying identification and licensure, certification, or registration, the elements of performance are intended to safeguard against inadequate care during a disaster.

**EM.03.01.01**

The critical access hospital evaluates the effectiveness of its emergency management planning activities.

**EM.03.01.03**

The critical access hospital evaluates the effectiveness of its Emergency Operations Plan.

**EM.04.01.01**

If the critical access hospital is part of a health care system that has an integrated emergency preparedness program, and it chooses to participate in the integrated emergency preparedness program, the critical access hospital participates in planning, preparedness, and response activities with the system.

## ORGANIZATION AND RESPONSIBILITY

Medical Staff: The Emergency Department Physician on duty at the time of the emergency will be responsible for providing medical services for the "Immediate Care" area. Additional physicians may be called in depending on the number of casualties and the nature of their injuries. If "Delayed Care" and/or "Minor Care" areas are established, a physician will be asked to coordinate medical efforts for these functions. The Medical Staff reviews the EOP Plan at the Medical Executive Committee (MEC).

Senior Leadership receives regular reports of the current status of the Emergency Management Program through the Disaster Management Committee and reviews the reports and, as necessary, communicates concerns about key issues and regulatory compliance to the Disaster Management Committee. The committee makes recommendations to Senior Leadership for purchase of supplies and equipment necessary for the improvement of the emergency response capability.

The Manager of Emergency Department and Disaster Planning (MEDDP) works under the general direction of the Chief Nursing Officer (CNO), the Chief Medical Officer (CMO) and the Chief Executive Officer. The MEDDP, in collaboration with the Disaster Management Committee is responsible for managing all aspects of the Emergency Management Program. The Disaster Management Committee advises Senior Leadership regarding emergency management issues which may necessitate changes in policies and procedures, orientation or education of personnel and/or purchase of equipment.

Individual personnel are responsible for learning and following job and task specific procedures for emergency response and for participation in emergency activities as appropriate to their jobs.

All Healthcare district personnel are considered essential to the operation of the healthcare district. HICS allows for easy expansion of the basic incident command structure to include additional personnel assignments designed to accommodate the needs of specific disaster situations. Designated staff have been assigned to fill HICS positions and trained to assume these rolls. In some emergencies, the Healthcare district may establish a personnel pool to supplement or staff essential response or operating functions. In those situations, employees may be assigned responsibilities commensurate with their abilities but outside their normal job responsibilities. Employees who are assigned key roles in the HICS are issued identification vests to clearly identify their role in the response effort.

Department Directors and Managers are responsible to implement their departmental emergency duties and take whatever actions are necessary to maintain needed services including maintaining a current emergency call-back telephone list. Depending on the scope and nature of the emergency some departments may be asked to close and send all available employees to the labor pool to assist with more acute needs. Department Directors and Managers are also responsible for educating their staff regarding emergency

procedures. In addition, they are responsible to be familiar with the specific roles which may be assigned to them or their department should the function(s) be activated by the Incident Commander. Each department must complete and submit a status report to the Incident Command Center (ICC) immediately following Code Triage. General guidance for emergency incidents is provided in the Management of the Environment of Care Manual for the immediate situation, i.e. Civil Disturbance, Bomb Threat, Earthquake Protocol, Utility Failures, etc. The Department Director will notify the Incident Command Center of additional staffing needs and request approval to utilize the call-back list to provide personnel necessary to cover necessary staff positions. Department Directors and Managers are responsible for determining the department level of response needed for the emergency, based upon such information as:

The nature and severity of the emergency;
Direction from the Incident Commander;
Number of victims;
Types of injuries;
Time of day;
Current staffing;
Conditions and availability of the healthcare district, its equipment and materials available.

Volunteers are responsible for knowing the overhead page, CODE TRIAGE, for the activation of the Emergency Preparedness Plan. Those volunteers assigned to specific departments are responsible to return to their assigned department, unless released to the labor pool. All other volunteers are responsible for reporting to the labor pool, if activated.

## HAZARD VULNERABILITY ANALYSIS (HVA)

The Disaster Management Committee, with the assistance of other pertinent personnel will conduct an HVA of the operations and environment of NIHD. The result of the HVA will be reviewed with Healthcare Coalition and a county HVA will also be developed. Both of these processes will be completed annually. Results will be shared with the Disaster Management Committee, Department Heads, and the Board of Directors.

MITIGATION, PLANNING, RESPONSE AND RECOVERY

The job action sheet of HICS includes sections addressing mitigation, planning, response, and recovery.

- **The Mitigation Section** describes equipment and human activity designed to be put in place in advance to minimize the impact of an emergency.
- **The Planning Section** describes the training, supplies, and equipment required to initiate full effective response at the time of an emergency. These planning descriptions include a list of available supplies and equipment and any required maintenance or inspection.
- **The Response Section** describes the command structure required to manage the plan after initiation, during the emergency situation, and sustaining operations during protracted disruptions.
- **The Recovery Section** describes the processes for moving from emergency operations back to normal operations, and the process for assessing and implementing a full recovery of the structure and all internal components and systems.

## COMMUNICATIONS SYSTEMS

Several alternate communication systems are available for use during emergency responses. The systems include the regular phone system, an emergency phone system, satellite telephones, two-way radios, Ham radios, and cellular phones. The implementation of the emergency plan focuses on maintaining vital patient care communications.

NIHD has established common equipment, communications and data interoperability resources with emergency medical services (EMS), public health, and emergency management that will be used during incident response. This element will be part of the annual evaluation of NIMS compliance.

NIHD will establish common language that is consistent with language to be used by local emergency management, law enforcement, emergency medical services, fire department, and public health personnel. Plan language will be used in training and tested during drill exercises.

## COMMUNITY-WIDE RESPONSE INVOLVEMENT

NIHD is part of Section VI (6). The Emergency Response Group works with local, county and state planning agencies to define the role each provider will play during an emergency. The anticipated role of NIHD is to function as an acute medical care facility capable of effectively treating many levels of injury/illness. This role might be reduced if environmental circumstances affect the integrity of the campus or the utility systems essential to providing care.

## COMMAND STRUCTURE

NIHD has chosen to use the ICS (Incident Command System) model to manage the implementation of emergency responses and to integrate the facility response with the community and other health care providers. The ICS model plan is developed to manage emergency responses that have unpredictable elements. These are determined as part of the HVA and priority analysis. Plans that stand alone are designed to allow immediately available staff to effect instant activation and to manage the consequences. Most others are designed to use the ICS for emergency management.

## COMMUNITY PLANNING

NIHD participates in the Inyo County Emergency Planning through the Unified Command and the Healthcare Coalition. The groups are made up of representatives of community emergency response agencies, health care organizations, and other organizations interested in developing coordinated regional emergency response plans. The discussions of the group are used to guide the development of the NIHD Emergency Operations Plan and planning.

## INITIATION OF EMERGENCY

The Administrator or Administrator on Call, and the Nursing Supervisor on Duty, have authority to activate the Incident Command Center (ICC) and initiate CODE TRIAGE, or other portions of the emergency plan whenever a defined emergency exists. The person activating the emergency plan and/or the EOC, serves as the Incident Commander until relieved by a senior Administrator, or relinquishes

responsibility to another individual for breaks or rest periods. It is always better to activate the EOC, and close it soon thereafter, then to delay activation and try to catch up with rapidly moving events. Each Emergency Operations Plan (HICS) clearly states the process for implementation of the plan. The description includes the command structure for the plan, the conditions, or criteria requiring activation of the plan, and the individual(s) responsible for implementation of the plan. The simplest implementation procedure is immediate activation of the response using an equipment-activated alarm for the fire plan. More complex response procedures involving setting up a command center and ICS response team are required for most emergencies, including major utility failures and community-based emergencies.

The healthcare district may receive three principle notifications: Advisory, Alert and or Activation.

- **An Advisory** is given when no system response is needed but the potential for a response exists.
- **An Alert** is given when a response is likely or imminent and should prompt an elevated level of response preparedness.
- **An Activation** is given when a response is required.

The local Public Health Department or emergency management office will usually receive these notifications.

Important information to obtain as soon as possible should include but not be limited to:

- Type of incident, including specific hazard/agent, if known
- Location of incident
- Number and types of injuries
- Special actions being taken (e.g., decontamination, transporting persons)
- Estimated time of arrival of first-arriving Emergency Medical Service units.

NIHD and local law enforcement will maintain access, crowd and traffic control. Volunteers from the labor pool would be used to expand the security force if needed.

## NOTIFICATION OF CIVIL AUTHORITY

Whenever a situation adversely affects the Healthcare district's ability to provide services to the community, the Healthcare District notifies appropriate authorities and city-county agencies and coordinates mutual aid and other response activities through the county Emergency Operations Center (EOC), if appropriate, or directly with receiving hospitals.

Several local agencies may play a role in managing an emergency. NIHD maintains a current list of these agencies and key contacts for various kinds of emergency situations. Contacts on the list include police, fire, Emergency Medical Services, local emergency management offices, and the Red Cross. The Incident Commander, or designee, notifies agencies as appropriate as soon as possible after an emergency response is initiated.

California Department of Health Services requires that all emergency/disaster related occurrences, which threaten the welfare, safety, or health of patients, must be reported to the Department of Health Services, Licensing and Certification Program.

## STAFF NOTIFICATION

Staff is notified of EOP plan implementation in several ways: overhead page, landline telephone, cellular phones, pagers, or runners in the healthcare district. Telephone trees, electronic computer notification, cellular phones, social media, pagers and other means of communication are used to notify staff that are away from the healthcare district.

## STAFF IDENTIFICATION

NIHD uses the regular staff identification badge to identify caregivers and other employees during mass casualty or major environmental disasters. Everyone coming into the facility needs to have a visible NIHD ID in order to enter. Staff without ID's must go through Labor pool, be positively identified, and receive a temporary badge or other approved alternate.

Key members of the Incident Command team are issued a vest with the ICS Command Title visible to identify their role in the response. These vests move with the job title and as more senior staff become available, and during longer incidents, jobs are handed from staff to staff. The Liaison Officer from the Incident Command team is assigned to work with law enforcement, fire services, emergency management agencies, contractors, the media, and volunteer responders to issue NIHD emergency identification or to determine what form of identification to each responding group will display.

## STAFF COVERAGE OF CRITICAL POSITIONS

The Emergency Operations Plan includes processes for the Incident Commander and Departments heads to communicate to determine staffing needs and to assign available staff to critical responder positions. Some response procedures assign departments or individuals specific roles automatically to assure timely and effective implementation. HICS includes organizational charts and processes to assure staff coverage.

## MANAGEMENT OF PATIENT CARE ACTIVITY

There is an Emergency Operations Plan that addresses management of patient care activities. The plans include procedures for discontinuation of elective treatment, for evaluation of patients for movement to other units, release to home or transfer to other facilities as space is needed, management of information about incoming patients and about current patients for planning, patient management, and informing relatives and other; and for transport of patients.

Victims will be admitted through the Emergency Department for initial triage and disposition to appropriate area as their condition warrants. Outpatient and elective procedures may need to be canceled and rescheduled, depending on resource allocation and facility status (i.e. condition of department, availability of staff & supplies) as a result of the emergency. Inpatients will be assessed on admission and placed in the following categories for discharge or transfer:

1. **very high-risk** – could only be cared for in an acute facility
2. **high risk** – could be transferred to an acute care facility
3. **moderate risk** – would be transferred to another facility
4. **low risk** – could be transferred home
5. **minimum risk** – could be discharged immediately

**DISASTER CREDENTIALING (See Healthcare District Policy)**

**EMERGENCY LOCATIONS FOR PATIENT CARE**

All patients will enter through Emergency Department, after triage outside, as appropriate. Patient Treatment Areas will be assigned as follows unless otherwise stated at the time of the Code.

- **Triage Area -** Emergency Parking Lot beside Emergency Department
- **Immediate Care Area -** Emergency Department
- **Delayed Care Area** – Rural Health Clinic
- **Minor Care Area** – Pioneer Medical Building
- **MORGUE** – To be determined at the time of emergency

**EMERGENCY LOCATIONS FOR NON-PATIENT CARE**

Pre-assigned locations of various functions (if activated) are as follows unless otherwise stated at the time of the Code Triage:

- **Healthcare District Command Center** – 2nd floor Conference Room
- **Labor Pool** – Main Lobby
- **Family Center/Human Services Center** – Rehabilitation Building
- **Press Center** – Administration Meeting Room
- **Dependent Adult/Child Care Center** – Rehabilitation Building

Procedures also address the transportation and housing of staff that may not be able to get to or from the facility during an emergency or who may need housing and other services for their families to be available for service. A procedure is in place for incident stress debriefing. Staff who are involved in emergency operations are offered an opportunity to address incident related issues with qualified behavioral health professionals, social services or chaplain.

Arrangements are made with vendors and other services to assure availability of supplies, materials, food and water in a timely fashion.

Release of information to the news media follows the procedures developed by the Public Information Officer (PIO)[4] who would act as spokes persons for the organization. The PIO, along with information Technology can give updates through social media. The Incident Commander will release information as appropriate to the situation. In larger incidents, the local Emergency Operations Center of Inyo County may act as spokesperson for the overall emergency and healthcare district information.

**STAFF AND FAMILY SUPPORT**

Because all Healthcare district personnel are considered essential during emergency response situations, the Healthcare district recognizes its responsibility to provide meals, rest periods, psychological, and other personnel support. In addition, the Healthcare district recognizes that providing support, such as communication services and dependent care, to employees' families during emergency situations allows employees to respond in support of the essential functions of the Healthcare district. The Operations Chief, working through the Human Service Director and his/her unit leaders will initiate support programs and activities, based on the demands of the specific emergency including but not limited to:

- Emergency child care
- Emergency transportation
- Staff/family lodging and meals
- Psychological and bereavement counseling
- Staff/family prophylaxis or immunization
- Animal and pet care

## ETHICAL OPERATING PROCEDURES

In emergency situations, certain standing policies and procedures of the Healthcare district and rules and regulations of the Medical Staff may be waived by the Incident Commander, the Medical Care Director or the other first-tier incident command center staff to ensure that essential patient care can be rendered and that the facility can be secured.

## EVACUATION

A facility evacuation plan is in place and can be implemented in phases. Relocation of staff away from the area of emergency may be undertaken by staff on the spot, moving to areas in adjacent zones. A full evacuation would be implemented if the impact of an emergency renders the healthcare district inoperable or unsafe for occupancy, and would be implemented with the involvement of the CEO or senior leadership available.

## SURGE AND ALTERNATE CARE SITES

Surge tent may be utilized for alternate care site. Other care sites may include Jill Kinmont Boothe School; City Hall, Pine Street School Gym; and the Fairgrounds.

The Incident Command Center works with Operations, Planning and Logistics Chiefs to coordinate appropriate staff to assure required equipment, medication, medical records, staffing communications and transportation are mobilized to support relocation and management of patients at remote sites.

## RECOVERY PLANS

NIHD has recovery plans to return operations to normal functions after most emergencies. The recovery plans are activated near the completion of the Emergency Operations Plan (HICS). The Incident Commander will determine the degree of activity required. Preset activity that is activated by the "all clear" includes action by medical records to capture the records of emergency services, capture of costs by patient billing, and return of facilities to their original and normal use. The plans also call for resetting and recovering emergency equipment and supplies, and documentation of the findings of the after the event debriefing. If substantial damage has been done to the facility, plans for reconstruction and renovation will be developed at that point. Documentation of current assets (buildings, equipment, etc.) has been recorded for baseline

Documentation for FEMA assistance will be based on pictures of damages and repairs, documentation and notes on damages and repairs, newspaper reports and stories, video footage from television stations, and records of all expenditures, receipts, and invoices. Short- term recovery frequently overlaps with response.

## ALTERNATE SOURCES OF UTILITY SYSTEMS

Alternate plans for supply of utilities for patient care are maintained for these contingencies. Plans include use of the emergency power, backup systems for water, fuel for heating and power, HVAC, and ventilation systems with alternate power sources. Managers and staff in all departments affected by the plans are trained as part of organization wide and department specific education. The plans are tested from time to time as part of the regularly scheduled drills of the Emergency Operations Plan (HICS), and actual outages of utility systems.

## CHEMICAL AND RADIOACTIVE ISOLATION AND DECONTAMINATION

The management of situations involving nuclear, biological, or chemical contamination is a joint effort between national, state, and local officials and the health care community. NIHD is prepared to manage a limited number of individuals contaminated with hazardous materials and to meet the care needs of others who have been decontaminated by other agencies.

If the facility is contaminated, a contractor experienced in the isolation and decontamination process will be contacted by the Incident Command staff. The Safety Officer, with Public Safety assistance, will assure isolation of the affected area until it is declared safe by appropriate experts.

## EDUCATION AND TRAINING

Each new staff member of NIHD participates in a general orientation that includes information related to the Emergency Operations Plan. Examples of such information include: The Emergency Operations Plan (HICS)s, job-specific roles, emergency communication plans, location of emergency supplies and equipment, and disaster management procedures.

The Human Resources Department conducts the general orientation program. The general orientation program is scheduled by the Human Resources Department, and records attendance for staff members who complete the general orientation program. They also track and reschedule staff members who did not to attend the general orientation program.

New staff members also receive a department-specific orientation. Each department manager provides new staff members with a department-specific orientation to their role in the Emergency Management Program. Information specific to the Emergency Management Program is included in the continuing education Program. The Safety Officer collaborates with individual department heads to develop content and supporting materials for general and department-specific orientation and continuing education programs.

Independent Study (IS) IS-100, IS-200, IS-700 and IS-800 is available to all healthcare district personnel likely to have a leadership role in emergency preparedness, incident management, and or emergency response during an incident; all directors and nursing supervisors.

## PERFORMANCE OF DRILLS/EXERCISES

**NIHD is a healthcare district that offers emergency services and has a defined role in community-wide emergency management therefore the emergency management plan is tested twice a year, in response to and actual or in a planned exercise. One exercise a year includes a communitywide exercise and an influx of actual or simulated patients.**

During planned exercises, an individual(s) is designated whose sole responsibility is to monitor performance and who is knowledgeable in the goals and expectations of the exercise, documents opportunities for improvement. The following core performance areas are monitored during planned exercises: event notification including processes related to notification of external authorities, communication including the effectiveness of communication both within the healthcare district as well as with response entities outside of the healthcare district such as local governmental leadership, police, fire, public health, and other healthcare organizations within the community, resource mobilization and allocation including responders, equipment, supplies, personal protective equipment, transportation, and security, patient management including provision of both clinical and support care activities, processes related to triage activities, patient identification and tracking processes.

All exercises are critiqued by a multi-disciplinary process that includes administration, clinical (including physicians), and support staff to identify deficiencies and opportunities for improvement based upon all monitoring activities and observations during the exercise.

After a drill or exercise, a corrective action report will be created. In the corrective after action report, the following points will be addressed for each identified issue:

- The identified action to correct the issue or deficiency
- The responsible person or group of people to implement the action,
- The due date for completion of the action, and
- The resulting corrective action will be incorporated into plans and procedures once completed.

The EOP is modified in response to critiques of exercises. Future planned exercises evaluate the effectiveness of improvements that were made in response to critiques of the previous exercise. Note: When improvements require substantive resources that cannot be accomplished by the next planned exercise, interim improvements are put in place until final resolution. The strengths and weaknesses identified during exercises are communicated to the multidisciplinary improvement team responsible for monitoring environment of care issues.

The MEDDP maintains performance indicators to objectively measure the effectiveness of the Emergency Management Program. The MEDDP determines appropriate data sources, data collection methods, data collection intervals, analysis techniques and report formats for the performance improvement standards. Personnel, equipment, and management performance are evaluated to identify opportunities to improve the Emergency Management Program. The performance measurement process is one part of the evaluation of the effectiveness of the Emergency Management Program. A performance indicator is established to measure at least one important aspect of the Emergency Management Program. The current performance indicators for the Emergency Management Program are:

1. # Drills
2. # actual implementation of HICS
3. # pts treated in ED requiring decontamination
4. # incidents of mass causality

In addition, all the objectives listed at the beginning of this plan are evaluated for effectiveness during the annual evaluation.

## ANNUAL EVALUATION

The MEDEP is responsible for coordinating the annual evaluation of the seven functions associated with Management of the EC. The MEDEP is responsible for performing the annual evaluation of the Emergency Management Program.

The annual evaluation examines the objectives, scope, performance, and effectiveness of the Emergency Management Program and the Hazardous Vulnerability Analysis. The annual evaluation uses a variety of information sources including the reports from internal policy and procedure review, after action reports, and summaries of other activities. In addition, findings by outside agencies, such as accrediting or licensing bodies or qualified consultants, are used. The findings of the annual evaluation lead to changes/improvements in the Emergency Management Plan.

The annual evaluation is presented to the Disaster Committee and Executive Committee as needed. The Emergency Management Plan is required reading for NIHD workforce.

## REQUEST FOR 1135 WAIVER

The 1135 waiver allows reimbursement during an emergency or disaster even if providers can't comply with certain requirements that would under normal circumstances bar Medicare, Medicaid or Children's Health insurance program (CHIP). The waiver applies to federal requirements only and nor state licensures.

Waiver requests can be made by sending an email to the CMS Regional Office in California. Information of the facility and justification for requesting the waiver is required. (See attachment for 1135 Waiver Request).

https://www.cms.gov/Medicare/Provider-EnrollmentCertification/SurveyCertEmergPrep/Downloads/CMS-Presentation-1135-Waivers.pdf

## DEFINITIONS

a. **Hospital Incident Command System (HICS)** – The "All Hazards" plan used to manage emergencies. This describes a management method that may be adapted to most emergency situations, both internal and external.

b. **Incident Planning Guides (IPGs)**: Plans that describe the specifics of how the organization plans to respond to specific emergency situations as identified by HVA and other analysis.

c. **Emergency Operations Plan (EOP)** – The Program to identify, plan for, prepare for, drill, recover from, and evaluate the response to the drills and actual emergencies, and to identify processes and elements that may be improved with better planning, equipment, or training.

d. **Emergency -** Emergencies are defined as natural or manmade events which cause major disruption in the environment of care such as damage to the organization's buildings and grounds due to severe wind storms, tornadoes, hurricanes, earthquakes, fires, floods,

explosions; or, the impact on patient care and treatment activities due to such things as the loss of utilities (power, water, and telephones), riots, accidents or emergencies within the organization or in the surrounding community that disrupt the organization's ability to provide care.

e. **Hazard Vulnerability Analysis (HVA):** a structured process to evaluate the potential for conditions or events that are likely to have a significant adverse impact on the health and safety of the patients, staff, and visitors of NIH or on the ability of NIH to conduct normal patient care and business activities.

**REFERENCES:**


1. National Incident Management System (NIMS) https://training.fema.gov/nims/docs/nims.2017.instructor%20student%20learning%20materials.pdf
2. Federal Emergency Management Agency (FEMA), ICS-100: Introduction to Incident Command System, (2018)

   https://training.fema.gov/emiweb/is/is100c/instructor%20guide/is0100c_ig.pdf
3. Joint Commission Resources, 3rd ed., (2016) Emergency Management in Healthcare: An All Hazards Approach.
4. Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH), (2019) Emergency Management (EM), EM 0.01.01 - EM 04.01.01.
5. Centers for Medicare and Medicaid Services (2009). 1135 Waivers and the Emergency

   Preparedness Rule


**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Evacuation Policy
2. HICS Organization Chart
3. Emergency: Internal/ External Disaster Plan
4. Credentialing Health Care Practitioners in the Event of a Disaster
5. Disaster Plan Perioperative Unit
6. Sterile Processing Disaster Plan
7. Emergency Room Overcrowding
8. Triage of Patients Suspected of Ebola*
9. Emergency Management Plan
10. InQuiseek – Severe Weather and External Disaster Policy
11. InQuiseek – Communication During Internal or External Situations

**RECORD RETENTION AND DESTRUCTION:** Emergency Operation Plan documents need to be retained for 15 years.

| Supersedes: v.4 Emergency Management Plan |
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RESOLUTION NO. 22-06

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTHERN INYO HEALTHCARE DISTRICT MAKING THE LEGALLY REQUIRED FINDINGS TO CONTINUE TO AUTHORIZE THE CONDUCT OF REMOTE "TELEPHONIC" MEETINGS DURING THE STATE OF EMERGENCY

WHEREAS, on March 4, 2020, pursuant to California Gov. Code Section 8625, the Governor declared a state of emergency stemming from the COVID-19 pandemic ("Emergency"); and

WHEREAS, on September 17, 2021, Governor Newsom signed AB 361, which bill went into immediate effect as urgency legislation; and

WHEREAS, AB 361 added subsection (e) to Government Code Section 54953 to authorize legislative bodies to conduct remote meetings provided the legislative body makes specified findings; and

WHEREAS, as of September 19, 2021, the COVID-19 pandemic has killed more than 67,612 Californians; and

WHEREAS, social distancing measures decrease the chance of spread of COVID-19; and

WHEREAS, this legislative body previously adopted a resolution to authorize this legislative body to conduct remote "telephonic" meetings; and

WHEREAS, Government Code 54953(e)(3) authorizes this legislative body to continue to conduct remote "telephonic" meetings provided that it has timely made the findings specified therein.

NOW, THEREFORE, IT IS RESOLVED by the Board of Directors of Northern Inyo Healthcare District as follows:

1. This legislative body declares that it has reconsidered the circumstances of the state of emergency declared by the Governor and at least one of the following is true: (a) the state of emergency, continues to directly impact the ability of the members of this legislative body to meet safely in person; and/or (2) state or local officials continue to impose or recommend measures to promote social distancing.

PASSED, APPROVED AND ADOPTED this 20th day of April, 2022 by the following roll call vote:

AYES:
NOES:
ABSENT:

_____
Jody Veenker, Chair
Board of Directors

ATTEST:

_____
Name: Erika Hernandez
Title: Board Clerk

| | |
|---|---|
| CALL TO ORDER | The meeting was called to order at 5:31 pm by Jody Veenker, District Board Chair. |
| PRESENT | Jody Veenker, Chair<br>Mary Mae Kilpatrick, Vice Chair<br>Topah Spoonhunter, Secretary<br>Jean Turner, Treasurer<br>Robert Sharp, Member-at-Large (via Zoom)<br>Kelli Davis MBA, Chief Executive Officer and Chief Operating Officer<br>Vinay Behl, Interim Chief Financial Officer<br>Joy Engblade MD, Chief Medical Officer<br>Allison Partridge RN, MSN, Chief Nursing Officer (via Zoom)<br>Keith Collins, General Legal Counsel (Jones & Mayer)<br>Sierra Bourne MD, Chief of Staff |
| OPPORTUNITY FOR PUBLIC COMMENT | Ms. Veenker announced that 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 being allowed 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. No public comments were heard. |
| NEW BUSINESS | |
| NORTHERN INYO HEALTHCARE DISTRICT BOARD GOVERNANCE COMMITTEE UPDATE AND REQUEST FOR NEW BOARD MEMBER ONBOARDING AD HOC COMMITTEE DEVELOPMENT | Chief Executive Officer, Kelli Davis, provided an update on the recent Board of Directors Governance Committee meetings with Director Veenker and Director Turner. Ms. Davis called attention to the need to appoint two members of the District Board to serve as members of the Board Member Onboarding Ad Hoc Committee Development. It was moved by Mary Mae Kilpatrick, seconded by Topah Spoonhunter, and unanimously passed to appoint Jean Turner and Robert Sharp to serve as members of the NIHD Board Member Onboarding Ad Hoc Committee Development as requested. |
| NORTHERN INYO HEALTHCARE DISTRICT 2022 COMMUNITY HEALTH NEEDS ASSESMENT (CHNA) | Ms. Davis called attention to the need to appoint two members of the District Board to serve as members of the Ad Hoc Committee Community Health Needs Assessment (CHNA) Planning Taskforce. It was moved by Ms. Turner, seconded by Mr. Sharp, and unanimously passed to appoint |

REQUEST FOR BOARD MEMBER APPOINTMENT OF AD HOC CHNA PLANNING TASKFORCE

Mr. Spoonhunter and Ms. Kilpatrick to serve as members of the Ad Hoc Committee Community Health Needs Assessment (CHNA) Planning Taskforce as requested.

NORTHERN INYO HEALTHCARE DISTRICT REQUEST TO APPOINT A BOARD MEMBER TO THE FINANCE COMMITTEE

Ms. Davis additionally called attention to the need to appoint a member of the District Board to serve as members of the Northern Inyo Healthcare District (NIHD) Finance Committee. It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to appoint Mr. Sharp to serve as a member of the Northern Inyo Healthcare District (NIHD) Finance Committee as requested.

NORTHERN INYO HEALTHCARE DISTRICT RECERTIFICATION WITH ASSOCIATION OF CALIFORNIA HEALTHCARE DISTRICTS

Ms. Veenker explained that in July 2018, Northern Inyo Healthcare District received an initial certification with Association of California Healthcare Districts (ACHD). District hospitals are required to seek re-certification every 3 years. The re-certification process was initiated during the summer of 2021 by Erika Hernandez, Administrative Assistant – Board Clerk. The District has officially received re-certification with ACHD and the next re-certification is December 2024.

RECOMMENDATION TO PURCHASE THE ABBOTT CHEMISTRY ANALYZER

Interim Chief Financial Officer, Vinay Behl called attention to a proposed recommendation to purchase the Abbot Chemistry Analyzer and clarified questions for the Board. It was moved by Ms. Turner, seconded by Ms. Kilpatrick, and unanimously passed to approve the purchase of the Abbot Chemistry Analyzer as requested.

CHIEF OF STAFF REPORT

ANNUAL REVIEW OF CRITICAL INDICATORS

Chief of Staff Sierra Bourne, MD, reported following review and consideration the Medical Executive Committee recommends approval of the following Annual Review of Critical Indicators:

1. Radiology 2022

It was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve the one (1) Annual Review of Critical Indicator as requested.

MEDICAL EXECUTIVE COMMITTEE REPORT

Doctor Bourne provided a report on the Medical Executive Committee meeting and clarified questions.

_____.

CONSENT AGENDA

Ms. Veenker called attention to the Consent Agenda for this meeting which contained the following items:

1. *Approval of District Board Resolution 22-04, to continue to allow Board meetings to be held virtually.*
2. *Approval of minutes of the February 16, 2022 Regular Board Meeting*

3. *Approval of minutes of the February 28, 2022 Special Board Meeting*
4. *Operating Room Flooring Replacement Update*
5. *Eastern Sierra Emergency Physician Quarterly Report*
6. *Compliance Annual Board Report 2021*
7. *Chief Executive Officer Report*
8. *Chief Medical Officer Report*
9. *Chief Nursing Officer Report*
10. *Financials and Statistical reports as of January 31, 2022*
11. *Approval of Policies and Procedures*
    - A. *Patient Visitation Rights*
    - B. *District Issued Cell Phones/ Electronic Communication Device Use by Employees*
    - C. *Consent for Medical Treatment*
    - D. *Compliant or Grievance Process for Reporting, Tracking, Investigating and Resolution*
    - E. *Regulatory Survey Security*
    - F. *District Furnished Uniforms*
    - G. *Disclosures of Protected Health Information Over the Telephone*
    - H. *Appointment to the NIHD Board of Directors*
    - I. *Election Procedures and Related Conduct*
    - J. *Northern Inyo Healthcare District Board of Directors Conflict of Interest*
    - K. *Suggested Guidance to Fill a Board Vacancy by Appointment*
    - L. *Work Flow for Appointments to Fill Board Vacancy*

It was moved by Ms. Turner, seconded by Mr. Sharp, and passed with 4 in favor 1 abstention vote to approve all eleven (11) Consent Agenda items as presented. Mr. Spoonhunter abstained from the February 16, 2022, Regular Board Meeting Minutes due to the fact that he was absent from that meeting.

BOARD MEMBER REPORTS ON ITEMS OF INTEREST

Ms. Veenker additionally asked if any members of the Board of Directors wished to report on any items of interest. No reports were provided.

PUBLIC COMMENTS ON CLOSED SESSION ITEMS

Ms. Veenker announced that at this time, persons in the audience may speak only on items listed on the Closed Session portion of this meeting. No public comments were heard.

ADJOURNMENT TO CLOSED SESSION

At 6:23 pm Ms. Veenker announced the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. Report involving Report involving trade secret – Health & Safety Code Section 1462 Discussion will concern proposed new service, program, or facility.
B. Conference with legal counsel, anticipated litigation. Significant exposure to litigation (pursuant to paragraph (2) of

subdivision (d) of Government Code Section 54956.9 (thirteen 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 (pursuant to Government Code Section 54957 (b)) title: Chief Executive Officer.

Ms. Veenker additionally noted that it was not anticipated that an action would be reported out following the conclusion of Closed Session.

RETURN TO OPEN SESSION AND REPORT OF ANY ACTION TAKEN

At 8:02 pm, the meeting returned to Open Session. Ms. Veenker reported that the Board took no reportable action.

OPPORTUNITY FOR PUBLIC COMMENT

Ms. Veenker announced that at this time, persons in the audience may speak only on the item listed on the open session portion of this meeting. No public comments were heard.

APPROVAL OF THE STRYKER ORTHOPEDIC SURGERY EQUIPEMENT PURCHASE AGREEMENT AND RELATED AGREEMENT

Mr. Behl called attention to the proposed Stryker Orthopedic Surgery Equipment Purchase Agreement and related agreement. It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve the Stryker Orthopedic Surgery Equipment Purchase Agreement and related agreement as requested.

ADJOURNMENT

The meeting adjourned at 8:04 pm.

_____
Jody Veenker, Chair

Attest: _____
Topah Spoonhunter, Secretary

FY2022

| *Unit of Measure* | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 |
|---|---|---|---|---|---|---|---|---|
| Cash, CDs & LAIF Investments | 51,541,102 | 51,660,613 | 51,218,981 | 44,626,386 | 48,069,372 | 48,192,815 | 44,293,619 | 42,120,322 |
| Days Cash on Hand | 194 | 192 | 192 | 158 | 176 | 174 | 160 | 136 |
| | | | | | | | | |
| Gross Accounts Receivable | 40,330,632 | 39,434,879 | 38,647,332 | 45,621,898 | 45,730,808 | 48,011,063 | 50,415,516 | 47,012,661 |
| Average Daily Revenue | 497,169 | 478,408 | 485,427 | 486,248 | 490,359 | 491,569 | 485,625 | 481,170 |
| Gross Days in AR | 81.12 | 82.43 | 79.62 | 93.82 | 93.26 | 97.67 | 103.82 | 97.70 |
| | | | | | | | | |
| ***Key Statistics*** | | | | | | | | |
| Acute Census Days | 215 | 170 | 196 | 254 | 306 | 188 | 290 | 232 |
| ICU Census Days | 0 | 7 | 33 | 11 | 7 | 0 | 2 | 0 |
| Swing Bed Census Days | 24 | 0 | 0 | 0 | 0 | 0 | 0 | 12 |
| Total Inpatient Utilization | 239 | 177 | 229 | 265 | 313 | 188 | 292 | 244 |
| Avg. Daily Inpatient Census | 7.7 | 5.7 | 7.6 | 8.8 | 10.4 | 6.1 | 9.4 | 8.7 |
| | | | | | | | | |
| Emergency Room Visits | 783 | 745 | 674 | 766 | 687 | 706 | 721 | 625 |
| Emergency Room Visits Per Day | 25 | 24 | 22 | 25 | 23 | 23 | 23 | 22 |
| Observation Days | 67 | 54 | 56 | 56 | 56 | 67 | 53 | 43 |
| Operating Room Inpatients | 24 | 23 | 14 | 16 | 21 | 17 | 18 | 19 |
| Operating Room Outpatient Cases | 107 | 89 | 89 | 82 | 98 | 126 | 3 | 6 |
| Observation Visits | 64 | 54 | 50 | 51 | 45 | 60 | 51 | 42 |
| RHC Clinic Visits | 2,297 | 2,743 | 2,775 | 3,030 | 2,707 | 2,722 | 3,426 | 2,559 |
| NIA Clinic Visits | 1,679 | 1,614 | 1,699 | 1,726 | 1,744 | 1,557 | 1,518 | 1,396 |
| Outpatient Hospital Visits | 8,690 | 9,250 | 8,980 | 9,162 | 8,728 | 8,630 | 8,526 | 7,994 |
| | | | | | | | | |
| ***Hospital Operations*** | | | | | | | | |
| Inpatient Revenue | 2,774,294 | 2,563,061 | 3,193,923 | 3,361,605 | 3,958,181 | 2,404,683 | 3,708,290 | 2,908,927 |
| Outpatient Revenue | 11,563,898 | 10,530,380 | 10,677,079 | 10,581,296 | 10,120,970 | 11,882,529 | 8,803,380 | 8,539,211 |
| Clinic (RHC) Revenue | 1,074,051 | 1,155,594 | 1,126,962 | 1,206,362 | 1,137,285 | 1,136,568 | 1,448,892 | 1,067,009 |
| Total Revenue | 15,412,242 | 14,249,034 | 14,997,964 | 15,149,263 | 15,216,437 | 15,423,780 | 13,960,561 | 12,515,147 |
| Revenue Per Day | 497,169 | 459,646 | 499,932 | 488,686 | 507,215 | 497,541 | 450,341 | 446,970 |
| % Change (Month to Month) | | -7.55% | 8.76% | -2.25% | 3.79% | -1.91% | -9.49% | -0.75% |
| | | | | | | | | |
| Salaries | 2,138,510 | 2,212,918 | 2,099,073 | 2,131,194 | 2,303,918 | 2,726,796 | 2,346,958 | 2,047,905 |
| PTO Expenses | 68,403 | 67,782 | 201,732 | 161,627 | 383,062 | 434,307 | 360,818 | 194,188 |
| Total Salaries Expense | 2,206,912 | 2,280,700 | 2,300,804 | 2,292,821 | 2,686,980 | 3,161,102 | 2,707,776 | 2,242,093 |
| Expense Per Day | 71,191 | 73,571 | 76,693 | 73,962 | 89,566 | 101,971 | 87,348 | 80,075 |
| % Change | | 3.34% | 4.24% | -3.56% | 21.10% | 13.85% | -14.34% | -8.33% |
| | | | | | | | | |
| Operating Expenses | 6,882,843 | 7,013,237 | 7,294,767 | 7,804,027 | 7,724,749 | 8,310,179 | 8,099,494 | 7,597,308 |
| Operating Expenses Per Day | 222,027 | 226,233 | 243,159 | 251,743 | 257,492 | 268,070 | 261,274 | 271,332 |
| | | | | | | | | |
| Capital Expenses | 36,416 | 3,000 | - | 104,159 | 9,546 | 403,591 | 594,928 | 76,030 |
| Capital Expenses Per Day | 1,175 | 97 | - | 3,360 | 318 | 13,019 | 19,191 | 2,715 |
| | | | | | | | | |
| Total Expenses | 8,511,732 | 8,533,790 | 8,636,587 | 9,124,560 | 9,203,811 | 10,127,813 | 9,618,792 | 8,992,284 |
| Total Expenses Per Day | 274,572 | 275,284 | 287,886 | 294,341 | 306,794 | 326,704 | 310,284 | 321,153 |
| | | | | | | | | |
| Gross Margin | 1,732,096 | (81,114) | 645,366 | (132,062) | (11,789) | (660,853) | (1,047,088) | (1,923,702) |
| | | | | | | | | |
| ***Debt Compliance*** | | | | | | | | |
| Current Ratio (ca/cl) > 1.50 | 2.13 | 2.10 | 2.84 | 2.78 | 2.54 | 2.70 | 2.65 | 2.54 |
| Quick Ratio (Cash + Net AR/cl) > 1.33 | 1.80 | 1.73 | 2.29 | 2.17 | 2.07 | 2.22 | 2.21 | 2.02 |
| Days Cash on Hand > 75 | 194 | 192 | 192 | 158 | 176 | 174 | 160 | 136 |

NIHD - Income Statement

| FY 2022 | FY 2020 | FY 2021 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | YTD 2022 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Total Net Patient Revenue | 76,229,126 | 86,844,620 | 8,614,939 | 6,932,123 | 7,940,133 | 7,671,965 | 7,712,959 | 7,649,326 | 7,052,406 | 5,673,606 | 59,247,456 |
| IGT Revenues | 13,729,686 | 20,295,927 | 394,000 | 1,106,255 | 530,242 | 394,000 | 394,000 | 2,780,184 | 856,511 | 2,676,270 | 9,131,463 |
| Total Patient Revenue | 89,958,812 | 107,140,547 | 9,008,939 | 8,038,378 | 8,470,376 | 8,065,965 | 8,106,959 | 10,429,510 | 7,908,917 | 8,349,876 | 68,378,919 |
| | | | | | | | | | | | |
| Cost of Services | | | | | | | | | | | |
| Salaries & Wages | 26,275,799 | 27,016,877 | 2,138,510 | 2,212,918 | 2,099,073 | 2,131,194 | 2,303,918 | 2,726,796 | 2,346,958 | 2,047,905 | 18,007,270 |
| Benefits | 18,316,171 | 22,382,407 | 1,618,760 | 1,635,349 | 1,795,655 | 1,801,576 | 2,059,894 | 2,085,215 | 2,199,930 | 1,799,225 | 14,995,603 |
| Professional Fees | 19,573,242 | 22,565,034 | 1,871,274 | 1,896,180 | 1,978,664 | 2,293,527 | 1,790,435 | 1,823,508 | 2,317,407 | 2,469,684 | 16,440,681 |
| Pharmacy | 3,105,981 | 4,035,279 | 274,517 | 354,714 | 344,942 | 405,802 | 392,006 | 380,870 | 286,978 | 362,249 | 2,802,077 |
| Medical Supplies | 4,199,962 | 4,136,111 | 277,812 | 255,157 | 358,049 | 369,855 | 451,788 | 497,972 | 184,989 | 159,263 | 2,554,885 |
| Hospice Operations | 505,000 | - | - | - | - | - | - | - | - | - | - |
| EHR System | 1,164,797 | 1,480,088 | 112,267 | 114,869 | 132,491 | 112,342 | 108,392 | 115,958 | 119,346 | 112,757 | 928,421 |
| Other Direct Costs | 4,813,483 | 5,810,258 | 589,703 | 544,051 | 585,893 | 689,732 | 618,316 | 679,861 | 643,886 | 646,224 | 4,997,667 |
| Total Direct Costs | 77,954,434 | 87,426,053 | 6,882,843 | 7,013,237 | 7,294,767 | 7,804,027 | 7,724,749 | 8,310,179 | 8,099,494 | 7,597,308 | 60,726,604 |
| | | | | | | | | | | | |
| Gross Margin | 12,004,378 | 19,714,494 | 2,126,096 | 1,025,140 | 1,175,609 | 261,938 | 382,211 | 2,119,331 | (190,577) | 752,568 | 7,652,315 |
| Gross Margin % | 13.34% | 18.40% | 24.68% | 14.79% | 14.81% | 3.41% | 4.96% | 27.71% | -2.70% | 13.26% | 12.92% |
| | | | | | | | | | | | - |
| General and Administrative Overhead | | | | | | | | | | | - |
| Salaries & Wages | 4,681,985 | 3,906,499 | 319,290 | 323,708 | 319,740 | 305,823 | 355,039 | 412,400 | 361,734 | 334,886 | 2,732,621 |
| Benefits | 4,150,743 | 3,754,395 | 283,420 | 299,665 | 312,500 | 243,511 | 322,152 | 382,695 | 335,529 | 310,036 | 2,489,509 |
| Professional Fees | 2,337,874 | 3,978,605 | 421,033 | 420,876 | 222,237 | 282,805 | 300,113 | 462,506 | 329,198 | 293,995 | 2,732,764 |
| Depreciation and Amortization | 4,275,662 | 4,094,658 | 370,335 | 358,995 | 347,178 | 358,655 | 347,192 | 369,148 | 334,665 | 298,932 | 2,785,100 |
| Other Administrative Costs | 1,412,451 | 1,396,332 | 234,811 | 117,308 | 140,164 | 129,739 | 154,566 | 190,884 | 158,172 | 157,128 | 1,282,772 |
| Total General and Administrative Overhea | 16,858,715 | 17,130,488 | 1,628,889 | 1,520,552 | 1,341,820 | 1,320,533 | 1,479,063 | 1,817,634 | 1,519,298 | 1,394,976 | 12,022,765 |
| | | | | | | | | | | | |
| Net Margin | (4,854,337) | 2,584,007 | 497,207 | (495,412) | (166,211) | (1,058,595) | (1,096,852) | 301,697 | (1,709,875) | (642,408) | (4,370,449) |
| Net Margin % | -6.37% | 2.98% | 5.77% | -7.15% | -2.09% | -13.80% | -14.22% | 3.94% | -24.25% | -11.32% | -7.38% |
| | | | | | | | | | | | |
| Financing Expense | 2,362,880 | 1,413,155 | 179,672 | 179,585 | 176,035 | 143,658 | 136,649 | 101,007 | 227,252 | 472,448 | 1,616,305 |
| Financing Income | 2,372,608 | 1,755,654 | 173,785 | 173,785 | 173,785 | 173,785 | 173,785 | 173,785 | 173,785 | 148,687 | 1,365,180 |
| Investment Income | 600,420 | 387,349 | 23,766 | 16,876 | 20,534 | 20,443 | 16,045 | 27,865 | 6,662 | 4,964 | 137,153 |
| Miscellaneous Income | 1712917.01 | 1361183.52 | 172,440 | 66,574 | 9,045,548 | 57,016 | 80,081 | (460) | 79,326 | 91,657 | 9,592,182 |
| | | | | | | | | | | | |
| Net Surplus | (2,531,273) | 4,675,038 | 687,526 | (417,762) | 8,897,620 | (951,010) | (963,590) | 401,879 | (1,677,354) | (869,548) | 5,107,761 |

| | July-21 | August-21 | September-21 | October-21 | November-21 | December-21 | January-22 | February-22 |
|---|---|---|---|---|---|---|---|---|
| Assets | | | | | | | | |
| Current Assets | | | | | | | | |
| Cash and Liquid Capital | 14,045,922 | 14,143,765 | 11,519,636 | 10,520,186 | 14,241,387 | 14,713,417 | 10,869,882 | 11,528,856 |
| Short Term Investments | 37,710,931 | 37,459,437 | 37,895,338 | 34,353,251 | 34,281,644 | 34,196,777 | 34,103,636 | 31,011,373 |
| PMA Partnership | - | - | - | - | - | - | - | - |
| Accounts Receivable, Net of Allowance | 17,138,201 | 16,475,304 | 16,272,228 | 19,413,168 | 20,940,657 | 21,359,592 | 23,422,744 | 21,478,443 |
| Other Receivables | 7,663,674 | 9,643,932 | 10,601,529 | 13,216,871 | 10,901,419 | 9,978,572 | 8,858,544 | 11,734,556 |
| Inventory | 3,364,669 | 3,426,323 | 3,413,915 | 3,371,955 | 3,379,016 | 3,341,506 | 3,375,509 | 3,382,777 |
| Prepaid Expenses | 1,788,612 | 1,636,519 | 1,778,307 | 1,476,186 | 1,554,182 | 1,612,547 | 1,651,594 | 1,292,820 |
| Total Current Assets | 81,712,009 | 82,785,279 | 81,480,953 | 82,351,618 | 85,298,304 | 85,202,410 | 82,281,909 | 80,428,825 |
| Assets Limited as to Use | | | | | | | | |
| Internally Designated for Capital Acquisitions | - | - | - | - | - | - | - | - |
| Short Term - Restricted | 2,499,267 | 2,499,373 | 1,639,227 | 61,230 | 61,232 | 61,232 | 61,236 | 1,307,758 |
| Limited Use Assets | | | | | | | | |
| LAIF - DC Pension Board Restricted | 665,411 | 916,906 | 981,005 | 1,046,467 | 1,118,074 | 1,202,941 | 1,316,833 | 1,409,097 |
| DB Pension | 18,395,253 | 18,395,253 | 18,395,253 | 18,395,253 | 18,395,253 | 18,395,253 | 18,395,253 | 18,395,253 |
| PEPRA - Deferred Outflows | - | - | - | - | - | - | - | - |
| PEPRA Pension | - | - | - | - | - | - | - | - |
| Total Limited Use Assets | 19,060,664 | 19,312,159 | 19,376,258 | 19,441,720 | 19,513,327 | 19,598,194 | 19,712,086 | 19,804,350 |
| Revenue Bonds Held by a Trustee | 3,215,549 | 3,375,336 | 3,535,124 | 3,694,911 | 4,004,827 | 14,392,668 | 14,073,128 | 13,804,794 |
| Total Assets Limited as to Use | 24,775,481 | 25,186,867 | 24,550,609 | 23,197,861 | 23,579,386 | 34,052,094 | 33,846,450 | 34,916,902 |
| Long Term Assets | | | | | | | | |
| Long Term Investment | 1,502,414 | 1,001,121 | 1,000,001 | 997,171 | 996,539 | 1,002,414 | 989,654 | 1,729,276 |
| Fixed Assets, Net of Depreciation | 76,716,557 | 76,469,300 | 76,345,403 | 76,203,344 | 75,900,447 | 75,809,403 | 76,833,219 | 76,915,188 |
| Total Long Term Assets | 78,218,971 | 77,470,421 | 77,345,404 | 77,200,515 | 76,896,986 | 76,811,816 | 77,822,872 | 78,644,464 |
| Total Assets | 184,706,460 | 185,442,568 | 183,376,965 | 182,749,993 | 185,774,676 | 196,066,320 | 193,951,231 | 193,990,191 |
| Liabilities | | | | | | | | |
| Current Liabilities | | | | | | | | |
| Current Maturities of Long-Term Debt | 3,383,794 | 3,382,136 | 3,350,577 | 2,901,929 | 2,866,983 | 1,601,919 | 1,596,844 | 1,574,086 |
| Accounts Payable | 3,353,229 | 3,965,055 | 3,242,192 | 3,578,083 | 4,124,296 | 2,899,914 | 3,252,430 | 2,515,732 |
| Accrued Payroll and Related | 6,153,387 | 6,804,295 | 6,354,107 | 7,392,086 | 8,762,183 | 9,981,694 | 9,408,509 | 10,660,919 |
| Accrued Interest and Sales Tax | 261,043 | 369,624 | 195,444 | 303,558 | 405,047 | 149,454 | 200,365 | 248,727 |
| Notes Payable | 9,386,372 | 9,386,372 | 458,744 | 458,744 | 458,744 | 458,744 | - | 500,000 |
| Unearned Revenue | 13,653,194 | 13,344,456 | 12,972,529 | 12,867,638 | 14,815,460 | 14,410,638 | 14,439,154 | 14,079,239 |
| Due to 3rd Party Payors | - | - | - | - | - | - | - | - |
| Due to Specific Purpose Funds | (25,098) | (25,098) | (25,098) | (25,098) | (25,098) | (25,098) | (25,098) | - |
| Other Deferred Credits - Pension | 2,124,655 | 2,124,655 | 2,124,655 | 2,124,655 | 2,124,655 | 2,124,655 | 2,124,655 | 2,124,655 |
| Total Current Liabilities | 38,290,575 | 39,351,496 | 28,673,149 | 29,601,595 | 33,532,270 | 31,601,920 | 30,996,860 | 31,703,358 |
| Long Term Liabilities | | | | | | | | |
| Long Term Debt | 35,607,947 | 35,607,947 | 35,257,947 | 35,257,947 | 35,257,947 | 47,102,947 | 47,102,947 | 47,102,947 |
| Bond Premium | 375,441 | 371,314 | 367,186 | 363,059 | 358,931 | 354,804 | 350,677 | 346,549 |
| Accreted Interest | 16,282,647 | 16,352,123 | 16,421,599 | 15,772,325 | 15,806,051 | 15,806,051 | 15,987,335 | 16,134,894 |
| Other Non-Current Liability - Pension | 45,570,613 | 45,570,613 | 45,570,613 | 45,570,613 | 45,570,613 | 45,570,613 | 45,570,613 | 45,570,613 |
| Total Long Term Liabilities | 97,836,648 | 97,901,997 | 97,617,346 | 96,963,944 | 96,993,542 | 108,834,415 | 109,011,572 | 109,155,003 |
| Suspense Liabilities | (70,699) | (70,699) | (70,699) | (70,699) | (70,699) | (70,699) | (70,699) | - |
| Uncategorized Liabilities | 629,381 | 656,981 | 656,756 | 705,749 | 733,749 | 712,992 | 703,159 | 691,039 |
| Total Liabilities | 136,685,905 | 137,839,774 | 126,876,552 | 127,200,589 | 131,188,862 | 141,078,627 | 140,640,892 | 141,549,400 |
| Fund Balance | | | | | | | | |
| Fund Balance | 44,833,874 | 44,833,874 | 44,833,874 | 44,833,874 | 44,833,874 | 44,833,874 | 44,833,874 | 44,833,874 |
| Temporarily Restricted | 2,499,156 | 2,499,156 | 2,499,156 | 2,499,156 | 2,499,156 | 2,499,156 | 2,499,156 | 2,499,156 |
| Net Income | 687,526 | 269,764 | 9,167,384 | 8,216,374 | 7,252,784 | 7,654,663 | 5,977,309 | 5,107,761 |
| Total Fund Balance | 48,020,556 | 47,602,794 | 56,500,414 | 55,549,404 | 54,585,814 | 54,987,693 | 53,310,339 | 52,440,791 |
| Liabilities + Fund Balance | 184,706,460 | 185,442,568 | 183,376,965 | 182,749,993 | 185,774,676 | 196,066,320 | 193,951,231 | 193,990,191 |
| | - | - | - | - | - | - | - | - |

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

| | | |
|---|---|---|
| Title: Forms Development and Control Policy | | |
| Owner: Compliance Officer | Department: Compliance | |
| Scope: District Wide | | |
| Date Last Modified: 03/04/2022 | Last Review Date: 01/17/2018 | Version: 2 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 10/28/2011 | |

**PURPOSE:**
Provide a standard process for form development, review and ~~approve~~ approval of all forms that are retained as a permanent part of the medical record.

**POLICY:**

1. Forms retained as a permanent part of the medical record must be approved by the Forms Committee prior to use, including trial forms and one-time printings.
2. Only approved forms may become a part of the medical record and must be reviewed and approved prior to inclusion in the medical record.
3. The Committee shall review, approve and monitor all forms to be included in the patient's medical record in accordance with the forms design standards and guidelines set forth in this Policy.
4. The Northern Inyo Healthcare District (NIHD) Forms Committee has the responsibility for defining standards for form layout, format, identification and duplication.
5. The NIHD Forms Committee shall establish and maintain oversight for medical forms standards compliance.
6. Patient Education handouts will be reviewed per standards for reading level, 12-point font, and translated per regulations to meet patient needs.
7. NIHD Forms Committee shall:
    a. Ensure that forms maintained in the permanent, legal medical record (paper-based, electronic and imaged) are appropriate for patient care, risk management and financial administration.
    b. Provide guidance to forms users as to what forms are considered part of the patient's medical record.
    c. Ensure that all Northern Inyo Healthcare District forms meet the requirements of the Joint Commission, California state statutes and federal laws and regulations governing health care, and health care documentation.
    d. Reduce the duplication of information in the permanent, legal health record through consolidation of forms.
    e. Improve the level of communication among health care providers by ensuring a minimum set of data elements be included in every permanent, legal medical record whether maintained in a paper-based, electronic or imaged format.
    f. Make the final determination as to where the form will reside in the medical record.
    g. The Compliance Department will maintain the following information on file:
        i. Bar coded, hard copy and final electronic versions of all forms
        ii. Correspondence/special instructions from the form sponsor regarding the form
        iii. All versions of forms that have been revised

iv. Completed Form Design and Approval Request form
v. Set specifications for all forms, which specifications shall be maintained in a document entitled: "Forms Specifications" and may be changed from time to time by committee vote.
vi. Publish the "Forms Specifications" on the hospital intranet.

8. The NIHD Forms Committee shall determine its composition and initially be comprised of:
    a. Admission Services
    b. Clinical Informatics
    c. Compliance
    d. Health Information Management (HIMS Department)
    e. Language Access Services
    f. Materials Management
    g. Medical Staff (as needed)
    h. Nursing
9. The NIHD Forms Committee may make changes to its composition by majority vote of its members
10. The NIHD Forms Committee may meet on any schedule deemed necessary by the membership.
11. Materials Management will work in conjunction with the HIM Department/Forms Committee to produce forms as requested.

**DEFINITIONS**:

**FORM -** Any printed, typed, or electronic document with blank spaces for insertion of required or requested information (handwritten or electronically generated) that is made a part of a patient's permanent, legal medical record.

**FORM SPONSOR** – Individual who requests the production of a new or revised form. The form sponsor is responsible for completing all necessary paperwork in accordance with the forms approval process and follow the form through the approval process and ultimately to implementation. The form sponsor has the responsibility of distributing the form to the necessary locations within and external to Northern Inyo Hospital and ensures that the obsolete versions of the same form have been removed from use.

**VITAL DOCUMENT –** Vital Documents shall include, but are not limited to, documents that contain information for accessing NIHD services and/or benefits. The following types of documents are examples of Vital Documents:

1) Informed Consent;
2) Advance Directives;
3) Consent and complaint forms;
4) Intake forms with potential for important health consequences;
5) "Notices pertaining to the denial, reduction, modification or termination of services and benefits, and the right to file a grievance or appeal;"[1]
6) Other hearings, notices advising LEP persons of free language assistance, or applications to participate in a program or activity to receive benefits or services.[2]

NIHD shall make available translated versions of Vital Documents, into the target language of any group that comprises at least 5% of the population of the geographical area served by the hospital, or of the actual patient population.[3]

**PROCEDURE (New Forms):**

1. The form sponsor will complete the on-line "Form Design and Approval Request" form (Exhibit A) and submit it to the Compliance Clerk along with the form to be approved.

   It will be required that the form will have been pre-approved by all the necessary users and departments prior to being presented to the Forms Committee for final approval.

2. The form sponsor will be contacted by the Forms Committee representative who will schedule the sponsor to attend an upcoming Forms Committee meeting to present the form.

   **NOTE:** The Forms Committee may meet monthly to review forms submissions. Form Sponsors must be in attendance to present the form and answer questions regarding the form and its usage.

3. Forms sponsors will need to ensure the following for all forms entering the approval process (see Form Design and Approval Request form Exhibit A):
   - Form is in compliance with hospital abbreviations policy or otherwise spell out abbreviations on the form. If necessary, an abbreviation key may be placed on the form for reference.
   - Define use of the form and suggest placement of the form within the medical record. Indicate form needs in terms of layout and special instructions for reproduction by Material Management.

4. Forms Committee will review all forms as scheduled to be presented and move to either approve the form as is or make recommendations for change.
   - If recommendations for change are requested to be made, the form sponsor will make the necessary revisions and resubmit the revised version to the Compliance Clerk.
5. Once approved, forms will be published to the Intranet. Form sponsors will be advised (via email) of its availability for use at that time
6. Forms will be filed electronically on a shared drive for reproduction upon request.
7. The form sponsor will be responsible for distributing the form to the necessary locations and ensures that the obsolete versions of the same form have been removed from use.

**PROCEDURE (Revising Existing Forms):**

1. Form sponsor must pull the most updated form currently on file from the Intranet or request the most updated form from the Compliance Department.
2. Form sponsor will make revisions as needed and resubmit the form to the Compliance Department. The Compliance Clerk and Compliance Officer will assess the revisions to determine if the further review by the Forms Committee is necessary. If so, form sponsor will be asked to attend an upcoming meeting to present the revised form for approval of the revisions.
3. For revisions made to generic templates which are used by multiple areas to specifically customize a form to their clinic/patient care area, the Forms Committee will notify all affected areas that a change has been made to the master and it will be the form sponsor's responsibility to revise the form so that it matches the revisions made to the generic template.
4. Form will be re-bar coded if necessary.
5. Revision date will be entered on the bottom of the form.
6. Form will be filed electronically on a shared drive to access for reproduction upon request.
7. The form sponsor will be responsible for distributing the form to the necessary locations and ensures that the obsolete versions of the same form have been removed from use.

**REFERENCES:**

1. California Health and Safety Code § 1367.04(b)(1)(B)(i)-(vi)

2. According to the Title VI Office of Civil Rights Guidance, the definition of Vital Documents "may depend upon the importance of the program, information, encounter, or service involved, and the consequences to the LEP person if the information in question is not provided accurately or in a timely manner."
3. Title VI of the 1964 Civil Rights Act, Emergency Medical Treatment and Active Labor Act, and California Health and Safety Code Section 1259.

**RECORD RETENTION AND DESTRUCTION:** N/A

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Barcode Rules & Assignments

| Supersedes: v.1 Forms Development and Control Policy |
|---|

**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Nondiscrimination Policy | | |
| Owner: Compliance Officer | Department: Compliance | |
| Scope: District Wide | | |
| Date Last Modified: 03/30/2022 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date:09/15/2010 | |

**PURPOSE:**

To assure compliance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972, and the Age Discrimination Act of 1975 and any future federal or state laws defining and prohibiting discrimination.

**POLICY:**

1. No person seeking services at Northern Inyo Healthcare District (NIHD) shall, on the basis or ground of race, color, sex (gender), sexual orientation, age, religion or national origin, be excluded from admission to NIHD, or excluded from any services provided by NIHD, or be otherwise subjected to discrimination in the admission to or provision of those services.

2. No persons with mental and/or physical disability shall, solely by reason of his/her disability, be excluded from admission to NIHD, or excluded from any services provided by NIHD, or be otherwise subjected to discrimination in the provision of those services, or be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity provided by NIHD.

3. NIHD employees or qualified applicants are considered for all positions without regard to race, color, religion, sex, pregnancy, childbirth, or related medical conditions, gender, gender identity, gender expression, national origin, ancestry, physical disability, mental disability, age, medical condition, genetic information, marital status, military and veteran status, sexual orientation, physical or mental disability, or any other basis protected by federal, state, or local laws.

4. Patients and Employees will be afforded reasonable accommodations within the available resources of the District in order to make the provision of services safely and conveniently accessible to an individual with the full intention that all persons be afforded the rights and benefits associated with the District.

**REFERENCE:**


1. California Hospital Association Record and Data Retention Schedule (2018).
2. The Joint Commission (CAMCAH Manual) (Jan. 1, 2022) RI.01.01.01 EP 4, 6, 9 & 29.
3. Patient Protection and Affordable Care Act; Section 1557 (2010).

**RECORD RETENTION AND DESTRUCTION:**

Employee and applicant records will be maintained by NIHD Human Resources Department for duration of employment, plus six (6) years.

Employees not entitled to pension, must have payroll records maintained for fifteen (15) years post separation.

Employees entitled to pension, must have payroll records maintained for the life of the employee plus six (6) years.

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Patient Rights
2. Rights of Swing Bed Patients
3. Visitation Rights
4. InQuiseek – Non-Discriminatory Policy

| Supersedes: v.2 Nondiscrimination Policy |
|---|

**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Overtime | | |
| Owner: Director of Human Resources | Department: Human Resources | |
| Scope: District Wide | | |
| Date Last Modified: 04/01/2022 | Last Review Date: No Review Date | Version: 3 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 11/20/2002 | |

**PURPOSE:**
To establish rules related to overtime pay.

**POLICY:**
Overtime hours require approval by your supervisor or department head prior to accrual. Department heads must comment on each incidence of overtime as approved within the payroll and time keeping system. Except for personnel on alternate work schedules, all non-exempt (hourly) personnel are paid time and one-half for hours worked over eight (8) in one day, or for hours worked which exceed forty (40) hours in a work week.

Non-exempt (hourly) personnel are eligible to be paid double time for hours worked over 12 in one day.

Exempt (salaried) employees are not eligible for overtime pay.

**REFERENCE:**
1. Fair Labor Standards Act (FLSA) https://www.dol.gov/agencies/whd/flsa#:~:text=The%20Fair%20Labor%20Standards%20Act%20(FLSA)%20establishes%20minimum%20wage%2C,%2C%20State%2C%20and%20local%20governments.
2. Memorandum of Understanding Northern Inyo Healthcare District and District Council 57, American Federation of State, County and Municipal Employees (AFSCME), AFL-CIO.

**RECORD RETENTION AND DESTRUCTION:**
Human Resource records are maintained life of employment plus six years
Payroll records maintained: Employees not entitled to pension: 15 years Employees entitled to pension: life of employment plus six years

**CROSS-REFERENCE POLICIES AND PROCEDURES:**
1. Personnel Classifications
2. Payroll Policies and Guidelines

| |
|---|
| Supersedes: v.2 05-01 OVERTIME |

**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Smoking/Tobacco Policy | | |
| Owner: CEO | Department: Administration | |
| Scope: District Wide | | |
| Date Last Modified: 03/15/2022 | Last Review Date: No Review Date | Version: 4 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 02/08/2001 | |

**PURPOSE:**

To provide a tobacco/nicotine free environment for all persons seeking care or providing services at Northern Inyo Healthcare District. This is consistent with the Northern Inyo Healthcare District mission of "One Goal, Your Health".

**POLICY:**

The following policies shall be adhered to by all patients, visitors, physicians and employees of Northern Inyo Healthcare District:

1. Patients, visitors, physicians, and employees of the hospital are not allowed to smoke within any buildings on hospital property or outdoors on hospital property. This includes use of nicotine delivery devices or tobacco products in cars while on hospital property.
2. It is the responsibility of the workforce who smoke off campus to mitigate any of their own personal smoke odors which may be irritating to others.
3. Visitors and workforce are not allowed to smoke, use tobacco products, or e-cigarettes on hospital property.
4. Cigarettes and other tobacco products will not be sold at Northern Inyo Healthcare District.
5. Signage will be posted at entrances as notification to persons entering the District campus of the "No Tobacco" environment.

**REFERENCE:**

1. California Assembly Bill 1807 (Jan 26, 2006).
2. California Assembly Bill 846, Chapter 342 Section 7596 to 7598, Section 19994.30 to19994.33 (Prohibits smoking within 20 feet of main entrances/exits and operable windows of all state, county and city buildings).
3. California Assembly Bill 2037, Chapter 989 California Labor Code, Section 6404.5. (Prohibits smoking in indoor workplaces.)
4. Health & Safety Code 1234 – Division 2 and Chapter 2 Clinics. (Requires signage that clearly states where smoking is prohibited for clinics.)

**RECORD RETENTION AND DESTRUCTION:** N/A

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Smoking Cessation
2. InQuiseek – Smoke-Free Workplace

| Supersedes: v.3 Smoking Policy |
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**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY**

| | | |
|---|---|---|
| Title: Standby/Callback | | |
| Owner: Director of Human Resources | Department: Human Resources | |
| Scope: District Wide | | |
| Date Last Modified: 04/04/2022 | Last Review Date: No Review Date | Version: 2 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 11/20/2002 | |

**PURPOSE:**
To clarify standby/callback pay process.

**POLICY:**

1. An employee is on standby call whenever the employee is not working his or her regular shift, but is available to be called back to the hospital on an emergency basis.
2. Standby is when an employee is available to her/his department, and when contacted, reports to work per department response time Policy and Procedure. Response time for Standby/Callback for all departments is 30 minutes or the usual commute time of the employee (not to exceed an hour).
3. The hourly Standby rate is paid at $8.00 per hour for each hour the employee is required to be on Standby.
    a. An employee shall not receive Standby pay during time she/he is called back for duty.
    b. When an employee is called upon to report to work during the period of such standby service, she/he shall be guaranteed a minimum of two (2) hours of work for each occasion for which she/he is called in not to exceed the total hours of the standby period.
    c. If the employee is scheduled and still on the clock when the employee is to be on Standby, this will be deemed holdover and no Standby pay shall be paid. Instead, the employee shall be paid standby pay upon clocking out of the holdover.
    d. When standby employees are called back to the hospital to work between 7:00 A.M. and 3:00 P.M., they will be paid at time-and-one-half their hourly "shift 1" pay rate, for each time they are called back.
    e. When standby employees are called back to the hospital to work between 3:00 P.M. and 11:00 P.M., they will be paid at time-and-one-half their hourly "shift 1" pay rate when they clock in at or after 3:00 P.M. and clock out not later than 6:30 P.M. Standby employees are paid a minimum of two hours, at time-and-one-half their hourly "shift 2" rate when they clock in after 3:00 P.M. and clock out after 6:30 P.M.
    f. When standby employees are called back to the hospital to work between 11:00 P.M. and 7:00 A.M., they will be paid at double their hourly "shift 3" rate, for each time they are called back. Because of the shift differential window, standby employees are paid at time-and-one-half their "shift 1" rate when they clock in at, or any time after, 6:00 A.M.
    g. Time worked beyond the two-hour minimum by standby employees during standby time will be paid at the appropriate aforementioned time-and-one-half or double-time rates. Standby employees are expected to swipe out immediately upon the completion of their work.

h. A new standby call period begins when the employee swipes out with the expectation of not immediately returning to work.

4. An employee who is not on Standby and is called in to work will receive One Time Callback pay in the amount of $27.50 in lieu of Standby pay.
5. All non-exempt employees who are on Standby or receive One Time Callback and are called into work shall receive Call-back pay.
    a. Call back pay begins at the time the employee arrives at work and swipes into timeclock.
    b. When the employee is called back to the hospital to work between 7:00 A.M. and 3:00 P.M., the employee will be paid a minimum of two hours, at time-and-one-half his or her hourly "shift 1" pay rate, for each call back.
    c. When the employee is called back to the hospital to work between 3:00 P.M. and 11:00 P.M., the employee will be paid a minimum of two hours, at time-and-one-half his or her hourly "shift 1" rate when the employee clocks in at or after 3:00 P.M. and clocks out not later than 6:30 P.M. The employee will be paid a minimum of two hours, at time-and-one-half his or her hourly "shift 2" rate when the employee clocks in after 3:00 P.M. and clocks out after 6:30 P.M.
    d. When the employee is called back to the hospital to work between 11:00 P.M. and 7:00 A.M., the employee will be paid a minimum of two hours, at double his or her hourly "shift 3" rate, for each call back. Because of the shift differential window, the called back employee is paid a minimum of two hours, at time-and-one half his or her hourly "shift 1" rate when the employee clocks in at, or any time after, 6:00 A.M.
    e. Time worked beyond the two hours minimum by these called back employees will be paid at the appropriate aforementioned time-and-one-half or double-time rates.

**REFERENCE:**

1. Fair Labor Standards Act (FLSA) https://www.dol.gov/agencies/whd/flsa#:~:text=The%20Fair%20Labor%20Standards%20Act%20(FLSA)%20establishes%20minimum%20wage%2C,%2C%20State%2C%20and%20local%20governments.
2. Memorandum of Understanding Northern Inyo Healthcare District and District Council 57, American Federation of State, County and Municipal Employees (AFSCME), AFL-CIO.

**RECORD RETENTION AND DESTRUCTION:**

Human Resource records are maintained life of employment plus six years
Payroll records maintained: Employees not entitled to pension: 15 years Employees entitled to pension: life of employment plus six years

**CROSS REFERENCE POLICIES AND PROCEDURES:**

1. Personnel Classifications
2. Payroll Policies and Guidelines

| Supersedes: v.1 05-02 STANDBY |
|---|

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

| | | |
|---|---|---|
| Title: Unusual Occurrence Reporting EC.04.01.01 | | |
| Owner: Compliance Officer | Department: Compliance | |
| Scope: Northern Inyo Healthcare District | | |
| Date Last Modified: 04/04/2022 | Last Review Date: No Review Date | Version: 2 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 12/16/2015 | |



## PURPOSE:

The purpose of the Unusual Occurrence Report (UOR) is to provide a confidential communication about events that are: unusual, unexplained, unanticipated or that affect the normal workflow, workforce, patient care or visitors.

UOR tool is utilized to facilitate an investigation of concerns or issues that may arise at Northern Inyo Healthcare District (NIHD) that will identify and/or verify opportunities for improvement in quality of service.

## POLICY:

At NIHD an unusual occurrence report is to be completed for all injuries/accidents or any situation/occurrence that could pose a safety risk to patients, visitors or staff. The UOR process provides identification of areas for process or system improvement to prevent future events by identifying what happened, why it happened, and possible changes necessary to mitigate future events of the same nature. Timely completion is required as soon as is possible, but must be completed within 24 hours of discovery.

## DEFINITIONS:

**Close call:** (or "Good Catch", "Near Miss") A patient safety event that did not reach the patient. Used to describe any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

**Hazardous condition:** A circumstance, other than the patient's own disease process, or condition, that increased the probability of an adverse event.

**No-harm event:** A patient safety event that reaches the patient but does not cause harm.

**Patient safety event:** An incident or condition that could have resulted or did result in harm to a patient. It can be the result of a defective system or process design, a system breakdown, equipment failure, or human error. Patient safety events also include adverse events, no-harm events, close calls and hazardous conditions.

**Sentinel Event:** An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. This may include "risk thereof" situations. (See Sentinel Event/Serious Harm Reporting and Prevention Policy/Procedure)

**Unusual Occurrences:** An incident is any unanticipated occurrence that deviates from regular District operations; injury may or may not result from the incident. At NIHD an Unusual Occurrence Report (UOR) is completed by staff aware of the unusual occurrence to allow for investigation, tracking/trending and performance improvement needs identification.

**Reportable Occurrences:** California Department of Public Health requires notification of events which could seriously compromise quality or patient safety. Title requires NIHD to report any occurrence, as soon as reasonably practicable, to the local health officer and to CDPH Licensing and Certification office (San Bernardino). which includes, but is not limited to, the following:

a. An epidemic outbreak;
a. Poisoning;
b. Fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety, or health of patients, personnel, or visitors.

**Serious Injury:** A serious injury is further defined as one that results in a transfer to a higher level of care, extended hospital stays or additional medical treatment.

**Risk Thereof:** For the purposes of this policy, the phrase "or risk thereof" is defined as an event that did not result in death or serious injury, but carries a significant chance of recurring; the recurrence of which may indeed have a more untoward outcome. In determining the risk of an event recurring, the following guidelines are used:

a. Processes involved in the event that are not well codified or standardized across the organization are more likely to result in the recurrence of the event.
b. Processes that cross multiple disciplines and department lines and involve multiple steps in the process are more likely to result in the recurrence of the event.
c. Processes that demonstrate significant variation (i.e. lack of stability) are more likely to result in the recurrence of the event.

**PROCEDURES:**

1. At the time of unusual incident discovery:
    a. Assists any injured or ill patient, visitor or staff member. Assure safety as the priority.
    b. Notify immediate leadership, or the House Supervisor, as soon as possible.
2. District Leaders:
    a. If significant adverse outcome, notify the Administrator-On-Call immediately.
    b. Support workforce members involved.
3. UOR is completed as soon as reasonable, but within 24 hours:
    a. By the person having the most knowledge of the occurrence.
    b. Multiple team members may choose to complete a UOR on a single incident.
4. All occurrences must be reported, even if no bodily harm or property loss resulted, utilizing the standard UOR Form. This includes: close call, hazardous condition, near miss, and risk thereof situations
5. Form location: NIHD Intranet>Quick Links>UOR.
6. Form completion instructions:
    a. Field boxes are completed (all items with asterisk * are required)
    b. Clicking within a field opens up options that allow the reporter to record data in usable format for data collection.
    c. The tool is designed to support the end user to obtain pertinent information based on the type of event.
    d. Narrative description is to be completed by the workforce member initiating the UOR who is the most involved in the event. This section describes what happened through the collection and organization of the data/facts surrounding the event.
    e. Complete recommendations for "anything that would help to avoid this in the future". This allows for workforce input on quality improvement process.
    f. Once information is documented, Click the "Submit" button in the bottom right corner.

7. Investigation of unusual occurrence:
    a. Reviews the facts and investigate further, if needed, to fully understand the sequence of events.
    b. Provide all information on what was gathered in the investigation within the UOR system.
    c. The UOR is electronically routed up the chain-of-command to the Chief, if necessary, over the service line or their designee.
    d. Response to the unusual incident will be determined based upon needs and may include, but is not limited to:
        i. Revision of Policy and/or Procedure documents
        ii. Education of workforce
        iii. Equipment updates
        iv. Environment of care modifications
8. Data/Performance Improvement
    a. Collected data is collated quarterly, which is then analyzed for opportunities to improve processes.
    b. Data is reported to NIHD Board of Directors quarterly via the Compliance Officer Report.
    c. Environmental-related occurrences are reported at least quarterly to the Safety Committee
    d. Data is reported to Quality Council and Professional Practice Council at least annually.

**REFERENCES:**

1. The Joint Commission CAMCAH Manual (Jan.-2021) EC.04.01.01 EP1, 3-6, 8-11.

**RECORD RETENTION AND DESTRUCTION:**

Unusual Occurrence Reports will be maintained for a minimum of 10 years at NIHD.

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Unusual Occurrence Reporting EC.04.01.01
2. Communication with the Patient/Family After a Harm Event
3. Patient/Customer Complaint policy
4. Unusual Occurrence Reporting EC.04.01.01

| Supersedes: v.1 Occurrence Reporting EC.04.01.01EP3; v.1 Unusual Occurrence Report Instructions |
|---|

**NORTHERN INYO HEALTHCARE DISTRICT**
**NON-CLINICAL POLICY**

| | | |
|---|---|---|
| Title: PAID TIME OFF (PTO) | | |
| Owner: Director of Human Resources | Department: Human Resources | |
| Scope: District Wide | | |
| Date Last Modified: 04/05/2022 | Last Review Date: No Review Date | Version: 7 |
| Final Approval by: NIHD Board of Directors | Original Approval Date: 11/20/2002 | |

**POLICY:** PTO combines all vacation time, holiday time and sick leave benefits. Full-time and regular part-time benefited employees earn and accrue a maximum number of hours per pay period to use for days off with pay including vacations, holidays, and all sick days.

**PROCEDURE:**

All benefited employees earn PTO according to the following schedule:

| PTO Accrual Level | Lifetime Benefit Hours (LBH) (A) | Pay Period Accrual Amount (B) | Number of Pay Periods Per Year (C) | Total PTO Hours Per Year (D) | Maximum Accrual Amount (D)+ 80 (E) |
|---|---|---|---|---|---|
| Level I | 0.00 to 8,319.99 | 7.69 | 26 | 200.00 | 280 |
| Level II | 8,320.00 to 18,719.99 | 9.23 | 26 | 240.00 | 320 |
| Level III | 18,720.00 or more | 10.77 | 26 | 280.00 | 360 |

The above hours of PTO (B) accrue only when the benefited employee receives pay for at least eighty-hours (80) during the pay period. Hours are prorated when above or below 80, with a maximum of 1.2 times the appropriate accrual rate. Whenever paid hours consisting of any combination of time worked, PTO or paid absence (excluding "hours" paid by an external source for income replacement) are less than fifty-six (56) hours during the pay period, the employee will earn no PTO for that pay period.

**PTO Cash Outs:** Whenever the PTO Maximum Accrual Amount (E) is reached, the employee shall no longer accrue PTO. An employee who reaches the Maximum Accrual Amount (E) can continue to accrue PTO when she/he uses PTO hours to fall below the maximum accrual or if she/he cashes out PTO as allowed below.

On three designated pay periods in April, August, and December of each year, benefited employees may elect to receive pay for up to one-hundred and twenty (120) hours total per year, of accrued (earned but not used) PTO. Any employee who elects to cash out PTO must leave a minimum of 40 hours in her/his PTO balance after cash-out. The District shall offer employees an additional cash out of accrued PTO up to 40 hours during times that the District initiates a "PTO freeze" for business-related purposes. Cash Outs are paid at the employee's base hourly rate of pay at the time of the cash out.

**Use of PTO:**

1. All requests to use PTO for vacation are subject to approval by the Director/Manager.
2. Approvals of requests to use PTO for vacation shall take place annually according to the following process:
    a. Employees shall request to use PTO for vacation during January of each year for the following fiscal year.
    b. Requests to use PTO for vacation shall be limited to two (2) weeks. Longer requests will require Executive Team approval. In the event that vacation requests from more than one employee for the same time period are received, the date and time of the receipt of the request shall determine the priority of the request.
    c. Requests shall be granted, modified or denied by the end of February.
    d. Vacations will only be granted if the needs of the department can be met with the employees available. Additional requests to use PTO for vacation time off may be granted if department size and skill mix allow.
3. Requests to use PTO for vacation submitted during the calendar year after the January deadline shall be granted as possible within 15 calendar days after the request. Time of the receipt of the request will be the tiebreaker if two requests are received on the same day, as described in section 2.b.
4. Requests to use PTO for vacation shall not be unreasonably denied.
5. Approved requests to use PTO for vacation shall be documented in writing and shall not be canceled once approved.
6. Requests to use PTO for vacation will be granted for time equal to or less than the PTO accrued by the employee at the time the request is made. Time off exceeding an employee's accrued PTO may only be granted by the Executive Team.
7. See above for information about PTO accrual amounts and cash outs.
8. Coverage for approved requests to use PTO for vacation:
    a. Management shall be responsible for securing coverage.
    b. If employee is part of a weekend work rotation, employee may submit a weekend switch proposal with her/his request to use PTO for vacation.
9. If the employee withdraws her/his request to use PTO for vacation prior to the posting of the schedule, the employee will work her/his regular shifts. If, however, an employee withdraws her/his request to use PTO for vacation after the schedule has been posted, he/she will not be guaranteed those hours and may have to use her/his PTO.
10. If an employee withdraws her/his approved request to use PTO for vacation, the Director/Manager will notify all of the employees in the Department of this change giving another employee a chance to request to use PTO for vacation at that time.
11. PTO combines all vacation time, holiday time and sick leave benefits.

**REFERENCE:**

1. Memorandum of Understanding Northern Inyo Healthcare District and District Council 57, American Federation of State, County and Municipal Employees (AFSCME), AFL-CIO.

**RECORD RETENTION AND DESTRUCTION:**

Human Resource records are maintained life of employment plus six years

Payroll records maintained: Employees not entitled to pension: 15 years Employees entitled to pension: life of employment plus six years

**CROSS REFERENCE POLICIES AND PROCEDURES:**

1. Personnel Classifications
2. Payroll Policies and Guidelines
3. Overtime
4. Holidays

Supersedes: v.5 Leaves of Absence - PAID TIME OFF (PTO) (08-01)

NIHD
RURAL HEALTH CLINIC

| Regulatory Compliance Policy | | |
|---|---|---|
| **J Tag References: J-0011; J-0012; J-0013 § References: 491.4** | **Policy Type:** Administrative | **Policy Number: 100.0** |
| Adopted or Revised Date: 1/31/2022 | | |

**Policy Declaration:** This is the Clinic's Regulatory Compliance Policy. The Clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to acknowledge and document the conditions of coverage as an RHC concerning compliance with Federal, State and Local laws pursuant to 42 CFR §491.4.

**Policy Statement**: It is the intention of the Clinic to remain in regulatory compliance as a Rural Health Center in respect to federal, state and local laws which generally and specifically apply to the operation of the clinic. More specifically, it is the intent of the clinic to adhere to **Section 6401 of the Affordable Care Act** and the corresponding revision to **Section 1902 of the Social Security Act** which, in part, states that a "provider of medical or other items or services or supplier within a particular industry or sector or category" establish a compliance program as a condition of enrollment in Medicare, Medicaid, or the Children's Health Insurance Plan. It is the intention of the clinic to establish a compliance plan of its own or in collaboration with its parent entity or home office identified as Northern Inyo Healthcare District.

**Policy Scope**: This policy is informational and regulatory in nature.
**Policy Body:**

1. **General Compliance with Federal, State and Local Laws**
   a. The clinic shall comply with all Federal regulations governing the certification of Rural Health Clinics (RHCs) as published in the Federal Register, 43 FR 136, and subsequent federal publications which address the conditions for coverage or participation for RHCs.

   *b.* The clinic shall comply with directives given by the Center for Medicare and Medicaid Services (CMS) and its contractors for the provision of services to Medicare participants as well as the billing of those services as described and explained in ***Chapter 13 of the Medicare Benefits Manual, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services and Chapter 9 of the Medicare Claims Processing Manual, Rural Health Clinics/Federally Qualified Health Centers*** and any other subsequent CMS publications, notices, statements or correspondence which give practical guidance on the application of the RHC regulations for program participation, benefits and claims processing.

c. The clinic shall comply with all laws and regulations governing the licensing and operation of a Rural Health Clinic in the State of California.
d. State licensure, *if required*, shall be continuously maintained with the understanding that a lapse in state licensure can jeopardize certification status granted by CMS.
e. Additionally, the clinic shall comply with the conditions of participation in the state Medicaid program as administered by either the state and/or approved Managed Medicaid Organizations (MMO) and to all publications, notices, statements, correspondence or communication which gives practical guidance on program participation, benefits and claims processing.
f. The providers of the RHC will maintain current professional licensure in their respective disciplines and comply with the Scope of Practice of their discipline as defined by state law.
g. The clinic shall comply with state directives and guidelines for the provision of services to Medicaid recipients and the billing of those services as mentioned above.
h. The clinic shall comply with any applicable local laws which regulate the operation of a medical clinic or business in Inyo County, California.
i. The clinic shall comply with any applicable local laws which regulate the operation of a medical clinic or business in city/town of Bishop.
j. The clinic shall maintain and renew licenses in a timely manner. The clinic shall have a process in place for monitoring license and certification expirations.
k. The clinic shall complete or be subject to annual inspections, application renewals, and annual reports as required to maintain federal, state, and local regulatory compliance.

**2. Objectives of the Formal Compliance Program**

The objectives of a Compliance Program as described above are to:

a. Avoid the potential for fraud, waste and abuse related to the provision of Medicare and Medicaid services (Federal and State False Claims Acts);
b. Increase the potential for proper submission and payment of claims;
c. Reduce coding and billing errors;
d. Promote patient safety and the delivery of quality patient care;
e. Educate and inform providers and employees in a way which encourages the proper utilization of resources and optimizes training and work processes

**3. Core Compliance Program Elements**

a. Written Compliance Policies and Procedures: The clinic shall provide written compliance policies and procedures and a formal, written Compliance Plan which identify the Compliance Officer and further explain the responsibilities of all ownership, management, and employees in adherence to the Plan. Accordingly,
    i. The policies and procedures or Plan will be readily available to all employees in a clearly written and understandable format;
    ii. The polices and plan shall be reviewed and updated on a regular basis and employees shall be informed and educated regarding material changes to the policies and procedures;
    iii. The policies and procedures or Plan shall include a Code of Conduct, which shall also be posted in an employee access area of the clinic;
    iv. The policies and procedures shall include reporting mechanisms;
    v. The policies and procedures shall include a non-retaliation statement which ensures employees and contracted parties that the reporting of

vi. alleged compliance violations shall not jeopardize the individual's relationship with the Rural Health Clinic.

b. **Compliance Program Oversight:** The clinic shall identify a Compliance Officer who is responsible for approving the Standards of Conduct, administering the aspects of the program, reporting on enforcement activity, and evaluating the effectiveness of the program on a regular basis. The Compliance Officer shall also be responsible for maintaining relationships within the organization which promote training, communication and awareness of the Program.

The Compliance Officer is:

Patty Dickson
760-873-2022
patty.dickson@nih.org

c. **Education and Training:** The clinic shall provide compliance training (as part of the Compliance Plan) for all employees including physicians, non-physician providers, licensed clinical staff, managers, supervisors and support staff:

vii. At or near the individual's hire initial date; and
viii. Annually as a refresher course with highlights of changes and developments; re-emphasizes the Code of Conduct; and provides examples of non-compliance;
ix. The training shall include information about Federal and State False Claims Acts;
x. Upon the reporting of a potential violation of a Compliance Plan, a focused training may be conducted to reinforce a particular compliance area or concern.

d. **Communication**: The clinic shall provide and promote clear communication concerning how to report compliance issues in a timely manner to the Compliance Officer. ***Communication of a compliance concern by an employee shall be taken seriously by the Clinic and shall not result in any consequence, retaliation, or negative outcome to the employee's job security or stability. The organization shall maintain an open-door policy and an employee shall not be hindered, dissuaded, or harassed in his/her efforts to report concerns.*** Any communication can be made by any of these methods discussed in the employee training.

e. **Auditing and Monitoring:** The clinic shall conduct periodic and ongoing auditing and monitoring functions to ensure compliance with all federal, state, and local regulations and compliance with participation within the Medicare and Medicaid programs for which it provides services. Auditing is defined as an independent formal compliance review which occurs at least annually. Monitoring is defined as periodic procedural checks. As part of the auditing and monitoring activities, The Rural Health Clinic shall also conduct risk assessments in order to evaluate the risk of non-compliance in specific areas brought to the organization's attention by CMS, OIG, State Agencies or the concerns of providers and staff.

f. **Disciplinary Actions:** The clinic shall establish as part of its formal Compliance Plan conditions which apply for employee discipline in respect to violation of the Standard of Conduct and/or for which the employee's behavior can be attributed to non-compliance of federal, state, or local regulations, including breaches the conditions of participation in Medicare and Medicaid programs or in the rendering of services to beneficiaries of the programs and failure to detect or report such activities.

g. **Corrective** The clinic shall clearing identify in the Compliance Plan the actions that will be taken to remedy any violations. This shall include a description of the processes and actions which shall occur when any or all of the actions below are necessary:

   i. Self-reporting violations; or
   ii. Making repayments of any credit balances or overpayments due a program; or
   iii. Disciplining employees; or
   iv. Re-training of employees at the point of detection.

4. **Biennial Review of Compliance Policies, Procedures and Plan:** The clinic shall review the Compliance Policy and Plan as a part of the biennial RHC evaluation process and shall revise the policy to reflect any changes, revisions or amendments necessary. If the RHC is part of a larger healthcare system, the Compliance Plan shall be reviewed according to the system's policy and/or the RHC portion of the review shall be forwarded to the appropriate committees within the system.

**Specific Procedures:** As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Local Inspections, Licenses or Permits on File | |
| | County (Parish) Inspections, Licenses or Permits on File | |
| | State Inspections, Licenses, or permits on File | |
| | Credentialing and HR Policies; Credentialing/HR Files | |
| | Formal Written Compliance Plan | |
| | Compliance Training Material | |

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# Formal Corporate or Organization Compliance Plan Policy

| J Tag References: J-0011<br>§ References: 491.4 | **Policy Type:** Administrative | **Policy Number: 105.0** |
|---|---|---|
| Adopted or Revised Date: 1/31/2022 | | |

**Policy Declaration:** This is the Formal Corporate or Organization Compliance Plan Policy of the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to acknowledge and document the conditions of coverage as a RHC concerning compliance with Federal, State and Local laws pursuant to §491.4 and to mandate the establishment of a formal, written Compliance Plan in accordance with Section 6401 of the Affordable Care Act.

**Policy Statement**: It is the intention of the Clinic to remain in regulatory compliance as a Rural Health Center in respect to federal, state and local laws which generally and specifically apply to the operation of the clinic. More specifically, it is the intent of the Clinic to adhere to **Section 6401 of the Affordable Care Act and the corresponding revisions to Section 1902 of the Social Security Act** which states that a "provider of medical or other items or services or supplier within a particular industry or sector or category" establish a compliance program as a condition of enrollment in Medicare, Medicaid, or the Children's Health Insurance Plan. It is the intention of the Clinic to establish a compliance plan of its own or in collaboration with its parent entity or home office, and to have written policies and employee training pertaining to Federal and State False Claim Acts.

**Policy Scope**: This policy is informational and regulatory in nature.

**Policy Body:** It shall be the policy of the clinic to have a formal Compliance Plan which is reviewed at least annually and includes the core elements which are required by Section 6401 of the Affordable Care Act as described within the section and discussed in Policy #100 of this collective documents. The most recent version of the Compliance Plan and any supporting documents, training material, internal memos or other relevant documents shall be readily available for review by any federal or state agencies, payers, or other third-party representatives to which compliance must be demonstrated.

**Specific Procedures:** As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Compliance Plan Document | |
| | Compliance Training Material | |

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RURAL HEALTH CLINIC

| Organizational Structure and Ownership | | |
|---|---|---|
| **J Tag References: J-0060, J-0061, J-0062, J-0081, J-0084, J-0086**<br>**§ References: 491.7, 491.8, 491.9** | **Policy Type:** Administrative | **Policy Number: 110.00** |
| Adopted or Revised Date: 1/31/2022 | | |

**Policy Declaration:** This is the Organizational Structure and Ownership Policy of the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to disclose in a written document the organizational structure of the Clinic which is Rural Health Clinic (RHC). Furthermore, the policy is designed to give detailed information about the governance, management and staffing of the clinic.

**Policy Statement**: The Clinic seeks to fully disclose its current ownership and organizational structure, as it pertains to both operational and medical direction, to all interested parties.

**Policy Scope**: This policy is informational in nature.

**Policy Body: Organizational Structure and Ownership**

1. **Legal Entity:** The legal entity name is Northern Inyo Rural Health Clinic.
2. **dba Trade Name:** The dba/trade name of the Clinic is:

   Northern Inyo Rural Health Clinic.
3. **Ownership Type**: The ownership type of the Clinic is a Governmental.
4. **Legal Organization:**
   a. The entity was officially created, incorporated or chartered in the State of California.
   b. This entity was organized on 1/7/1946.
   c. All trade names, trademarks or logo have been registered with the Secretary of State as required by state or federal regulation.
   d. Any changes in ownership or managing control shall be reported to federal and state authorities, including CMS, in a prompt manner.
5. **Clinic Type**: The RHC Clinic Type is provider-based entity.

6. **Clinic Administrator/Director**: The individual principally responsible for directing the operation of the clinic is:

   Jannalyn Lawrence, BSN, RN
   153 Pioneer Lane, Suite B
   Bishop, CA 93514

7. **Medical Director**: The individual responsible for medical direction of the clinic is:

   Stacey Brown, MD
   153 Pioneer Lane, Suite B.
   Bishop, California 93514

   *a.* The medical director is a duly licensed physician in the State of California.
   *b.* The medical director's license number is A54711.
   *c.* The medical director's license is in good standing and was first issued on 9/1/1997.

8. Staffing and Staff Responsibilities: The organization of the RHC allows for the following medical staff positions:

   a. At least one physician who is the individual responsible for the medical direction of the clinic;
   b. At least one physician assistant or nurse practitioner who is available to furnish medical services at least 50% of the time that the clinic operates, i.e, regular posted patient care hours.
   c. Sufficient ancillary and/or support staff who are supervised by the professional staff.

   The responsibilities of each position are further delineated through written job descriptions. Written job descriptions identify the employee or staff member's supervisor. The adequacy of staffing and the current staffing model is reviewed at least once annually during the Annual Evaluation process.

9. Organizational Chart: More details about the clinic's organizational structure is graphically represented on the clinic organizational chart which is a supplemental document related to this policy. The organizational chart illustrates the lines of authority.

10. **Staff Roster**: The Clinic Administrator maintains a roster of current employees and medical staff.

11. Written Policies: Written policies have been established and implemented to further outline the policies and procedures related to 1) the administrative functions of the clinic, including human resource management; and 2) clinical care of patients. Patient care policies are developed with the advice of a group of professional personnel that includes one or more physicians, and one or more nurse practitioners or physician assistants. The policies are reviewed at least once annually for appropriateness, completeness and relevance as part of the Annual Evaluation process.

These written policies seek to ensure:

a. Compliance with local, state, and federal regulations;
b. Consistency within the performance of administrative and clinical functions, tasks and responsibilities;
c. A level of performance with respect to best practices; and
d. Guidance for the administration, employees, healthcare providers, and contracted third-parties, as applicable.

**Specific Procedures**: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Organizational Chart | Administrative Section |
| | Job Descriptions | HR Files/HR Section |
| | Clinical Staffing Policies | Patient Care Section |
| | Current Staff Roster | Administrative Section |

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| Organizational Chart Policy | | |
|---|---|---|
| **J Tag References: J-0062**<br>**§ References: 491.7** | **Policy Type:** Administrative | **Policy Number:** 120.00 |
| Adopted or Revised Date: 1/31/2022 | | |

**Policy Declaration:** This is the Organizational Chart Structure Policy of the Clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to disclose the organizational structure of the Clinic in the form of an organizational chart which is a graphic representation of the lines of authority.

**Policy Statement**: The Clinic seeks to fully disclose its organizational structure. The graphic representation shall be updated any time there is a significant change in the lines of authority.

**Policy Scope**: This policy is informational in nature.

**Policy Body:** See Org Chart as evidence to this policy.

**Additional Organizational Information:**
None

**Specific Procedures:** The organizational structure and the accuracy of this graphic will be reviewed at least once annually as part of the Annual Evaluation process. Also see additional procedures as described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**
***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| 110.00 | Organizational Structure and Ownership | Administrative Section |
| | Job Descriptions | HR Files |
| | Current Employee Roster | |
| | Board Roster | |

NIHD
RURAL HEALTH CLINIC

| Non-Discriminatory Policy | | |
|---|---|---|
| **J Tag References: J-0011**<br>**§ References: 491.4**<br>**Other References: See Citation in Body of Policy** | **Policy Type:** Administrative | **Policy Number:** 130.00 |
| Adopted or Revised Date: 1/31/2022 | | |

**Policy Declaration:** This is the Non-Discriminatory Policy of the Clinic. The Clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purposes of this policy are to clearly outline the civil rights protection and anti-discriminatory policies which protect the patients, employees and public of the Clinic.

**Policy Statement**: The Clinic seeks to clearly define the processes by which civil rights are protected and by which those protections are communicated and safeguarded. This statement is written in accordance with the provisions of Title VI of the Civil Rights Of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Regulations of the US Department of HHS issued pursuant to these statutes at Title 45 Code of Federal Register Parts 80, 84, and 91. Furthermore, the Clinic complies with Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116.

As a Recipient of Federal financial assistance, the Clinic does not exclude, deny benefits to, or otherwise discriminate against any persons on the grounds of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs or activities, which carried out by the provider directly or through a contractor with which the provider arranges to carry out its programs and activities.

**Policy Scope**: This policy is procedural and regulatory in nature.

**Policy Body: Non-Discriminatory Policy**

1. **All Inclusive Policy To Ensure Civil Rights: There exists an all-inclusive policy to ensure the civil rights of employees, patients, and other individuals as provided for above in the statutes.**
    a. **Provision of Medical Services and Benefits--**
        i. No patient will be denied the provision of medical services or benefits based on the grounds of race, color, national origin or on the basis of disability or age.
        ii. No patient will be denied provision of medical services or benefits on the ground of sex including gender identity or sexual preference.

b. **Provision of Employment Opportunities-**
   i. No individual will be denied an employment opportunity based on the grounds of race, color, national origin, or on the basis of disability or age.
   ii. No patient will be denied provision of medical services or benefits on the ground of sex including gender identity or sexual preference.

c. **Accommodation**- Patients and employees will be afforded reasonable accommodation within the available resources of the Clinic in order to make the building and the provision of services safely and conveniently accessible to any individual with the full intention that all persons be afforded all the rights and benefits associated with the clinic.

2. Identification of Individuals with language barriers and impaired sensory skills: The following steps will be used to identify and facilitate communication obstacles concerning individuals with limited speech, hearing or vision and in the case of individuals for whom a disability or native language restricts communication.
   a. The clinic staff will identify the individual's need for assistance.
   b. The clinic staff will enlist the help of a family member, companion or acquaintance to assist in interpreting the immediate needs of the patient. ***A family member, and more specifically a minor child, may not be used as a medical interpreter.***
   c. The clinic staff shall maintain a current list of all local, county/parish, and state resources which can provide assistance to and on behalf of patients with impairment or disabilities related to speech, language, hearing, and vision. These agencies, institutions, or programs shall be contacted to assist patients with these conditions. To the extent that the clinic is able to reasonably accommodate patients with these disabilities, it will do so to ensure that medical care is not hindered or compromised.
   d. The clinic providers and staff will use a number of other resources in an effort to meet the communication needs of patients and other individuals for whom English is not the primary language:
      i. Certified medical interpreters or internet-based services which allow face to face translation in person or via an audio/video application. The clinic has an agreement with Language Access Services Department, NIHD.
      ii. Certified medical interpreters or services available through parent entity hospitals or health care systems or available under agreement with other healthcare organizations.
      iii. Internet-based interpreter programs and tools
      iv. Other organizations or services include: .

   e. These consolidated resources will be used to communicate the availability of communication access services, that these services are without charge and that the services will be used to ensure the provision of medical services without discrimination.

3. Employee and Staff Training: The following aspects of civil rights and non-discriminatory training will be provided:
   a. All employees will receive initial training about the clinic's non-discriminatory policy and the related laws and statutes for which this policy is implemented.

b. Employees will be directed to workplace notices which further communicate or explain the non-discriminatory actions.
c. Employees will be given examples of possible situations in which an individual's civil rights may not be protected for the purpose of instructing them on how to make provisions for equal and fair services and benefits.
d. Subsequent, periodic training will be conducted as needed to make sure that the staff has an adequate understanding of issues and concerns related to the protection of civil rights.

4. **Notice: A copy of the non-discriminatory policy in the form of a notice will be publicly posted at all time.** Additional methods of communication will be utilized to ensure that all parties are aware of the protections offered against discrimination and the types of discrimination for which the federal law offers these protections. Tag lines in non-English languages shall be placed on forms, notices, and patient communications. These tag lines will represent all foreign languages known to exist in the service area as reported in current US Census data or identified by OCR.

5. Questions or Comments: **Questions from patients or from the public concerning the non-discriminatory practices and accommodation of the Clinic, may be directed to:**

Michael Leoz
Pacific Region
800-368-1019
Email: OCRMail@hhs.gov

Or

Northern Inyo Rural Health Clinic
Patty Dickson
760-873-2022
patty.dickson@nih.org

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Copy of Posted Notice | |
| | Copies of Translation Agreements or Service Contracts | |
| | US Census Data for Service Area | |
| | List of Community and State Resources | |

NIHD
RURAL HEALTH CLINIC

| RHC Service Area (Location) | | |
|---|---|---|
| **J Tag References: J-0020, J-0021, J-0022, J-0023**<br>**§ References: 491.5** | **Policy Type:** Administrative | **Policy Number: 140.00** |
| Adopted or Revised Date: 1/31/2022 | | |

**Policy Declaration:** This is the RHC Service Area (Location) Policy of the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to acknowledge and document the conditions of coverage as an RHC pertaining to the location and service area.

**Policy Statement**: It is the intention of the Clinic to remain in regulatory compliance as a Rural Health Clinic.

**Policy Scope**: This policy is informational and regulatory in nature.

**Policy Body: RHC Service Area**

1. **Location of the Clinic:**
   - **a.** The Clinic location meets the requirement "that it is not an urbanized area" as defined by the Bureau of the Census; AND
   - **b.** The Clinic is located in an area that has been designated as having a shortage of personal health services; OR
   - **c.** The location qualifies under one of the program exemptions as defined in 42 CFR §491.5 as determined by CMS; AND
   - **d.** The rural location and HPSA status has been validated by the state rural health officer or other state agency as meeting the location requirements prior to pursuing initial CMS certification.

2. **Type of Structure:**
   - **a.** Permanent Structure: The clinic is housed in a permanent structure located at 153 Pioneer Lane, Suite B. Bishop, California 93514.
     - i. Floor plans and/or drawings have undergone any necessary architectural site plan reviews and/or inspections by the state fire marshal's office, if required; and,
     - ii. Any other local, county or state office reviews that are required to initial or zoning, building codes and occupancy.
   - **b.** Mobile Units: The clinic operates no mobile units. The clinic does not provide services at any other location.

**Specific Procedures:** As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | State Site Verification Letter, if applicable | Administrative Section |
| | HRSA HPSA/MUA Printout | Administrative Section |
| | If mobile units are in service, the same information is needed for each stop and proof of published route. | |

NIHD
RURAL HEALTH CLINIC

| Advertising, Web-Presence and Social Media Representation | | |
|---|---|---|
| **J Tag References: J-0023, J-0062 § References: 491.5, 491.7** | **Policy Type:** Administrative | **Policy Number: 150.0** |
| Adopted or Revised Date: 1/31/2022 | | |

**Policy Declaration:** This is the Advertising, Web-Presence and Social Media Representation Policy of the Clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to establish the guidelines that will be used to represent the RHC via advertising, web presence and social media sites.

**Policy Statement:** It is the intention of the Clinic to remain in regulatory compliance as a Rural Health Clinic.

**Policy Scope:** This policy is informational and regulatory in nature.

**Policy Body: Advertising, Web-Presence and Social Media Representation**

1. **Representation of the RHC**
    a. The RHC shall be held out to the public under the same legal name or trade name, ownership and medical directorship that has been approved by CMS at the time of initial certification;
    b. If the rural health clinic is one of several medical offices, RHC and non-RHC, operated by same organization or ownership:
        i. Each RHC shall be distinguished from other clinics or clinic types;
        ii. An individual RHC shall not be held out as one of several locations without distinction; the RHC shall not operate or advertise satellite location or be mistaken by the public as a satellite office.
        iii. Any mobile units operated under the RHC's CCN number shall be held out in the same way as the permanent structure.
    c. If changes are made in the ownership or management structure, clinic name, medical directorship or physical location, such changes will not be advertised prior to written approval of any 855-A or CMS-29 changes in enrollment have been received.

2. **Promotion of Clinic Services and Activities:** No services or activities shall be promoted or advertised which are not consistent with the Rural Health Clinic Program and with requirements for providing both RHC and non-RHC services.

The guidance as provided in 42 CFR §491, in sub-regulatory guidance such as the IOM CMS Policy Benefit Manual Chapter 13, and in state Medicaid RHC program regulations shall be considered prior to:

a. Deciding to provide a new service;
b. Deciding to participate in or promote a community activity or event;
c. Advertising a new service or promoting an activity;
d. Development of a new website or social media site

3. **Proofing of signage, print advertising, web-site designs or social media sites:** All signage, advertising, web publishing or promotion materials shall be proofed and approved prior to publication by a member of the RHC administrative team who is familiar with RHC regulations as pertaining to public disclosure requirements and program compliance.

**Specific Procedures:** As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Policy #100- Organizational Structure & Ownership | Administrative Section |
| | HR Policies on Employee Social Media Use | HR Section |
| | | |

NIHD
RURAL HEALTH CLINIC

| Physical Plant Safety: General Policy | | |
|---|---|---|
| **J Tag References:J-0041 § References: 491.6** | **Policy Type:** Physical Plant and Environment | **Policy Number:** 200.0 |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Declaration:** This is the Physical Plant Safety: General Policy of (labeled as "Clinic" throughout this policy) the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to acknowledge and document compliance with state and local building, fire, and safety codes.

**Policy Statement:** It is the intention of the Clinic to remain in compliance with applicable regulations and codes which are related to the Clinic's physical plant.

**Policy Scope:** This policy is informational and regulatory in nature.

**Policy Body: Physical Plant Safety**

1. **General Design and Construction:** The Clinic design and construction accommodates patient care in a traditional layout suitable for a medical clinic. Historically, the design has proved adequate in space for the patient load. Construction, renovation, or remodeling of the clinic shall conform with local and state codes and shall be subject to appropriate permitting, inspection, and review. Any architectural changes shall be consistent with the use of the building as a Rural Health Clinic which provides medical services.

2. **Office of the State Fire Marshal:**

    a. The Clinic has submitted or will submit all necessary plans, drawings, photos, or building specification to the State office or agency, as applicable, to the construction, renovation, or normal operation of a Rural Health Clinic.
    b. The Clinic shall comply with any annual or periodic inspections or re-inspections required by the Office of State Fire Marshal.
    c. The Clinic shall comply with all requirements for fire safety equipment and fire prevention systems including, but not limited to, fire extinguishers, smoke alarms, sprinkler systems, exit ways and signage.

3. **Office of Public Health:**
    a. The Clinic shall comply with initial inspections required by the state's Office of Public Health or similar agencies which may include, but are not limited to,

sanitation inspections, inspections of the water supply/water quality or sewerage systems.

**b.** The Clinic shall comply with any subsequent re-inspections as required by law or regulation.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Office of State Fire Marshal Reports | |
| | Office of Public Health Inspection Report | |
| | Clinic Floor Plan and Drawings/ Photos | |
| | Other review documents | |

NIHD
RURAL HEALTH CLINIC

| Preventive and Required Maintenance | | |
|---|---|---|
| **J Tag References: J-0042, J-0043, J-0044**<br>**§ References: 491.6** | **Policy Type:** Physical Plant and Environment | **Policy Number:** 210.0 |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Declaration:** This is the Preventive and Required Maintenance Policy of (labeled as "Clinic" throughout this policy) the clinic.

The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to outline the procedures related to preventive and/or required maintenance.

**Policy Statement**: It is the intention of the Clinic to maintain all essential mechanical, electrical and patient care equipment in safe working order.

**Policy Scope**: This policy is informational and procedural in nature.

**Policy Body: Preventive Maintenance**

1. **Responsibility for Building Maintenance:** The Clinic building/suite is Owned under written agreement or arrangement with the Parent Entity.
   Maintenance and upkeep of the building, necessary to ensure that the RHC maintains an appropriate work space and safe environment, is provided under a contractual agreement, arrangement or clear understanding. Periodic maintenance and upkeep shall be scheduled at appropriate intervals.

2. **Essential Equipment Systems**: Periodic and preventive upkeep of essential mechanical electrical systems, and equipment used or accessed by patients is the responsibility of The Clinic shall notify the designated representative(s) of any suspected concerns or of malfunctions for essential systems which arise in between periodic servicing. Whenever a maintenance service has been contracted or provided under agreement, the Clinic shall notify the vendor or supplier when maintenance is required in between regular servicing. This policy shall apply to the maintenance of electrical and other utility supplies & systems, HVAC systems, elevators or any other essential equipment system.

3. **Biomedical and Equipment Used to Deliver Patient Care**
   a. The clinic shall maintain a service agreement or have an arrangement to routinely inspect and maintain equipment related to direct patient care, diagnostic procedures, or therapeutic procedures. The agreement or arrangement shall provide for:

i. An initial inspection of all bio-medical equipment shall be made in preparation for initial RHC certification.
ii. Regularly scheduled inspections shall be conducted at subsequent intervals which shall not exceed 12 months from the initial inspections (at least annually).
iii. The service provider shall be notified immediately of any suspected malfunction or operational concern of which the Clinic becomes aware so that immediate inspection and/or repair can be made.
iv. The biomedical equipment inspections are performed annually by Scott Stoner, Manager of Clinical Engineering.

**b.** The appropriate actions shall be taken to utilize provisions for warranties and manufacturer service agreements when applicable. Service technicians and vendors shall ensure that manufacturer's recommendations for operation and repair of equipment are followed and not voided.
**c.** A record of all inspections and repairs shall be maintained by the Clinic.
**d.** Service record of any type, essential equipment or biomedical equipment, shall be maintained.
**e.** The RHC's annual program evaluation shall include information on the maintenance of essential mechanical, electrical and patient care equipment.
**f.** The staff shall visually inspect the equipment during regular use or prior to point of care.
**g.** Any equipment suspected of having an operational or safety issue shall be taken out of service, marked as "DO NOT USE" until the equipment can be tested and repaired.
**h.** Equipment which has not been routinely serviced or which is not currently used shall be removed from the clinical areas of the building.
**i.** If essential equipment needed to provide any mandatory service become inoperable, the equipment shall be replaced immediately to prevent disruption of services.
**j.** Major disruptions in utility service or essential systems which could potentially require the need for emergency response shall be addressed in the RHC's Emergency Preparedness Plan.

**Specific Procedures:** As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Biomedical Equipment Service Agreements | Clinic Administrator |
| | Maintenance Records and/or Asset Lists/Repair Logs | Clinic Administrator |
| | Leases or Service Agreements | |
| | Parent Hospital Policy (if applicable) | |
| | EPP, if applicable | |

NIHD
RURAL HEALTH CLINIC

| Building Sanitation and Cleanliness | | |
|---|---|---|
| **J Tag References: J-0044**<br>**§ References: 491.6** | **Policy Type:** Physical Plant and Environment | **Policy Number:** 215.0 |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Declaration:** This is the Building Sanitation and Cleanliness Policy of the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to acknowledge and document compliance with state and federal regulations concerning building sanitation and cleanliness.

**Policy Statement**: It is the intention of the Clinic remain in compliance with applicable regulations and codes which are related to maintaining a clean and orderly environment for patients, employees and the public.

**Policy Scope**: This policy is informational and regulatory in nature.

**Policy Body: Sanitation and Cleanliness**

1. **Cleanliness of Food Storage and Dining Areas:** The Clinic shall keep all areas where food is stored, prepared or served neat and clean. Employees shall be informed during orientation or other on-the-job training of the procedures for maintaining clean and neat break rooms, meeting rooms and other common areas of the RHC.
    a. Employees are responsible for cleaning up after themselves and properly disposing of trash and leftover food in accordance with procedures implemented by the clinic;
    b. Employees may not eat or drink at work stations located in patient care area.
    c. Employees are responsible for food items they have placed in cabinets, refrigerators or on surfaces of common areas. Leftover food, partially eaten food, or food waste shall not be left in common areas of the clinic for more than a reasonable amount of time. Employees are responsible for disposing of or taking away leftover or opened and uneaten food items.
    d. Food items shall only be stored in designated areas, cabinets or refrigerators, which are labeled "Food Only".
    e. Employees shall be responsible for clearing surfaces (countertops, tables, microwave surfaces) of food debris, spills, crumbs, used paper products created from their own dining activities.
    f. The clinic shall use disposable paper goods and utensils in the serving or consuming of food items.
    g. Coffee pots, counter-top appliances, or stove-tops are allowable.

h. Trash or waste from areas where food has been consumed must be disposed of daily and taken to exterior garbage receptacles or bins.
i. No food items shall be consumed in patient care or treatment areas even if that area is the employee's regular work space.
j. Patients shall be discouraged from eating or drinking in the waiting room or other public areas of the clinic. Should an employee notice that food or drink has been consumed in these areas, the employee should dispose of the waste or notify the appropriate housekeeping staff whichever is most expediate.
k. Kitchen areas, breakrooms and other common areas shall be included in regular cleaning schedule of the clinic.

2. Pest (Vermin) Control Management: The Clinic shall make provisions for pest control management and treatment that is appropriate for the geographic location, climate, season and building structure type. Pest and vermin control management and treatment shall apply to both interior and exterior areas of the clinic and to any outbuildings or storage sheds. Pest control management shall be provided by service contract or arrangement either periodically or as needed.
    a. Employees shall be notified in advance of scheduled pest treatment spraying. Such disclosure shall be consistent with state requirements for notifying employees of chemical and insecticide use in the workplace.
    b. Employees shall notify the clinic manager or clinic administrator if they see or suspect insect infestation inside (cockroaches, ants, mice, etc.) or outside (ants, wasps, bees, termites, etc.) of the clinic.
    c. Providers shall immediately notify the clinic manager or clinic administrator if they treat a patient for an insect or parasite-related conditions (lice, bedbugs, or scabies, for example) which might require special cleaning or treating of an area occupied by the patient and/or family members. The manager in cooperation with the clinical staff shall implement actions to detect, control and limit exposure and the spread of disease. The medical staff shall determine if specific medical management polices are needed in situations of outbreaks of infestation within the community.
    d. Caution should be exercised by pest control contractors, maintenance workers, and employees to ensure that the safest possible environment is maintained during extermination and other deployment of pest management services.

3. Maintaining a Clean Environment During Renovation/Remodeling: The Clinic shall maintain a clean and orderly environment during renovation or construction projects. When such projects require active construction, access to the area shall be restricted with caution or warning signs. Employees and patients shall be given written instructions on alternative entrances and routes throughout the building. Debris, construction waste, old carpeting or wall coverings and trash shall be disposed of according to local and state guidelines. Remedial construction to remove mold, asbestos or other hazards shall be performed by licensed contractors who are recognized by the city or state. Any building renovation or remodeling shall be subject to federal, state or local requirements that apply to the RHC. The state rural health office, the state department of health (if the RHC is licensed) and the CMS MAC shall be informed of changes in address or in the original certified space, as is applicable.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Medical Waste Disposal Agreement/Policy | |
| | Pest Control Service Agreement | |
| | Clinic Cleaning Schedule | |
| | Pest Control Notice to Employees, if applicable | |

NIHD
RURAL HEALTH CLINIC

| Storage, Handling & Administration of Drugs, Biologicals, and Pharmaceuticals | | |
|---|---|---|
| **J Tag References:** **J-0043, J-0125** **§ References:** **491.6, 491.9, 491.12** | **Policy Type:** Physical Plant and Environment | **Policy Number: 220.0** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Declaration:** This is the Storage, Handling & Administration of Drugs, Biologicals, and Pharmaceuticals Policy of the clinic.
The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to outline the procedures related to the storage and handling of drugs, biological and pharmaceuticals.

**Policy Statement**: It is the intention of the Clinic to ensure that drugs, biological, and pharmaceuticals are stored, handled and administered in a manner that safeguards the products and controls usage.

**Policy Scope**: This policy is informational and procedural in nature.

**Policy Body: Storage, Handling and Administration of Drugs, Biologicals, and Pharmaceuticals**

1. **General Storage and Handling Guidelines:**

   a. Drugs, biological and other pharmaceuticals shall be ordered, received, stored retrieved, and administered by authorized clinic employees only.
   b. The storage of drugs, and specifically DEA scheduled drugs, shall be secured according to federal and state laws.
   c. The clinic shall designate authorized clinical staff to monitor, handle, and administer drugs and biologicals.
   d. Drug storage shall be located in an area which prevents unmonitored or unauthorized access. Authorized staff should be able to continuously monitor storage areas.
   e. All drugs, biological, and other pharmaceuticals, including sample medications, shall be stored in a secure area or areas that have secure, controlled access.
   f. Unsecured drugs or biologicals shall be in the custody of an authorized individual at all times. If a medication cart is used, for example for immunizations, the cart shall be remain under the control of an authorized individual at all times.
   g. All drugs shall be stored in their original containers with legible labeling.
   h. All drugs shall be stored according to the specific environmental conditions (temperature, lighting, humidity, etc.) as labeled by the FDA or as recommended by the U.S. Pharmacopeia (USP) requirements. If it is unclear how to correctly

store a drug, biological or pharmaceutical or if the original insert is unavailable, the clinic shall contact the manufacturer, the distributor or otherwise access the USP database via a pharmacy or other third-party.

i. If the clinic is unable to determine if a drug has been stored or handled correctly, the clinic should use caution and err on the side of caution by not using or administering the substance.

j. Multiple-Dose Vials must not be stored in areas of immediate patient care. Multi-dose vials must be dated with first-opened date and discard date. The discard date must not be later than 28 days after the first-opened date.

k. Single-dose vials must be for single patient, single use only.

l. Any emergency drug cart or case should be secured to prevent tampering or unauthorized access.

m. Portable Oxygen tanks should be secured via cart, chains, or crate and have appropriate tubing and masks immediately available for use.

n. All Scheduled drugs shall be accounted for when purchased, received, stocked, administered or disposed.

o. All drugs and biologicals shall be inventoried for expiration dates (beyond use dates) on a monthly basis by a designated staff member, usually a member of the nursing staff or medical assistant. The Clinic Manager shall periodically spot check the supply area to ensure compliance.

p. All medications shall be labeled with an open and discard date when applicable.

q. Any expired, deteriorated, or adulterated drugs shall be stored separately to prevent use and shall be discarded following the appropriate method as set forth by state and federal laws, regulations, and guidelines.

r. The Clinic shall have current drug references and antidote information available. Employees shall be trained on how to access and use these resources.

2. Compounding of Drugs: The clinic shall only prepare solutions that are common in a medical office. Solutions shall be mixed by qualified clinical staff who have been trained, are knowledgeable, and who are within their scope of practice to perform the task. Solutes shall only be mixed according to the package insert using the correct solvent. In no case, should a substitute solvent be used to create the solution.

3. **Administration of Drugs**

   a. Use of Patient Identifiers: The clinic shall use acceptable patient identifiers to confirm that the patient name, the order, and the selected drug are in agreement prior to administration. The clinic has selected the patient's name and date of birth to be the two unique patient identifiers.

   b. The Six Rights: All staff who are responsible for medication administration shall follow the "Six rights" to ensure accurate administration of drugs.

      1. Right Patient
      2. Right Medication
      3. Right Dose
      4. Right Route
      5. Right Time
      6. Right Documentation

   c. Clarification of Orders Prior to Administration: If the clinic staff has questions or concerns about a medication order, the employee shall ask the ordering provider for clarification prior to administration.

4. Drugs and Products Requiring Refrigeration
   a. All products requiring refrigeration will be kept in refrigerators that are monitored daily for temperature control. Temperatures should be logged at least twice a day using a temperature monitoring device. Purpose-built refrigerators are preferred. The use of dorm-style or mini-refrigerators will be prohibited. Household refrigerators may be used if the freezer and refrigerator compartments have separate doors which seal completely. Single door units should not be used for medication or vaccine storage. The freezer section of a household refrigerator should not be used for storage of frozen vaccines.
   b. A purpose-built freezer storage unit shall be used for frozen vaccines.
   c. Drugs shall be stored at the manufacturer's recommended temperature as found in the FDA package insert and labeling.
   d. No food items or personal items will be stored in the same refrigerator(s) as drugs, biological, and pharmaceuticals.
   e. Refrigerators that are used for drug storage will be marked with signs:
      1. No Food
      2. Do Not Unplug
   f. Only one refrigerator or freezer unit shall be plugged into each receptible. Breaker boxes should be marked with a sign warning about drug storage if the power is disconnected.
   g. Refrigerators used for food or personal items shall be marked "No Drugs":
   h. Drugs should be centrally stored in the refrigerator with appropriate space observed between the top, bottom and sides of the unit. No drugs or biological shall be stored in the door areas or bottom crisper units of the refrigerator. The door areas will be stocked with ice packs or water bottles to prevent use of the door areas and to help maintain constant temperature control. The placeholder bottles should be marked as "Do Not Drink". The door areas of the freezer section of any refrigerator will be stocked with ice packs or frozen water bottles.

5. Vaccines (VFC and Private Stock):
   a. Private stock vaccines and vaccines that are provided through the ***Vaccines for Children*** program shall be stored separately on open shelves or open bins. Each vaccine should be clearly identified and marked by type of vaccine and type of stock.
   b. Thermometers shall be used to monitor storage temperatures as required by the program and per best practices. The CDC recommends the use of a temperature monitoring devise (TMD) with a digital data logger (DDL).
   c. Vaccines will be inventoried periodically for the purpose of maintaining appropriate levels of stock and for reconciling usage as needed. All state requirements for inventory rotation, monitoring, and reordering shall be followed.
   d. Vaccines will be checked for expiration dates on a regular basis. VFC guidelines shall be followed for reporting vaccines which are received with short expiration dates and for returning vaccines under program guidelines.
   e. All other terms and conditions of the VFC program will be observed. This includes reporting of immunization administration, recordkeeping and exception reporting.

6. Patient-Supplied/Third-party supplied Drugs: The clinic does not store, handle or administer patient or third-party supplied drugs and biologicals. Exceptions may include immunotherapy (allergy shots) vials received from a known Allergist or ENT provider.

7. **Controlled Substances, Scheduled Drugs:** If the clinic chooses to stock, distribute or administers controlled substances even in limited amounts, the federal DEA diversion and state pharmacy board regulations for secure storage, administration and recordkeeping shall be strictly followed.

8. **Sample Drug Distribution:** The following procedures apply if sample medications are dispensed to patients.
    a. Sample drugs shall be received, stored and managed in a secure manner.
    b. Sample drugs which are distributed to patients should be logged with the following information:
        1. Patient Name
        2. Date dispensed
        3. Name of Drug
        4. Dosage
        5. Lot Number of Drug
        6. Quantity Given (# of samples)
    a. Sample medications will only be dispensed to a patient if the product:
        1. Is in the original tamper-proof packaging;
        2. Is clearly labeled;
    b. If the clinic becomes aware of a recall, the log shall be reviewed. Patients affected by the recall will be notified.

9. **Loss of Power:** In the event of loss of electricity or a malfunction of a refrigerator, the specific emergency preparedness plan shall be activated. In the event that an alternative action is taken, one or more of these procedures shall be followed:
    a. Move the drugs and biological to temporary coolers or ice chests using the frozen water bottles and ice to maintain the proper temperature.
    b. The clinic administrator or provider on-site will be responsible for moving the drugs to an alternate location with a back-up power supply or generator. The clinic administrator or provider on-site will maintain custody of the drugs during the transport and alternate storage periods.
    c. The clinic has made the following arrangements for being notified of power outages which may occur outside of normal operating hours.

**Specific Procedures:** As described in the body of the policy.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | **Patient-Supplied Drug Policy** | |
| | **Sample Medication Log Sheet** | |
| | **Correspondence with Energy Providers** | |
| | **Emergency Preparedness Plans** | |
| | **Drug Medication Error Poster** | |

NIHD
RURAL HEALTH CLINIC

| Blood Borne Pathogens: Exposure Control (Including Needle Sticks) | | |
|---|---|---|
| **J Tag References:** **J-0040** **§ References: 491.6** **Other References:** | **Policy Type: Physical Plant and Environment** | ***Policy Number: 230.0*** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Declaration:** This is the Blood Borne Pathogens: Exposure Control Policy of the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purposes of this policy are to clearly outline the immediate steps that should be taken if an employee is exposed to blood-borne pathogens and biohazards in the workplace.

**Policy Statement**: The clinic has a high regard for the health and safety of its employees and, in particularly, in those incidents when those occupational hazards might also create a situation in which employees may be at risk of exposure of blood-borne pathogens. The intent is to safeguard employees from occupational hazards in compliance with federal and state laws and regulations.

**Policy Scope**: This policy is informational, procedural and regulatory in nature.

**Policy Body: Blood Borne Pathogen Exposure Control**

1. **Exposure Control Administration**: The Clinic Administrator shall be responsible for:
   a. Identifying the exposure risk of an employee by job description;
   b. Notifying the clinic employees of potential exposure risks and safeguards and providing training on exposure control;
   c. Providing proper labeling of bio-hazardous materials and storage areas;
   d. Providing Personal Protection Equipment;
   e. Maintaining a cleaning schedule;
   f. Offering Hepatitis B vaccination to all employees at risk of exposure free of charge;
   g. Providing post-exposure examination and follow-up including a medical record outlining the treatment;
   h. Maintaining records of exposure incidents and other documentation as needed.
   i. Conducting a post-exposure evaluation of exposure incidents.

2. **Biohazardous Materials:** Bio-hazardous Materials, as defined by OSHA, include:
   a. Human Blood
   b. Semen
   c. Vaginal Secretions
   d. Cerebrospinal Fluid
   e. Synovial Fluid
   f. Plural Fluid
   g. Pericardial Fluid

h. Amniotic Fluid
i. Saliva
j. Other body fluids that are contaminated with blood or situations in which it is impossible to differentiate between fluids.

3. **Personal Protection Equipment**: The Clinic shall supply and make available appropriate personal protection equipment (PPE), such as gloves, masks, gowns, or facial protection as needed to prevent or limit exposure to biohazards during the performance of job tasks.

4. **Prevention of Accidental Needle Sticks**: The incidence of accidental needle sticks can be prevented and/or greatly reduced by several simple procedures, which include:
   a. Proper sharps disposal;
   b. Never recapping needles;
   c. The provision and use of PPE (personal protection equipment);
   d. Staff education on the risks of transmission;
   e. Staff education on the techniques and methods.

5. **Immediate First Aid Procedures:** In the event of an accidental needle stick or other biohazard exposure, the following actions should be taken immediately by the employee. If the employee needs help in performing these tasks, he or she shall ask a supervisor or co-worker to assist. PPE should be worn and all efforts to minimize additional exposure or contamination should be exercised. The immediate steps should include:
   a. Wash needle sticks and cuts with soap and water;
   b. Flush splashes to the nose, mouth, or skin with water;
   c. Irrigate eyes with clean water, saline, or sterile irrigates;
   d. Report the incident to your supervisor;
   e. Immediately seek medical treatment;
   f. If you have questions about appropriate medical treatment for occupational exposures, 24 hour assistance is available from the Clinicians' Post Exposure Prophylaxis Hotline (PEPline) at **1-888-448-4911**.

6. **Diagnostic Testing and Prophylaxis Treatment Guidelines:** The clinic follows all recommendations of the CDC for the management of accidental exposure to blood-borne pathogens. Resources and best practices can be located at cdc.gov/niosh/topics/bbp/guidelines.html.

7. ***Subsequent Testing and Treatment**: The* subsequent ordering of diagnostic testing and treatment shall be the direct responsibility of the clinic administrator, or in the absence of the clinic administrator, the direct responsibility of the supervising healthcare provider. The clinic may refer additional treatment of the exposed individual to a specialty healthcare provider.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures.***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Cleaning Schedule | |
| | Updated U.S. Public Health Service Guidelines (referenced above) or OSHA for Medical Practices Guide | |

NIHD
RURAL HEALTH CLINIC

| Infection Control Policy | | |
|---|---|---|
| **J Tag References: J-0040 § References: 491.6** | **Policy Type: Physical Plant and Environment** | ***Policy Number: 235.0*** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Declaration:** This is the Infection Control Policy of the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.
**Policy Purpose:** The purposes of this policy are to clearly outline the procedures which shall be taken to protect patients and employees from infections and communicable diseases.

**Policy Statement:** The clinic has a high regard for the health and safety of its patients and employees in regard to preventing the spread of infectious disease.

**Policy Scope**: This policy is informational, procedural and regulatory in nature.

**Policy Body: Infection Control Policy**

1. **Hand washing**: Hand washing is an essential means of preventing the spread of disease. Employees and clinical staff shall thoroughly wash their hands with an antibacterial soap and water ***or*** use an alcohol-based sanitizer in the following situations:
   a. Before examining or performing a procedure on a patient
   b. After examining or performing a procedure on a patient
   c. Before and after eating
   d. After using the toilet
   e. Before and after Handling contact lens or other personal health devices
   f. Any other situation or activity in which exposure or contamination could have occurred

2. **PPE:** PPE--including gloves, masks, and gowns--shall be used in all clinical situation where the judgment of the clinician and according to best practices it is necessary to prevent exposure or contamination by blood or airborne particles.

3. **Blood-Borne Pathogens:** Refer to the Blood- Borne Pathogen Policy for more specific guidelines and procedures.

4. **Communicable Diseases:**
   a. The Clinic shall ensure that all employees have been or shall be appropriately screened for communicable diseases as required by federal, state or local law.
   b. The Clinic shall report incidents of communicable diseases as required by federal, state, or local law.
   c. The Clinic shall use universal and standard precautions when treating patients who are known or suspected of being infected with a communicable disease.

5. **Universal and Standard Precautions:**
   a. Blood and body fluid precautions are used with every patient and specimen.
   b. Disease-specific precautions are used as indicated.
   c. Gloves are used when touching body fluids and non-intact skin of all patients.
   d. Gloves are used when handling items and surfaces which have been soiled with blood or body fluids.
   e. Sharps are handled with great care and are disposed of in tamper-proof containers which are secured.
   f. Mouthpieces or bags for use during emergency mouth-to-mouth resuscitation are available.
   g. Employees with open skin lesions or open wounds refrain from patient care.

6. **Clean and Dirty Areas**: The Clinic maintains clearly marked areas to separate Clean and Dirty equipment and/or instruments. The providers and nursing staff ensure that the path used when transporting contaminated/dirty supplies or instruments minimized the chance of cross-contaminating clean areas or surfaces.

7. **Cleaning Between Patients:** The exam rooms or treatment areas shall be cleaned after each patient use. Staff shall be trained on proper methods for disinfection of surfaces.
   a. Soiled or used disposable items are properly discarded and replaced.
   b. Medical waste is properly discarded.
   c. Hard surfaces are disinfected or decontaminated following the wet and dry times per the manufacturer's directions for disinfecting.
   d. Dirty instruments are properly handled, stored, and cleaned.
   e. Any spills are properly handled and the effected surfaces cleaned and disinfected.

8. **Contaminated Clothing or Fabric Items**: If an employee's clothing or any other fabric item is contaminated, the items shall be placed in a red bag for disposal or until such time that complete decontamination can be properly performed.

**Specific Procedures**: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**
***Please refer to these other related policies or attachments for more specific information or procedures.***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Blood Borne Pathogen Policy | |
| | Housekeeping Policy | |

NIHD
RURAL HEALTH CLINIC

| Disinfection and Sterilization Policy | | |
|---|---|---|
| **J Tag References:**<br>**J-0040**<br>**§ References: 491.6**<br>**Other References:** | **Policy Type: Physical Plant and Environment** | ***Policy Number: 238.0*** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Declaration:** This is the clinic's disinfection and Sterilization Policy. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purposes of this policy are to clearly outline the procedures which shall be taken to disinfect and sterilize equipment, supplies, instruments, and surfaces.

**Policy Statement**: The clinic has a high regard for the health and safety of its patients and employees in regard to the spread of infectious disease.

**Policy Scope**: This policy is informational, procedural and regulatory in nature.

**Policy Body: Disinfection and Sterilization**

1. **Sterile Instruments and Supplies**: The Clinic does not perform sterilization of medical instruments or reusable medical devices or supplies on-site.
    a. **Disposable, Single Use Items**
        i. All sterile supplies, trays and kits shall be purchased in a prepackaged and disposable form from a reputable medical supply company.
        ii. The integrity of the item (package condition, expiration date and appearance) shall be verified prior to use.
        iii. Sterile single use items shall not be reused.
        iv. After single use, disposable supplies or trays shall be disposed of in the appropriate manner.

    b. **Receiving and Using Instruments that are processed off-site**
        i. Should supplies or instruments be sent to an outside source for sterile processing, the items shall be packaged appropriately in sealed pouches using appropriate methods of disinfection and sterilization.
        ii. The integrity of the items is validated:
            1. at the time there are received back into the clinic, and
            2. prior to patient care use
        iii. Should a problem with the item be detected (pouch condition, expiration, chemical marker, position of instrument), the item will not be used for patient care. It shall be returned to the off-site processing department for reprocessing.
    c. Dirty instruments shall be handled and transported to the designated dirty area in a manner which prevents contamination of other areas.

2. Handling and Pretreating of Instruments After Use: When dirty instruments are to be returned to the off-site location for sterile processing the following procedures should be followed.
    a. Dirty items shall be transported to a designated dirty area within the clinic. Care shall be taken to prevent contamination during transport.
    b. Appropriate PPE shall be used by staff during the handling of instruments and when using or mixing solutions.
    c. If the instruments are to be pre-treated or soaked prior to pick-up by the off-site processing department, follow the instructions for mixing the cleaning solution making sure that the product is used according to manufacturer's directions.
    d. Hinged instruments should be soaked in the open position when possible.
    e. Follow the manufacturer's directions on how long to soak or rinse the instruments.
    f. Follow the off-site sterile processing department's specific procedures for pretreating the instruments.

3. Transporting of Instruments to the Sterile Processing Location
    a. Pretreated or dirty instruments should be transported in an appropriate container with a securely fitting lid.
    b. The container should be clearly marked as a containing biohazardous material.

4. Disinfection of Surfaces and Non-Submersible Equipment: The following procedures shall be used to disinfect surfaces and non-submersible equipment.
    **a.** A hospital-grade sanitizer/disinfectant/viricide will be diluted per the manufacturer's recommendation, placed in clearly labeled spray bottles or containers and stored appropriately. Wipes which contain a hospital-grade sanitizer/disinfectant/viricide may be used when appropriate for the surface being cleaned.
    **b.** Other surfaces, equipment, furniture and fixtures shall be cleaned periodically, and as needed, in accordance with all manufacturers' directions for optimal cleaning.
    **c.** Upholstered furnishings (exam tables, side chairs, exam stools, etc.) shall not have rips or tears which could compromise disinfection.
    **d.** Toys shall only be present areas accessible to patients and visitors when the items can be adequately cleaned between patient use.

5. Cleaning Solutions and Trays: Any trays or containers which have been filled with disinfecting cleaning solution shall include information or dates which clearly state when the solutions should be replaced or refilled.

6. Reusable DME and Supplies: Any durable medical equipment (wheel chairs, walkers, crutches, etc.) or supplies which may be reused by multiple patients shall be labeled as either clean or dirty to alert staff of the condition of the item

7. Third-Party Cleaning Services: The section of this policy pertaining to the disinfection of surfaces shall be discussed with any third-party cleaning service to ensure the procedures are understood and followed.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures.***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | **Blood Borne Pathogen Policy** | |
| | **Infection Control Policy** | |
| | **Cleaning Service Agreement** | |
| | **Cleaning Schedule** | |
| | **Recipe for mixing solutions** | |

NIHD
RURAL HEALTH CLINIC

| Accidental Needle Sticks | | |
|---|---|---|
| **J Tag References:**<br>**J-0161**<br>**§ References: 491.6** | **Policy Type: Physical Plant and Environment** | **Policy Number: 240.0** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Declaration:** This is the Accidental Needle Sticks Policy of the Clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purposes of this policy are to clearly outline the immediate steps that should be taken if an employee is exposed to an accidental needle stick.

**Policy Statement:** The Clinic has a high regard for the health and safety of its employees and, in particularly, in those incidents when those occupational hazards might also create a situation in which employee or other individual may be at risk to the exposure of blood-borne pathogens through accidental needle stick.

**Policy Scope:** This policy is informational and procedural in nature.

**Policy Body:** **Accidental Needle Sticks**

1. **Prevention of Accidental Needle Sticks**: The incidence of Accidental needle sticks can be prevented and/or greatly reduced by several simple procedures, which include:
    a. Proper sharps disposal;
    b. Never recapping needles;
    c. The provision and use of PPE (personal protection equipment);
    d. Staff education on the risks of transmission;
    e. Staff education on the techniques and methods.

2. **Immediate First Aid Procedures:** In the event of an accidental needle stick, the following actions should be taken immediately by the employee. If the employee needs help in performing these tasks, he or she shall ask a supervisor or co-worker to assist. PPE should be worn and all efforts to minimize additional exposure or contamination should be exercised. The immediate steps are:

    a. Wash needle sticks and cuts with soap and water;
    b. Flush splashes to the nose, mouth, or skin with water;
    c. Irrigate eyes with clean water, saline, or sterile irrigates;
    d. Report the incident to your supervisor or provider on duty;
    e. Immediately seek medical treatment;

f. If you have questions about appropriate medical treatment for occupational exposures, 24-hour assistance is available from the Clinicians' Post Exposure Prophylaxis Hotline (PEPline) at **1-888-448-4911**.

3. **Diagnostic Testing and Prophylaxis Treatment Guidelines:** The Clinic follows all recommendations of the CDC for the management of accidental exposure to blood-borne pathogens. The following publications, or a similar publication, will be used if needed for as written references:

   a. ***Updated U.S. Public Health Service Guidelines for the Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis, 9/25/2013 Update (May 23, 2018) which can be found at*** https://stacks.cdc.gov/view/cdc/20711 ***and;***

   b. ***Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis, MMWR Recommendations and Reports, Volume 50, Number RR-11 which can be found at*** http://www.cdc.gov/mmwr/PDF/rr/rr5011.pdf

4. ***Subsequent Testing and Treatment****: The* subsequent ordering of diagnostic testing shall be the direct responsibility of the clinic administrator, or in the absence of the clinic administrator, the direct responsibility of the supervising healthcare provider. The clinic may refer additional treatment of the exposed individual to a specialty healthcare provider.

**Specific Procedures:** As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**
***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Blood Borne Pathogen Policy | |
| | Infection Control Policy | |
| | | |
| | | |

NIHD
RURAL HEALTH CLINIC

| Medical Waste Handling and Disposal | | |
|---|---|---|
| **J Tag References: J-0040, J-0044 § References: 491.6.** | **Policy Type:** Physical Plant and Environment | ***Policy Number: 250.0*** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Declaration:** This is the Medical Waste Handling and Disposal Policy of the Clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to provide information about the disposal of bio-hazardous and medical waste.

**Policy Statement**: The Clinic is committed to the appropriate disposal of potentially infectious or bio-hazardous waste (Regulated Medical Waste) in accordance with federal, state and local laws.

**Policy Scope**: This policy is informational, procedural and regulatory in nature.

**Policy Body: Medical Waste Handling and Disposal**

1. **Trash Receptacles:** All trash receptacles in patient care areas shall be equipped with lids.

2. **Red Bags:** Regulated Medical Waste (soft waste) shall be discarded into containers with closable, puncture-proof, leak-resistant red bags.
   a. Receptacles for medical waste which are located in patient treatment areas shall be equipped with lids. The receptacles shall be red in color and/or marked as containing medical waste.
   b. Medical waste shall be removed from the patient care or treatment area as soon after the performance of a procedure as is practical and placed in the secondary storage area.
   c. Secondary containers for medical waste shall be located in areas with secure access away from patient care areas. The containers are marked as bio-hazardous waste.
   d. Medical waste shall not be stored in areas where clean medical supplies are stored.
   e. Red bags and other waste containers are provided through the service vendor under agreement.

3. Sharps Containers: Contaminated needles are discarded in closable, puncture-resistant, leak-resistant containers which are labeled as bio-hazardous. The containers are emptied or replaced when the manufacturer-placed indicator is reached. Containers shall be placed at an appropriate height and be out of reach of children. Containers

should be mounted and secured. Containers shall be dated if the state regulations require them to be discarded based on duration of use and not full status.

4. **PPE and Disposable Items:** Providers and clinical staff shall use PPE, as needed, to protect themselves from exposure to contaminated equipment and exposure to body fluids. Contaminated PPE (gloves, masks, gowns) and disposable laundry items (gowns, drapes, sheets) shall be discarded in red bags

5. **Disposal of Bio-Hazardous Waste**: The off-site disposal of Regulated Medical Waste is performed under a service agreement with a third-party which is compliant with federal, state and local laws pertaining to medical waste management. The agreement covers the disposal of sharps and red bag waste. The service provider makes routine, scheduled pick-ups of regulated medical waste and is available as needed for additional services. The Clinic's agreement for waste disposal is currently with MediWaste.

**Specific Procedures:** As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**
***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Agreement for Medical Waste Disposal | |
| | | |

NIHD
RURAL HEALTH CLINIC

| Hazardous Materials | | |
|---|---|---|
| **J Tag References: J-0040, J-0044 § References: 491.6.** | **Policy Type:** Physical Plant and Environment | ***Policy Number: 260.0*** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Declaration:** This is the Hazardous Materials Policy of the Clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to provide information about the presence and use of hazardous and/or chemical materials in the workplace.

**Policy Statement**: The Clinic seeks: 1) to provide employees and third-parties with information about materials and chemicals which might be hazardous; 2) to define precautions for handling and using these substances; and 3) to outline procedures to be followed in the event of exposure to these substances. Furthermore, it is the intent to comply with federal, state, and local laws which regulate hazardous materials, as applicable.

**Policy Scope**: This policy is informational, procedural and regulatory in nature.

**Policy Body: Hazardous Chemicals and Materials**

1. **Definition:** According to the Department of Labor, Occupational Health and Safety Administration (OSHA), hazardous and toxic substances are defined as those chemicals present in the workplace which are capable of causing harm. The link to the OSHA web page can be found here: *https://www.osha.gov/SLTC/hazardoustoxicsubstances/*

2. **Identification of Hazardous Chemicals and Materials:** The clinic administrator or manager is responsible for identifying these substances in the workplace. A master list of materials is found in the SDS notebook. (See #3.)

3. **Safety Data Sheets**:
   a. The Clinic shall maintain Safety Data Sheets on all potentially hazardous and toxic materials including those used in or for:
      i. Procedures and Treatments as part of patient care
      ii. Cleaning and Disinfecting of skin
      iii. Cleaning and Disinfecting of the clinic surfaces
      iv. Cleaning and Disinfecting of equipment, instruments, and reusable supplies
      v. Cleaning and Disinfecting of air or water, if applicable
      vi. Operation of office and clinical equipment
   b. The SDS Sheets contain information about precautions, exposure risks, and first aid measures for each substance in the clinic.

c. The SDS sheets shall be organized in a notebook and assessable to all employees. The notebook includes a master list of materials. Alternatively, the sheet may be available electronically as long as all employees know how to locate and access the data sheets.
d. The employees have been in-serviced on the location and use of SDS sheets.

4. **Patient Care and Public Areas**: Care shall be taken to restrict the presence of hazardous chemicals and toxic materials in the patient care or common areas of the Clinic. Soaps, cleansers, or other products required for hand-washing or hygiene which may be located in these areas shall be in the original packaging and are clearly labeled.

5. Storage and Handling of Chemical or Hazardous Materials: The following procedures shall be followed in respect to toxic and chemical products.

   a. The products shall be stored in a secure area away from direct patient access.
   b. The products shall be stored in original packaging and clearly labeled.
   c. Employees shall be instructed on the appropriate use of products that are required for the performance of their job duties.
   d. Proper PPE (personal protection equipment) shall be used, when indicated, by individuals handling these products.
   e. New products shall be added to the master list and the MSDS data shall be updated.

6. Eye Wash Station: The clinic maintains an eye wash station. Employees have been in-serviced on the location of the eye wash station. The MSDS notebook is located within proximity of the station.

7. Blood Spill Kit: The Clinic shall have a blood spill kit on the premises.

8. Accidental Exposure or Misuse: In the event of exposure to a chemical or hazard material, an employee should:

   a. Remove patients and employees from the area a spill has occurred. Take precautions to further exposure.
   b. Notify the Clinic Administrator or provider on-site of the incident.
   c. Consult the SDS sheet for the first aid instructions related to the product or substance. A co-worker or supervisor should assist with this step if the employee is impaired due to the exposure.
   d. Seek further medical treatment if indicated.
   e. Consult or contact local, county/parish, or state agencies, if necessary.
   f. Document the incident in the clinic records.
   g. Conduct a post-exposure evaluation to determine how future incidents of like-kind could be prevented. Re-train employees or revise policies as needed.

**Specific Procedures:** As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | SDS Notebook | |
| | Employee Training Records | |

NIHD
RURAL HEALTH CLINIC

| Smoke-Free Workplace | | |
|---|---|---|
| **J Tag References: J-0040, J-0044 § References: 491.6, 491.9** | **Policy Type:** Physical Plant and Environment | ***Policy Number:*** *270.0* |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Declaration:** This is the Smoke-Free Workplace Policy of the Clinic. The Clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to reinforce the position of maintaining a smoke-free workplace.

**Policy Statement**: The Clinic acknowledges state and local laws, as applicable, which mandate that a healthcare facility be a smoke-free workplace. Furthermore, the Clinic seeks to reinforce the health benefits of not smoking or using tobacco products to its patients and employees.

**Policy Scope**: This policy is both informational and procedural in nature.

**Policy Body: Tobacco Free/Smoke-Free Workplace**

1. **Designation as Smoke-Free Workplace:** The clinic is a tobacco free/smoke-free workplace.
   a. Cigarette or cigar smoking, as well as pipe use, within the clinic building is prohibited.
   b. The use of e-cigarettes or vapors is also prohibited.
   c. This policy applies to employees, patients, and the general public.
   d. International NO SMOKING signs shall be posted.
   e. Tobacco use in clinic-owned vehicles or auxiliary buildings is also prohibited.

2. **Designated Smoking Areas**: The Clinic Administrator may choose to designate smoking areas outside of the clinic away from the main entrance. The designation of smoking areas is discretionary and subject to state and local ordinances. Smoking areas must be away from main entrances and handicapped access areas.

3. **Use of Other Tobacco Products:** The use of smokeless tobacco products is also prohibited on the Clinic premises.

4. **Smoking Cessation Counseling and Assistance:** The Clinic shall offer smoking cessation counseling and assistance to patients and employees who wish to stop smoking. The services may be billable, covered services under some health plans.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | | |
| | | |

NIHD
RURAL HEALTH CLINIC

| Fire Safety, Training and Evacuation | | |
|---|---|---|
| **J Tag References:**<br>**J-0040**<br>**§ References: 491.6** | **Policy Type:** Physical Plant and Environment | ***Policy Number: 280.0*** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Declaration:** This is the Fire Safety, Training and Evacuation Policy of the Clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to reduce to writing the policies and procedures related to fire safety, employee training, and evacuation.

**Policy Statement**: The Clinic assures the safety of its patients and employees by having policies and procedures in place for fire safety and fire emergencies.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: Fire Safety, Training, and Evacuation**

1. **Fire Safety:** The Clinic follows measures in place to assure the safety of its patients and employees in a fire emergency.
   a. The Clinic shall be equipped with ABC rated fire extinguishers that are in working order and which are regularly inspected and tagged. Fire extinguishers shall be mounted in the building as either required by the total square footage of building or by local or state regulation.
   b. The Clinic shall be subject to any required initial and on-going inspections by the Office of the State Fire Marshal. Any deficiencies shall be corrected promptly.
   c. The Clinic shall maintain unblocked/unlocked access to all exterior doors.
   d. The Clinic must have at least two exterior doorways which are accessible to all persons.
   e. Designated fire exits shall not pass through a mechanical room or a kitchen with a heat source.
   f. The Clinic shall maintain a smoke-free environment.

2. **Employee Training**: Employees shall receive training on fire safety.
   a. Employees shall be trained in the proper use of a fire extinguisher using the acronym, PASS: Pull, Aim, Squeeze and Sweep.
   b. Employees shall be trained in rescue procedures using the acronym, RACE: Rescue, Alarm, Contain, Evacuate or Extinguish.
   c. The Clinic shall perform fire drills periodically.
   d. The Clinic shall maintain records of training which are updated at least annually.
   e. Floor Plans are posted in each hallway of the Clinic with evacuation routes marked.

3. **Evacuation**: The following procedures shall be in place if a fire emergency occurs. The staff shall follow the steps in the RACE acronym.
    i. Rescue or remove any patients from immediate danger.
    ii. Alarm emergency officials and occupants that a fire emergency is present.
        1. Notify others in the building.
        2. Call 911.
    iii. Obtain a headcount of all persons in the building prior to evacuation.
    iv. Contain the fire by closing doors or taking other precautions.
    v. Evacuate patients and other individuals using the closest evacuation route away from the fire location.
    vi. Attempt to extinguish the fire ONLY after all persons are removed from the building and IF it is safe to attempt.
    vii. Use the acronym PASS when using a fire extinguisher.
    viii. Gather occupants outside at a designated meeting safe spot and take a second headcount.
    ix. Follow all directions and instructions given by local law enforcement and fire department personnel concerning management of the evacuation including when to re-enter the building.

**Specific Procedures:** As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**
***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Clinic Evacuation Route Floor plan | |
| | Office of Fire Marshal inspection reports | |
| | Disaster Training Logs | |
| | Employee Training Records | |

NIHD
RURAL HEALTH CLINIC

| Severe Weather and External Disaster Policy | | |
|---|---|---|
| **J Tag References:** **J-0040** **§ References: 491.6, 491.12** | **Policy Type:** Physical Plant and Environment | ***Policy Number:*** *290.0* |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Declaration:** This is the Severe Weather and External Disaster Policy of the Clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Purpose:** The purpose of this policy is to provide information about how to handle non-medical emergencies or conditions which threaten the safety of employees or patients as related to severe weather conditions.

**Policy Statement**: The Clinic is committed to protecting and safeguarding the wellbeing of our patients and staff during a weather-related emergency.

**Policy Scope**: This policy is informational and procedural in nature.

**Policy Body: Severe Weather and External Disaster Emergencies**

1. **Severe Weather Definition**: This policy applies to unexpected or severe weather conditions or natural disasters which pose a potential threat to the safety and health of individuals in our community and service area. These conditions may include:
   - Wild Fire
   - Earthquake
   - External Flood
   - Volcano Eruption
   - Landslide
2. **External Disaster Definition**: This policy applies to external disasters which pose a potential threat to the safety and health of individuals in our community and service area. External disasters may include the following types of situations:
   - Mass Casualty
   - Pandemic
   - Supply Shortage
   - IT Failure
   - Biological Terrorism

3. **Warnings and Announcements**: Clinic Management and Staff shall take advantage of emergency notification systems and warnings from:
    a. Local media
    b. Local law enforcement
    c. Text and phone alerts from a) the National Weather Service; b) County/Parish or City automatic notification systems; c) Office of Homeland Security and Emergency Preparedness (OHSEP); and d) local television and radio stations. Other alert source: .
    d. Information about how to respond to specific types of disasters which are common to our geographic location can also be found here: inyocounty.us/services/emergency-service

4. Emergency Preparedness & Response: The primary concern in any threatening situation is the protection of life and limb.
    a. Warnings, instructions, and emergency declarations given by local and state agencies, including the OHSEP and law enforcement, should be heeded by all clinic employees.
    b. The clinic shall participate in available emergency preparedness training and drills as required by 42 CFR 491.12.
    c. The clinic shall communicate and collaborate with OHSEP and local agencies to prepare for and respond appropriately to emergencies and disasters.
    d. The Clinic shall have an emergency call plan.
    e. The Clinic shall independently comply with 42 CFR 491.12 and Appendix Z for emergency preparedness.

5. Scheduling and Closure in Advance of an Emergency: In anticipation of severe weather, road closures, or utility outages, if possible:
    a. Cancel or reschedule appointments to prevent patients or employees from traveling into and out of potentially hazardous conditions.
    b. Post closure signs with emergency instructions for obtaining care.
    c. Secure the clinic building and take precautions to protect and safeguard equipment, medical records, refrigerated drugs and other valuables.
    d. Follow all directives given by local and state authorities concerning evacuation routes, sheltering in place orders, or other disaster-related instructions.

6. Unexpected, Sudden Weather Emergencies: In the event that severe weather strikes unexpectedly, the clinic staff should:
    a. Move patients, visitors and employees into interior rooms or hallways away from doors, windows, or glass and away from the potential danger of flying objects.
    b. If flooding is probable, move people to the highest point.
    c. Make a head count and verify that all individuals are accounted for.
    d. Assess the immediate needs of patients.
    e. Have alternate sources of lighting available- flashlights or flashlight apps on devises.
    f. Communicate the evacuation routes within the clinic based on your current location.
    g. Depending on the amount of forewarning or known weather hazards, be prepared to shelter in place for a short period of time.
    h. Provide first aid if injuries or illnesses occur.
    i. Notify emergency personnel of your conditions and location.

j. Follow any other specific directives (for example: to stay indoors, boil orders, road closures, and shelter locations) given by local, state and federal authorities.
k. Instruct patients and employees clearly based on the instructions or protocols.
l. Follow other detailed directives in the formal EPP for the type of threat.

7. **External Disasters**: In the event of an external, non-weather-related disaster:
   a. Follow instructions as given by the OHSEP or local and state authorities pertaining to evacuations, shelter in place orders, or specific instructions.
   b. Assess the immediate needs of patients and employees.
   c. Have alternative methods of communication in case landlines are disabled.
   d. Notify emergency personnel of your specific location and needs.
   e. Secure the building as needed to protect life and limb.
   f. Be available to provide first aid and medical services to others as directed by emergency and law enforcement authorities.
   g. Follow other detailed directives in the formal EPP for the type of threat.

**Specific Procedures:** As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Letter To/From Parish Emergency Preparedness Agency | |
| | Drug Storage Policy | |
| | Emergency and Disaster Preparedness Training Policy | |
| | Emergency Call Plan | |
| | Employee Training Records | |
| | Formal EPP Documents | |

NIHD
RURAL HEALTH CLINIC

| Communication During Internal or External Situations | | |
|---|---|---|
| **J Tag References: J-0040 § References: 491.6; 491.12** | **Policy Type:** Physical Plant and Environment | ***Policy Number: 291.0*** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Declaration:** This is the Communication During Internal or External Situations Policy of the clinic.
The clinic is identified as Northern Inyo Rural Health Clinic.
**Policy Purpose:** The purpose of this policy is to provide information about how to the Clinic shall communicate internally and externally during emergency situations.

**Policy Statement:** The Clinic committed to open and clear communication with external agencies, local & state officials, and our employees & staff in either the preparation for an emergency or during the execution of internal or external disaster policies. An emergency call plan shall be established to facilitate appropriate response and communication.

**Policy Scope**: This policy is informational and procedural in nature.

**Policy Body: Communication During Internal or External Situations**

1. **Types of Emergencies**: Emergencies may arise from different situation which may be internal or external. Examples of situations which pose a potential threat or require emergency response for the Clinic could include:
    a. Severe Weather: Thunderstorms, High Winds, Tornados, Flooding, Fire Danger
    b. Other External Disaster Effecting the community: Industrial Accidents, Explosions, Derailments, Chemical Spills/Hazmat Response; School Disasters; Disruption of Transportation; Disruption of Public Utilities; Epidemic Disease.
    c. Internal Disaster Within the Clinic: Medical Emergencies including injury or death of a patient or employee; Fire; Damage or Destruction to the Building; Loss of Utilities; Loss of Communication; Disruptive or Violent Patient/Citizen; Active Shooter.
    d. Other urgent situations, which are neither internal nor external emergencies, may require open and clear communication between the Clinic and either internal or external stakeholders.
    e. Refer to the clinic's Emergency Preparedness Plan for all identified risks.

2. **Emergency Call Plan:** The Clinic shall create and maintain an emergency call plan. This plan shall include the names and contact information of all internal & external stakeholders who should be contacted in the event of an emergency. The call plan shall be updated at least biennially or whenever there is a change in local or state

agencies and/or personnel. The location of the written call plan shall be disclosed to all employees and/or posted as appropriate.

3. **Initiation of Emergency Call Plan**: The Clinic Administrator or the provider on call shall determine when the Emergency Call Plan (call tree) shall be initiated in response to an emergency, disaster or anticipated threat. In the absence of the administrator or a provider, any employee may initiate the call plan under appropriate circumstances. Refer to the Orders of Succession in the EPP.

**Specific Procedures**: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**
***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Emergency Call Plan | |
| | Emergency/Disaster Preparedness Plan | |
| | | |
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NIHD
RURAL HEALTH CLINIC

| Visitor Policy | | |
|---|---|---|
| **J Tag References: J-0041 § References: 491.6; 491.12** | **Policy Type:** Physical Plant and Environment | **Policy Number:** 295.0 |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** This policy discusses the presence of visitors in the clinic.

**Policy Statement**: The clinic seeks to ensure the safety of its patients and employees by protecting and safeguarding the clinic from access by unauthorized or uninvited individuals. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Scope**: This policy is procedural and regulatory in nature.

**Policy Body: Visitor Policy**

1. **Presence of Visitors:** From time to time, it is necessary for visitors to be present in the clinic for purposes other than the provision of medical services. Visitors should not be left unattended or unobserved in the clinic at any time. Visitors may include the following individuals:
    a. Caregivers, family members and individuals who accompany patients or provide transportation services;
    b. Individuals who represent companies that provide supplies, materials, samples or equipment for the clinic;
    c. Individuals who provide third-party services, such as equipment maintenance, cleaning, pest control, consulting, etc., to the clinic under arrangement or contract;
    d. Community representatives (Chamber of Commerce, Local Governmental representatives, etc.);
    e. Officials from local, state, and federal regulatory agencies including administrative representatives, inspectors, surveyors, or auditors;
    f. Law enforcement officers and other emergency personnel;
    g. Other individuals with an occasion to visit the clinic other than to receive medical care.

2. **Visitors Accompanying Patients**:
    a. The clinic administrator, the provider on-site or other key personnel have the discretion to limit the number of family members or other individuals who are allowed to accompany the patient into the exam room or other treatment areas of the clinic.

b. The clinic administrator, the provider on-site or other key personnel have the discretion to limit the number of people in the waiting room to patients and an appropriate number of non-patient family members or friends in order to accommodate patients.

3. **Disruptive Visitors:** If a visitor becomes disruptive, engages in behavior that is offensive, hostile, or potentially harmful to others, the visitor will be asked to leave.
   **a.** Clinic staff should call 911 if they need assistance in removing a disruptive visitor from the premises.
   **b.** Clinic employees should have a designated code word or other signal to alert clinic staff of a potentially dangerous situation. Employee training should include policies and procedures for dealing with disruptive or potentially dangerous individuals. Refer to the Emergency Preparedness Plan.

4. **Business-Related Visitors:** Before an individual is permitted into the back of the house, the front desk employee should confirm the identity of the person, the company which the person represents, and the reason for the visit. This verification can be made by:
   **a.** The employee's personal knowledge of the person's identity and company affiliation based on the visitor's prior visits to the clinic or based on knowledge of the person in the community.
   **b.** Business-related visitors can further be identified by name tags, name badges, business uniforms which include names or logos, or by presentation of a business card.
   **c.** The visitor should remain at the front desk or waiting room area until it is an appropriate time for them to enter other parts of the building or meet the appropriate person responsible for the visit reason.
   **d.** When required, a Business Associate Agreement shall be executed prior to the individual entering areas where protected health information can be accessed.

5. **Visitor Log:** It is at the discretion of clinic administrator to initiate the use of visitor log if visitor traffic in and out of the clinic becomes a security concern. In this case, a visitor log will be maintained at the front desk.

6. **Law Enforcement, Governmental and Agency Visitors:** These visitors should likewise be identified by name tag, name badge, uniform, business card, or through personal knowledge by the staff in the event of local officials or repeat visitors. Other considerations include:
   **a.** Clinic personnel should abide by any emergency instructions or directives given by officials from local, state, or federal law enforcement agencies when these officials enter the building in an emergency or disaster situation.
   **b.** Other governmental and agency officials should wait to be escorted to the back by the party who is responsible for coordinating the visit.
   **c.** The clinic administrator or provider on duty has the discretion to mandate restrictions or ask for additional requirements when law enforcement officers accompany prisoners who are being seen as patients.

**Specific Procedures**: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Employee Training Materials | |
| | Emergency Preparedness Plan | |

NIHD
RURAL HEALTH CLINIC

| Animals and Pet Policy | | |
|---|---|---|
| **J Tag References: J-0011, J-0044**<br>**§ References: 491.6; 491.4; 491.12** | **Policy Type:** Physical Plant and Environment | **Policy Number:** 296.0 |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** This policy discusses the presence of pets and animals in the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Statement: The clinic seeks to ensure the safety of its patients and employees by protecting and safeguarding the clinic from hazards created by animals being in the clinic. Patients and employees are prohibited from bringing animals inside the clinic during operating hours or after hours. The exceptions to this policy are provisions which involve service animals.

**Policy Scope**: This policy is procedural and informational in nature.

**Policy Body: Pet Policy**

1. **Presence of Pets:** Pets are NOT allowed in the Clinic because they potentially pose the following hazards or risks. Neither Patients nor Employees shall bring animals into the clinic unless the animals are trained service animals. The risks include:
    - Allergies to fur or dander;
    - Accidental animal bites or scratches;
    - Fear and Discomfort of other patients;
    - Parasite infestation;
    - Urine or Feces Contamination;
    - Exposure to other infectious diseases or agents.

2. Exception for Specifically Trained Service Animals: The clinic respects and promotes the use of service animals generally but not limited to dogs who have been trained to mitigate disabilities and conditions. We will accommodate service animals for our patients with disabilities and other illnesses for which the service animals have been specifically trained. Animals who provide only emotional support, companionship or comfort for the owner but are not specifically trained as service animals are not defined as service animals. These animals shall not be allowed under this provision unless support animals are afforded the same rights as service animals under specific state law.
    a. ADA/Civil Rights Requirements for Healthcare Facilities: The clinic shall abide by all guidance as prescribed by HHS and the US Department of Justice concerning ADA and Civil Rights requirements for non-discrimination of individuals requiring service animals including, but not limited to, these provisions:
        i. Healthcare facilities must recognize the use of service animals.

ii. Healthcare facilities can restrict the presence of the service animal if:
    1. The presence of the animal compromises infection control such as in operating rooms;
    2. The animal is uncontrollable and/or not housebroken;
    3. The environment is not safe for the service animal; or
    4. If the owner's condition precludes him/her from being able to control the service animal.

iii. The presence of service animals shall be allowed during the execution of emergency or disaster efforts unless conditions in section 2A(ii) prevail.

iv. Allergies or fear of animals shall not be considered substantial enough concerns alone to limit service animals in the healthcare environment.

b. Validation of Service Animal Training: When it is not obvious to the Clinic administrator or staff that an animal is actually performing a work or service task, the clinic may ask the patient-owner only two questions:
(1) Is the dog a service animal required because of a disability, and
(2) What work or task the dog has been trained to perform.

The Clinic is prohibited from requiring the patient-owner to discuss his or her disability in detail or give the details of the animal's training.

3. **Exception for Therapy Animals Used in the Facility:** Should the facility engage in an organized, recognized pet therapy program as part of a treatment plan for its patients or for a subpopulation of clinic's patients, these animals shall be permitted in the clinic for the designated times for therapy programs. The trainer or therapist must accompany the animals at all times. The clinic administrator shall have the right to initiate or terminate pet therapy at his/her discretion.

4. **Companion Animals**: The Clinic shall **not** permit the presence of companion or emotional support animals unless specific state law affords companion animals the same rights as service animals. If state law requires that companion animals be treated on par with service animals, the provisions above shall apply.

**Specific Procedures:** As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**
***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | ASPR Service Animals in Healthcare Facilities | |
| | Department of Justice Service Animal FAQ | |

NIHD
RURAL HEALTH CLINIC

| RHC Provision of Services | | |
|---|---|---|
| **J Tag References: J-0122, J-0123, J-0124, J-0125, J-0135, J-0140 § References: 491.9** | **Policy Type:** Administrative and Patient Care | ***Policy Number:*** *300.00* |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purpose of this policy is to acknowledge the requirements for Conditions of Coverage: Provision of Services sections of the SOM, Appendix G for Rural Health Clinics.

**Policy Statement**: The Clinic provides patient care services within the nature and scope of both the federal and state regulatory guidance for Rural Health Clinics. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: RHC Provision of Services**

1. **Primary Care Services:** The clinic provides primary care services which:
    a. Are provided at least 51% of the time that the clinic is open;
    b. Are the majority of services that the clinic provides;
    c. Include treatment for chronic and acute medical problems which usually bring a patient to a physician's office;
    d. Are within the scope of practice as determined by each specific provider's federal and/or state license;
    e. Provided within at least the minimum state-required hours of operation, if applicable.

2. **Description of Services:** The services provided by the Clinic include diagnostic and therapeutic services for illnesses, diseases, conditions, signs & symptoms, and minor injuries for which a patient would normally seek care from a medical clinic. The scope of services provided relate directly to the patient's chief complaint and other health conditions or factors determined to be significant to the patient's overall care plan and wellbeing. These services include, but are not limited to:
    a. Taking medical histories;
    b. Performing medical examinations;
    c. Assessments of health status;
    d. Performing or ordering of routine lab tests;
    e. Performing or ordering other diagnostic tests;
    f. Diagnosis and/or treatment of common acute medical conditions;
    g. Diagnosis and/or treatment of common chronic medical conditions;
    h. Participation in state immunization and EPSTD programs, if applicable;
    i. Counseling of patients concerning health status, family planning, and lifestyle;

j. Providing treatment for injuries within the scope and training of the providers;
k. Providing emergency care within the scope and training of the providers;
l. Coordinating care with other physicians, providers, and facilities.

3. **Direct Services**: The Clinic and its providers directly furnish services that are commonly furnished in a physician practice or at the entry point into the health care delivery system. These services include:
   a. Services of the like and kind described above under ***"Description of Services";***
   b. ***CLIA Waived, On-Site Laboratory Services*** which are essential to the immediate diagnosis and treatment of the patient, including:
      i. Chemical examinations of urine by stick or tablet method or both
      ii. Hemoglobin or hematocrit
      iii. Blood sugar
      iv. Examination of stool specimens for occult blood (FOB)
      v. Pregnancy tests
      vi. Primary culturing for transmittal to a certified laboratory
      vii. Other waived tests that have been approved by CMS.

4. Indirect Services/Referrals: The Clinic provides for indirect services and referred services when the services are not available in-house. These services may include:
   a. Ordering Send-out or Reference Lab Services;
   b. Ordering Ancillary Services not related to primary care or not furnished as a core RHC service;
   c. Referring of Patients to Specialists, other healthcare providers, and other facilities for services outside the scope and nature of the RHC core services;
   d. Other services by arrangement or agreement (either formal or informal) with other providers in the medical community within the service area.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Protocols for In-House Lab Testing | |
| | CLIA Certificate | |
| | Referral Policy/Referral List | |
| | Emergency Care and Treatment | |

NIHD
RURAL HEALTH CLINIC

| Medical Management Guidelines | | |
|---|---|---|
| **J Tag References: J-0100, J-0101, J-0124, J-0125** **§ References: 491.9** | **Policy Type:** Patient Care | ***Policy Number:*** *310.0* |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purpose of this policy is to document the medical management guidelines that are followed by the providers at the Clinic.

Policy Statement: The clinic utilizes medical management guidelines which provide the appropriate standard of care under best practices for the practice of family medicine. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: Medical Management Guidelines**

1) Clinical Guideline References: **The providers at the Clinic shall rely on the following references for medical management guidelines:**
   - up-to-date
   - American Family Phusician
   - Epocrates
   - USPStF

   **Additional resources as recommended or agreed upon through collaboration with the physician or medical director.**

2) Medical Direction and Collaboration: The providers at the Clinic shall rely on the medical direction of the physician/medical director who provides consultative and supervisory services. The collaborative physician of record or a staff physician on duty shall be consulted in cases where the Nurse Practitioners or Physician Assistants require guidance in addition to the established or previously agreed upon protocols in the medical management of acute and chronic conditions. Additionally, any medical management guidelines as prescribed or identified by federal or state scope of practice shall be followed.

3) Specific Patient Care Policies: Individual policies shall be established whenever the Clinic Administrator, in collaboration with the medical director and RHC providers, determines that a specific aspect of patient care would be better managed by a written directive to the professional staff. Best practices and the standard of care shall be followed.

4) Specialty Referral: The Clinic shall make referrals to specialists for appropriate treatment of patients whose conditions or diseases require further management

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related
policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | All Policies within the Patient Care Section. | |
| | Other Medical Management Policies, as applicable | |
| | Credentialing Files | |

NIHD
RURAL HEALTH CLINIC

| Patient-Provided or 3rd Party Pharmaceuticals | | |
|---|---|---|
| **J Tag References: J-0043, J-0124, J-0125 § References: 491.6, 491.9** | **Policy Type:** Patient Care | **Policy Number: 330.0** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purpose of this policy is to provide guidance for the storage, handling and administration of injectable drugs and pharmaceuticals which have been furnished to the clinic by a patient or a third party.

The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Statement:** The clinic seeks to clearly define the processes and conditions under which these types of medications shall be stored, handled and administered.

**Policy Scope**: This policy is both informational and procedural in nature.

**Policy Body: Patient-Provided Injectable Pharmaceuticals**

1. **Reasons for these types of injectables:** From time to time it is necessary for a patient to bring an injectable drug into the clinic for the purpose of the clinic providers overseeing the administration of the substance. Sometimes these drugs are mailed directly to the clinic by a third-party. Examples of this type of arrangement include:
    a. Allergy shots/Immunotherapy provided by a specialist;
    b. Drugs considered as self-administered which have been obtained by a prescription;
    c. Drugs which have been legally dispensed by a licensed professional, but for which the patient needs assistance or oversight in administration.
    d. Drugs which are a pharmacy benefit under the patient's health plan.

2. **Medical Necessity**: The therapy will only be administered if the provider on-site determines that the treatment is medically necessary and consistent with existing treatment plans of the clinic or a referring physician.

3. **Storage of these substances:** These types of drugs will be stored by the clinic at the temperatures recommended on the labeling. General storage policies and procedures for storing drugs will apply to these substances. However, the clinic is not obligated to provide this service. The storage of these drugs is provided as a convenience to the patients and with the continuity of treatment in mind.

4. **Packaging and Labeling:**

    a. The drugs must be in original packaging with legible labeling. The drugs must not appear to have been tampered with or altered.

b. These drugs will either be labeled with the patient's name, initials, or other patient identifier. The date that the drug entered the clinic's custody will also be either marked on the box or logged.

c. All other policies and procedures related to the storage, handling and administration of drugs and biologicals, including labeling and discarding, shall be applied to medications addressed in this policy as applicable.

5. **Expiration dates**: The expiration date of the drug, if applicable, will be checked prior to each administration. Expired drugs will not be administered. Expired drugs will be discarded in accordance with federal and state laws, regulations, and guidelines.

6. **Other restrictions and limitations**:

   a. If the origin of the drug cannot be verified, the drug will not be administered or stored.
   b. If a question exists concerning the storage method of the drug prior to the clinic taking custody of the drug, the drug will not be administered or stored;
   c. If the original packaging of the drug is torn, missing, or appears to have been altered, the drug will not be administered or stored.
   d. Only substances known to the healthcare provider as being commonly administered for a disease or condition for the unique patient will be stored or administered.
   e. Controlled substances shall not be administered.
   f. The Clinic Administrator or on-site provider reserves the right to confirm the prescription status, dosage, and administration guidelines for any substance brought in by a patient.
   g. The Clinic Administrator or on-site provider reserves the right to refuse to administer a drug if the origin, medical necessity, or chain of custody of the substance is not verifiable.
   h. The patient is responsible for the acquiring and purchasing the injectables from the original source. Furthermore, the patient is responsible for the services related to the administration and for following the provider's instructions concerning wait times, reactions, or other warnings.

7. Other Patient Responsibilities: The patient shall agree to the terms and conditions described herein as it pertains to the administration of a self-provided drug. The patient shall respect and acknowledge any limitations or restrictions placed on the storage and administration of an outside drug. The patient will be responsible for the integrity of the source and chain of custody of the drug.

**Specific Procedures**: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Storage and Handling of Drugs, Biologicals and Pharmaceuticals Policy | |
| | | |

NIHD
RURAL HEALTH CLINIC

| Referral Policy | | |
|---|---|---|
| **J Tag References: J-0011, J-0140 § References: 491.9** | **Policy Type:** Patient Care | ***Policy Number: 340.0*** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose**: The purpose of this policy is to outline the policy of referring patients for indirect or outside services.

The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Statement**: The clinic complies with the RHC requirement to be able to provide by arrangement or agreement, formally or informally, outside or indirect services for its patients.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: Referral Policy**

1) **Specialty Care:** The clinic maintains professional relationships with a network of physician and specialty care providers for the purpose of referring patients who require consultation or the transfer of care due to a disease, condition or health status which requires services beyond the scope of a primary care clinic. These services may include specialists, ancillary services, and care required in other settings.

   - ***Scheduling of Appointments***: The Clinic staff, either a provider or a member of the nursing staff, shall make appointments for the patient at such time that the need for a specialty referral is identified.

   - ***Follow-up of Referrals***: A member of the nursing staff shall follow-up as necessary with the patient and the specialty provider concerning:

     i) The appointment status
     ii) Any test results or findings
     iii) Follow-up care requirement

   - ***Provider to Provider Communication***: As determined on a case to case basis, the providers shall communicate one-on-one with the specialty provider to ensure coordination and continuity of patient care.

2) Hospital Admissions: The clinic will arrange for any inpatient admission through the hospitalist program at the hospital of the patient's choosing. The Clinic maintains a professional, informal relationship with each facility within the service area. The Clinic will provide any necessary medical records and be available for provider-to-provider communication as needed for coordination and continuity of care related to admission and discharge of patients.

3) Referral Tracking and Patient Follow-up: The Clinic is able to track referral status within the features of the Practice Management and EHR information systems. The nursing staff is able to monitor referral requests, test results and follow-up actions either using tools within the software systems or through a manual process.

4) Patient's Discretion: The Clinic will facilitate in finding additional sources for indirect or outside services which meet the needs of the patient and which are compatible with the patient's personal preferences, the patient's insurance plan, or the patient's ability to access care. In these cases, additional referral sources other than those on the clinic's referral list will be used.

5) **Stark Law**: The Clinic shall not violate any provision of the Stark Law and/or other federal and state law during the course of referring patients for other healthcare services.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Referral List/ Referral Log | |
| | Letter or Agreement for Hospital admits, if applicable | |
| | Copy of Provider's hospital privileges, if applicable. | |

NIHD
RURAL HEALTH CLINIC

| Transitional Care and Continuity of Care Management | | |
|---|---|---|
| **J Tag References:** **J-0011, J-0140** **§ References: 491.9** | **Policy Type:** Patient Care | **Policy Number: 341.0** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purpose of this policy is to outline how the clinic shall participate in transitional care management and continuity of care management.

**Policy Statement**: The clinic shall be engaged in transitional care management and the continuity of care for its patients.

The clinic is identified asNorthern Inyo Rural Health Clinic.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body:** Continuity of care management and transitional care management are important aspects of managing the health and wellness of our patients.

1) **Transitional Care Management:** Our providers and licensed staff shall engage in transitional care management either when resuming care of our patients after inpatient or residential discharge or when facilitating in the transition of our patients to inpatient services, long term care services, skilled nursing services, or services in other care settings. The following professional and nursing tasks may be associated with transitional care management as pertinent to the specific case:

    - ***Review of Discharge Summary or Hospital Discharge Summary***
    - ***Review of other records, lab values or consultative reports***
    - ***Revision of any existing care or treatment plans based on the discharge data***
    - ***Medication Reconciliation***
    - ***Oversight or monitoring of outpatient services including, but not limited to, physical therapy, occupational therapy, speech therapy, home health services, or mental health counseling.***
    - ***Coordinating care with other healthcare providers***
    - ***Patient, Family or Caregiver counseling***
    - ***Referral to community and/or social services***

2) **Interdisciplinary Care Coordination:** Our providers and licensed staff shall engage in coordinating care & treatment interventions across all disciplines. This care coordination shall include:
    - ***Referrals for specialty, ancillary, and support services.***
    - ***Communication with other healthcare providers to assess progress, revise care plan or treatment options;***
    - ***Receiving care summaries via electronic exchange or hard copy report***
    - ***Communication with family members or care givers***
    - ***Additional referral to other providers or services***

3) **Advanced Care Planning**: Our providers shall participate in advanced care planning with our patients for whom end-of-life planning is determined to be an integral part of total care management. We are committed to the dignity of life and to providing information, guidance and support to our patients and their families/caregivers at this stage of life. Advanced care planning could include any of these services, as applicable to the patient's situation:
    - ***Preparation of Advanced Directives***
    - ***Admission to Palliative Care/Hospice***
    - ***Residential living alternatives***
    - ***Caregiver Respite***
    - ***Palliative treatment alternatives***
    - ***Patient and family counseling***
    - ***Referral to social or community resources***

**Specific Procedures**: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**
***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Referral List/ Referral Log | |
| | Community Resource Guide | |
| | | |

NIHD
RURAL HEALTH CLINIC

| Missed Appointments | | |
|---|---|---|
| **J Tag References: J-0124, J-0125 § References: 491.9** | **Policy Type:** Patient Care | ***Policy Number: 342.0*** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purpose of this policy is to outline how the clinic will handle missed appointments and the rescheduling of appointments. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Statement: The clinic desires to promote continuity of care by encouraging patients to keep all scheduled appointments. Furthermore, the Clinic desires to treat all patients fairly when rescheduling appointments and to sustain provider-patient relationships.

**Policy Scope**: This policy is informational and procedural in nature.

**Policy Body: Missed Appointments**

1) **Appointment Reminders:** The clinic shall routinely notify patients in advance to remind them of upcoming, scheduled appointments. ***The patient's communication preferences shall be honored when reminding patients of appointments***. The following methods of communication may be used to notify patients:
   - Telephone Calls (Personal or Auto-dial)
   - Electronic reminders
   - Post cards or Letters

2) **Rescheduling Appointments:** The clinic shall encourage patients to reschedule appointments prior to missing a previously-scheduled appointment or within 72 Hours of a missed appointment. Should the patient not reschedule the appointment, the clinic staff shall try to reach the patient by phone to reschedule within a week of the missed appointment. Priority shall be given to reschedule patients who are in active treatment or who are due for scheduled preventative or screening services. The Clinic shall follow any guidance from health plans or managed care plans on how to notify the plan of missed appointments for EPSDT screenings or other required preventative services.

3) **Dismissing A Patient for Missed Appointments:** Patients may be dismissed if they habitually miss appointments. The conditions within **Policy 360: Discharging or Dismissing a Patient** shall be followed in this situation. No patient may be denied emergency care after dismissal.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| 360 | Dismissing A Patient | |
| 340 | Referral Policy | |
| | Sample Dismissing Patient Letter | |

NIHD
RURAL HEALTH CLINIC

| Emergency Care and Treatment | | |
|---|---|---|
| **J Tag References: J-0136, J-0140 § References: 491.9** | **Policy Type:** Patient Care | **Policy Number: 350.0** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purpose of this policy is to outline the policies and procedures related to medical emergencies.

**Policy Statement**: The clinic complies with the RHC requirement to be able to provide medical emergency procedures as a first response to common life-threatening injuries and acute illnesses. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: Emergency Care and Treatment**

1) **Emergency Kit:** The clinic shall have on hand an emergency kit that includes drugs and biological commonly used in life saving procedures, such as:
   - Toradol
   - Xylocaine
   - Zithromax
   - Ceftriaxone
   - TDap

***Antidotes and emetics, serums and toxoids*: Patients presenting to the clinic due to poisoning, either by ingestion or by venomous bite will not be administered antidotes, emetics, serums or toxoids due to: 1) the controversial practice of administering emetics; 2) to the short shelf life and cost of maintaining an inventory of serums and toxoids; and due to the limited availability of certain drugs and biological. (See Below for Poisoning)***

a) The providers and medical director shall approve a list of the drugs which are appropriate to treat emergency illnesses and injuries for which patients might commonly present base on the geographic location of the clinic. This approved list shall be documented. Providers may choose not to stock ipecac. See Poisoning below.

b) Other drugs, such as those required in order to provide ACLS or if additional emergency treatments are required by any specific state requirement shall be available.

c) Other medical supplies and equipment that has been determined necessary for providing emergency care within the scope and training of the providers.

d) The emergency kit is securely stored with a list of contents visible on the exterior of the cart or box.

e) Oxygen should be securely stored on a rack or chained. Cannula, mask and tubing shall be attached to the tank for immediate use.

2) **Poisoning**: If the clinic becomes aware of an incident of patient poisoning, the staff and providers shall respond in this manner:
   a) If a patient notifies the clinic by phone of the incident:
      (1) The staff shall direct the patient to call the Poison Control Hotline at **1-800-222-1222** if the patient is not in a life-threatening situation.
      (2) The staff shall direct the patient to call **911** or to go to the Emergency Department at the closest hospital in the event of an emergency, life-threatening situation.

   b) If the patient presents to the clinic after a poisoning incident:
      (1) The staff shall attend to the patient and provide emergency medical care within the scope of training of the clinical staff and providers;
      (2) The staff shall call the Poison Control Hotline at **1-800-222-1222**;
      (3) The staff will call 911 or arrange for emergency transport via ambulance of the patient to the Emergency Department of the closest hospital.

3) **Life-Threatening Medical Emergencies**: The clinic shall provide the following medical care to patients with life-threatening emergencies.
   a) If a patient notifies the clinic by phone of a life-threatening emergency:
      (1) The staff shall direct the patient to immediately call **911**;
      (2) The staff shall direct patients to go to the Emergency Department of the closest hospital if the situation described is serious, but not immediately life-threatening.
      (3) The patient shall be directed to call **911**, if the seriousness of the situation cannot be ascertained by a layperson's description or judgment of the situation.
   b) If the patient presents to the clinic with a serious or life-threatening condition:
      (1) The staff shall call **911** or arrange for emergency transport of the patient to the Emergency Department at the closest hospital.
      (2) The staff shall attend to the patient and provide emergency medical care within the scope of training of the clinical staff until the patient can be transported.

4) **Emergency Training of Staff and Providers**: The clinic shall train staff and providers on medical emergency procedures periodically.

   **(1)** CPR/BCLS: The staff and providers shall maintain certification in basic life-saving procedures consistent with job function and responsibility.
   **(2)** ACLS/PALS: Providers shall maintain certification in advanced life-saving procedures consistent with any applicable federal or state regulations.
   **(3)** The staff shall be trained on the procedures outlined in this policy.
   **(4)** Clinical staff shall know the location of the Emergency Kit. The drugs within the emergency kit shall be inventoried and checked for expiration dates in a manner consistent with any other drug handling and storage policies.

5) Transfer Agreements: The clinic shall maintain transfer agreements with local emergency medical services/ambulance services and the nearest local hospital with an emergency department to ensure that patients may be transported by qualified services and received at an emergency department.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | CPR and ACLS Certificates | |
| | Transfer Agreements | |
| | Approved List of Emergency Drugs/Supplies | |

NIHD
RURAL HEALTH CLINIC

| Discharging/Dismissing a Patient | | |
|---|---|---|
| **J Tag References: J-0010, J-0124, J-0136 § References: 491.4, 491.8, 491.9** | **Policy Type:** Patient Care | **Policy Number:** 360.0 |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purposes of this policy are to define the situations which might result in a patient being discharged or dismissed or terminated from primary care provided by the clinic and to outline the procedures for dismissing a patient from the clinic.

**Policy Statement:** The clinic seeks to clearly define the process of patient discharge in order to maintain clarity and consistency during the termination of the provider-patient relationship. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Scope**: This policy is both informational and procedural in nature.

**Policy Body: Discharging/Dismissing a Patient**

1. **Reasons for Patient Discharge/Dismissal:** A patient may be discharged or dismissed for one or more of the following reasons.
    a. **Non-Compliance with Treatment Plans**--the patient or guardian fails to follow established treatment plans even though the importance or benefit of the treatment is understood by the patient or guardian.
    b. **Disruptive, Hostile or Abusive Behavior**--the patient or guardian displays disruptive, hostile or abusive behavior(s) toward the providers, staff or employees of the clinic while on clinic premises or during conversations in person or on the telephone with providers or employees. These behaviors may include, but are not limited to, abusive language, profanity, outbursts of anger, threatening to harm or do ill toward the staff, inappropriate gestures, and inappropriate comments containing sexual, racial, or otherwise discriminatory inferences.
    c. **Failure to Keep Appointments**--the patient habitually fails to keep scheduled appointments.
    d. **Failure to Maintain Financial Responsibility**--the patient fails to pay deductibles, co-insurance, and other amounts determined to be the patient or guarantor's personal financial responsibility. All patients are provided with the clinic's financial policy upon initial patient registration at the clinic.
    e. **Other Reasons--**the Clinic Administrator, in collaboration with the providers may determine that in certain other circumstances it is in the mutual best interest of all parties to terminate the provider-patient relationship.

2. **Exclusions from Discharge**: The provider-patient relationship **cannot** be terminated under the following conditions or circumstances:
    - **a.** Reasons resulting out of any discrimination toward the patient (for example: race, gender, religion, national origin, or sexual orientation);
    - **b.** Reasons which would otherwise perpetrate a violation of the patient's civil rights;
    - **c.** A discharge which would violate the terms of an applicable managed care contract without due process;
    - **d.** A patient who is actively receiving on-going care or treatment for a condition which requires continuity in care may not be discharged until the patient's care has been transferred to another provider. A condition requiring on-going care is either deemed to be unstable in nature or such that it requires uninterrupted, direct provider involvement. Chronic, stable conditions would not normally be included in this classification.

3. **Notice of Termination**: The patient will be given written notice of the practice's intention to terminate the provider-patient relationship (e.g. *Patient Termination Letter*). The letter shall contain the following information:
    a. The reason(s) for which care is being withdrawn;
    b. The effective date of the termination (no longer than 30 days);
    c. Instructions for obtaining care from another provider;
    d. Instructions for the transfer of medical records to another provider;
    e. The circumstances in which emergency care will be provided to the patient;
    f. The limitations of care during the 30-day transition period.

    A copy of the termination letter will be retained as part of the clinic's records.

4. **Transfer of Records**: Upon the final discharge or dismissal of a patient, the clinic provided copies of the patient's record to the new provider upon receipt of an authorized request from the new provider or as needed for continuity of care/treatment.

5. **Emergency Care**: The clinic shall ***not*** withhold emergency medical care from any patient previously discharged from the practice. Emergency medical care is defined as medical treatment required to stabilize the patient in the event of a life-threatening acute illness or injury as a first responder.

**Specific Procedures**: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Patient Termination Letter | Forms/Appendix |
| | Emergency Care Policy | Patient Care |
| | Civil Rights Policy | Administrative Section |

NIHD
RURAL HEALTH CLINIC

| After Hours Care | | |
|---|---|---|
| **J Tag References: J-0010, J-0011,J-0012 § References: 491.4** | **Policy Type:** Patient Care | **Policy Number: 370.0** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose**: The purpose of this policy is to disclose the arrangement for after hour care for patients.

**Policy Statement**: The clinic to provide information about access to professional medical care at all times. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body**: The clinic shall follow one or more of these processes in ensuring that patients are provided medical care at all time that the rural health clinic is not open or operating to provide patient care.

1. **Answering Machine/Voice Message**: An answering machine or voice message shall provide patients with the following information when the clinic's main phone number is called outside of normal clinic hours. The caller shall be instructed to

    a. Hang up and Call 911 if this is a medical emergency.
    b. Call during normal operating hours for non-emergency or non- urgent situations; or
    c. Leave a message for the provider on-call. If the managed care plans do not require that a provider be on call or that a call must be returned within a stated number of minutes, the clinic shall use its discretion in how on-call services are provided.

2. **Managed Care Plan Requirements**: The clinic shall comply with any managed care plan requirements or state requirements for after-hours patient care. Depending on the specific requirement or contract terms, the clinic may respond to after-hours calls with any of these actions, as allowed by the plan:

    a. Have the clinic phone forwarded to an answering service that would contact the provider on call;
    b. Have the clinic phone forwarded to a delegated back-up provider or to the parent hospital's emergency department.
    c. Have the voice message instruct the caller on how to reach their plan's nurse line;
    d. Use a service to transcribe voice messages to text that is forwarded either to the provider on-call or other designated staff to screen calls;
    e. Have the clinic phone forwarded to a dedicated after-hours cell phone that is assigned to either the provider on-call or another designated staff to screen calls.

3. **Follow-up on patients seen elsewhere after hours**: The clinic shall follow-up with the patient, patient's guardian or the outside provider when it comes to the clinic's attention that a patient has been seen in the emergency room or by another provider in an after-hours care situation. When determined relevant to the patient's on-going care and patient history, the clinic shall obtain copies of treatment records, reports and other clinical documents from the outside provider.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Managed Care Contracts | |
| | Call Schedule, if applicable | |

NIHD
RURAL HEALTH CLINIC

| Medical Records Policy | | |
|---|---|---|
| **J Tag References: J-0151, J-0152, J-0153 § References: 491.10** | **Policy Type:** Patient Care | **Policy Number: 380.0** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purpose of this policy is to outline the policy and procedures related to the creation, maintenance, storage and safeguarding of medical records.

**Policy Statement**: The clinic complies with federal and state regulations concerning medical records as well as the privacy and security of PHI. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: Medical Records Policy**

1) **Custodian of Records:** The clinic shall have an individual designated as being responsible for maintaining the records and for ensuring that they are complete, accurate, and organized.

2) **Periodic Auditing of Records for Completeness:** The clinic staff shall periodically audit a random selection of charts to validate that all necessary documentation elements are present in the individual medical records per 42 CFR §491.10. The clinic administrator shall be made aware of the audit findings. The audit findings shall be presented to the appropriate individuals or committees at least quarterly.

3) **Medical Director/Physician Review**: Additionally, the medical director or a physician member of RHC medical staff shall conduct peer review of any nurse practitioner or physician assistant charts as required by state or federal guidelines. These reviews shall be documented and traceable. The chart review process shall be included in the annual RHC program evaluation.

4) **Individual Patient Records**: The Clinic shall maintain a medical record for each patient. The record shall contain the following components:
   a) Patient Demographic Information
   b) A clinic note for each encounter which shall include any or all of the pertinent data elements:
      1) Reason for the visit (Chief Complaint)
      2) Medical history which is pertinent to the visit and health status of the patient
      3) Personal, Social, & Family history which is pertinent to the visit/health status
      4) Assessments and Exam Findings
      5) Orders
      6) Problem List
      7) Medication List

8) Immunization record, if required
9) Lab test results
10) Other diagnostic test results
11) Consultative findings
12) Flow Sheets or Progress Notes
13) Treatment Plans
14) Follow up Plans
15) Patient Instructions
16) Other pertinent information required to monitor the patient's progress and health status.

c) The note for each encounter must be signed off by the provider either electronically or by another means of authentication. This finalization of the record shall be done in a timely manner.

3) Protection of Medical Records: The Clinic shall protect the privacy and security of the medical records and safeguard the records from loss, destruction or unauthorized use.
   a. The Clinic uses an Electronic Health Record information system. The clinic's practice management/EHR is Cerner.
   b. The system contains features which protect and safeguard the medical records:
      Unique user IDs and passwords for system access
      1. User Audit Trails
      2. Timestamps
      3. Authentication
      4. Security levels (permissions) which are set based on the individual user's job description
      5. Time out features to safeguard workstations
      6. Administrative features
   c. The information system vendor provides data back-up and disaster recovery for the medical records.
   d. If records are removed from the Clinic in any format, they will remain in the custody of an authorized employee or the custodian of the records.
   e. If any paper records are located within the clinic, those records are securely stored to prevent unauthorized access. Paper charts are also stored in a way to minimize damage or loss resulting from an internal or external disaster.

4) Release of Information: The Clinic shall require the patient's written consent for release of protected health information (PHI).
   a. The authorization form used to request PHI shall be a valid, HIPAA-compliant form which meets all state and federal requirements.
   b. The Clinic will not honor requests for release of PHI unless a signed and valid, HIPAA-compliant authorization is received.
   c. The Clinic may access charges for the reproduction and handling of medical records according to state statute.

5) Retention of Records: Medical records will be retained for at least 6 years from the date of last entry **or longer** if required by a state statute or any other regulatory agency. The Clinic recognizes the retention period is longer for minors and Medicare beneficiaries.

6) **Off-site storage of Records**: The clinic may choose to store inactive paper records which have been purged but are still within the legal retention period to be stored off-site. This off-site location shall be a secured location owned by the clinic or parent hospital or it may be another off-site location provided by a reputable records management company that guarantees HIPAA compliance for privacy and security. A Business Associate Agreement should be in place with any 3rd party vendor responsible for the transporting and storing of records which include PHI.

7) **Destruction of Records**: The clinic shall follow these guidelines when destroying medical records.
   a. One of these approved methods of destruction will be used:
      i. Paper record methods of destruction include burning, shredding, pulping, and pulverizing.
      ii. Microfilm or microfiche methods of destruction include recycling and pulverizing.
      iii. Laser discs used in write once-read many document-imaging applications are destroyed by pulverizing.
      iv. Computerized data are destroyed by magnetic degaussing.
      v. DVDs are destroyed by shredding or cutting.
      vi. Magnetic tapes are destroyed by demagnetizing.
   b. A written log shall be maintained to record the individual records destroyed, the dates of services included in the records, the destruction date, the method of destruction and signatures of the individuals who observed the destruction.
   c. The clinic may choose to contract with a vendor for the destruction of records. If doing so, the clinics must ensure that the 3rd party can provide indemnification and that a Business Associate Agreement has been executed. The vendor shall provide all necessary data to substantiate the proper destruction of records.

**Specific Procedures**: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Authorization for Release of Medical Records | |
| | Chart Auditing Form | |
| | Quality and UR Policy | |
| | Medical Director UR Chart Review Form | |
| | | |

NIHD
RURAL HEALTH CLINIC

| Medical Records Integration Policy | | |
|---|---|---|
| **J Tag References: J-0151, J-0121**<br>**§ References: 491.10, 491.9, 413.65** | **Policy Type:** Patient Care | ***Policy Number: 385.0*** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purpose of this policy is to outline the policy and procedures used to create retrievable and/or integrated medical records between the provider-based RHC and NorthernInyo Healthcare District.
The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Statement**: The clinic complies with federal regulations concerning the requirements for provider-based entities.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: Medical Records Integration**

1. **Cross-referencing of clinic account information and patient demographics to the hospital medical record at the point of clinic registration.**
    a. During the registration process for the clinic patient, the hospital medical record number will be entered into a user-defined field within the clinic practice management system:
        i. Existing/Established Hospital Patients—The clinic staff will look up the patient using hospital practice management system and use personal identifiers to verify the existence of the patient in the hospital master patient index. The hospital MR# will be entered into the patient's demographics on the clinic side as a cross reference.
        ii. New Patients—The clinic staff will determine if the patient has a valid entry in the hospital master patient index. If no matching entry is located, the clinic record will not be cross-referenced at this time.
2. **Cross-referencing of the clinic record and the hospital medical record after clinic registration.**
    a. After other hospital services are ordered such as ancillary services (lab, radiology, imaging):
        i. The clinic staff will use the reference logs to periodically check the hospital information system for the creation of the patient's corresponding, newly-created MR#.
        ii. The hospital MR# will then be entered by the clinic staff into the designated field within the clinic practice management system.
    b. After the clinic provider becomes aware that the patient has received other hospital services:

i. The clinic staff will use the hospital information management system to locate the hospital MR# .
ii. Demographic information within the clinic practice management system (date of birth, gender, address, social security number, etc.) will be used to confirm patient identity before assigning the number.

3. **Retrieval of Hospital Records by Clinic Providers**: The clinic providers will have full access to:
    a. The hospital information management system for:
        i. Diagnostic Results
        ii. History of Previous Admissions
        iii. Any other clinical information stored in an electronic format.
    b. The hospital paper chart as referenced by the MR#.

4. **Access of Clinic Records by Other Hospital-Based Providers**
Hospital-based providers (HBP) shall have access to clinic records accordingly.
    a. Upon referral for hospital inpatient admission:
        i. The clinic provider who refers the clinic patient to a hospital-based provider for inpatient status will provide the HBP with a copy of the current clinic note in a timely manner for use in establishing a care plan and completing the H &P.
        ii. The clinic provider will coordinate care with the HBP by providing additional information from previous episodes of care as needed.
    b. Upon referral for other outpatient services (other than diagnostics):
        i. The clinic provider who refers the clinic patient to a hospital-based provider or consulting physician for more extensive outpatient services will provide the HBP with a copy of the most current clinic note in a timely manner for use in establishing a care plan.
        ii. The clinic provider will coordinate care with the HBP by providing additional information from previous episodes of care as needed.

5. **Periodic Comparison of Clinic and Hospital Information**

    On a periodic basis, as agreed by the clinic director and the Director of HIM, system tools from both systems shall be used to verify that the clinic records are adequately cross-referenced with the main provider records.

**Specific Procedures:** As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**
***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Authorization for Release of Medical Records | |
| | Clinic Medical Record Policy | |

NIHD
RURAL HEALTH CLINIC

| Health Information Technology/IT | | |
|---|---|---|
| **J Tag References:** **J-0121, J-0121, J-0123, J-0124, J-0125** **§ References: 491.9** | **Policy Type:** Patient Care | **Policy Number:** 390.00 |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purpose of this policy is to establish guidelines for the use of health information technology (HIT) and information technology (IT) and the safeguarding of the appropriate use of HIT and IT applications and access.

Policy Statement: The clinic is committed to using HIT for improved patient care, to comply with reporting requirements, and to optimize workflow.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: Health Information Technology and Information Technology**

1. **System Maintenance**: The clinic shall maintain all hardware and software by performing routine maintenance, security checks and by installing updates in a timely manner.

2. **System Security:** The clinic shall ensure that all IT systems have adequate security features. The clinic is identified as Northern Inyo Rural Health Clinic.

3. **System Privacy** The clinic shall reduce the risk of breeches in privacy by training employees on HIPAA as it relates to specific job functions and by having guidelines in place for protecting PHI. Standard procedures shall be followed for accessing the electronic medical record and protecting the privacy of our patients through the safeguarding of data and information.

4. **HIPAA Security Risk Assessment**: The clinic shall conduct an annual HIPAA Security Risk Assessment. The assessment shall include all work processes and functions including electronic system-related functions as well as manual work flow processes.

5. **User Access:** The clinic shall ensure that users are trained on the systems needed for their specific job role or function. Users will be trained on privacy and security as it relates to the IT and HIT systems/applications. Appropriate privacy and security measures will be in place for all users. Users shall not share passwords, leave applications open when away from the work area, and must have screens set to "sleep" after 3 minutes. When an employee quits or is terminated, the employee's access to the systems shall cease immediately. This includes access to local systems, cloud-based applications, and third-party sites (payers, clearinghouses, banks, or vendors).

6. **Use of Personal Devices**: The clinic shall give directives on the use of personal devices in the workplace. PHI shall not be transmitted via personal devices (phone, text, or tablet) unless it is in adherence to clinic policies and is a patient communication preference.

7. **Personal Internet Use**: The clinic shall reserve the right to control personal internet use and to limit access to certain sites, pages or entertainment domains. Employees are prohibited from downloading applications or installing executable programs without permission from the Clinic Administrator or IT Manager.

8. **Additional Policies and Procedures**: The clinic shall implement additional policies and procedures as needed to adequately maintain and update all systems and to ensure that privacy & security measures are in place at all time.

**Specific Procedures:** As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**
***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | IT Services Agreements | |
| | HIPAA Training Records | |
| | HIPAA Security Risk Assessment | |

NIHD
RURAL HEALTH CLINIC

| General Employment Policies | | |
|---|---|---|
| **J Tag References: J-0013, J-0083 § References: 491.4** | **Policy Type:** Employment | **Policy Number: 400.0** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purposes of this policy are to clearly point employees and other interested third-parties toward the current employment policies of the clinic.

**Policy Statement**: The Clinic seeks to clearly define the processes by human resources are managed and administered.

The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Scope**: This policy is procedural and informational in nature.

**Policy Body: Employment Policies**

1. The general employment practices and guidelines of the clinic are compiled in its Employee Handbook. The handbook is a resource for employees and contains information about employment at the clinic.

2. The clinic administration has the right to update or revise information in the handbook.

3. All employees shall be given a copy of the handbook and each will sign that they have received and read the material. Employees will be given a copy of the handbook at initial hire and subsequently whenever any significant changes are made to the document.

4. The following topics, at a minimum, are included in the current handbook:

    a. Employment Terms and Conditions
    b. Safety and Health Concerns
    c. Payroll Policies and Procedures
    d. Overtime Policies
    e. EOE Statement, Non-Discriminatory and Ethical & Legal Guideline Statements
    f. Employment and Payroll Forms (which may be given separately)
    g. Benefits and Calculation Method for PTO
    h. A list of paid Holidays
    i. Safe and non-hostile work environment (including harassment and violence)

5. Questions about employment practices and human resource management not found in the handbook shall be brought to the attention of the Clinic Administrator who will provide the necessary information and consider revisions or clarifications to the handbook.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Employee Handbook | Appendix |
| | | |
| | | |
| | | |

NIHD
RURAL HEALTH CLINIC

| Credentialing and Employment Policy | | |
|---|---|---|
| **J Tag References: J-0011, J-0084, J-0085**<br>**§ References: 491.4, 491.8**<br>**Other References:** | **Policy Type: Human Resources and Employment** | **Policy Number: 410.0** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** This policy describes the general steps that the clinic shall take when credentialing licensed professional employees and contracted professionals. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Statement**: It is the intention of clinic to ensure that all professional clinical employees and staff are in good standing with federal and state licensing boards and in compliance with federal & state programs, as applicable. Pre-employment screening of all employees is also covered in this policy. Maintaining a quality workforce shall be a priority of the clinic.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: Credentialing Policy**

1. **Professional Licenses**: All professional licenses of clinical staff will be verified for license status. All licenses must be current and in good standing with the board which oversees the discipline. These licenses could include one or more of these as is applicable to the individual's scope of practice:
    a. Medical License (physician, MD or DO)
    b. Nursing License (advanced practice, registered nurse, vocational)
    c. Physician Assistant License (often appended to the supervising physician's license)
    d. DEA (all applicable provider types)
    e. State Controlled Substance license (all applicable provider types)
    f. Other professional licenses or professional certifications per the scope of practice of services within the clinic.

2. **Professional Peer Reference**: Professional peer references will be contacted at the discretion of the clinic administrator. Another licensed professional in the clinic may participate in validating references.

3. **Education and Employment History**:
    a. Copies of diplomas and/or primary source verification of education shall be obtained for the purpose of credentialing professional clinical staff.
    b. Employment History shall be confirmed to establish that no unexplained gaps in work experience have occurred. A copy of a professional CV shall also serve this purpose.

4. **Certifications**: The clinic administration or other designated person shall verify current skill or competency certifications for specialty or provider type. A copy of the current certification shall be kept in the employee's file.

5. **Background Checks**: The Clinic Administrator shall conduct any required background checks, including those required by federal or state agencies.

6. **Pre-Employment Screening**: The Clinic Administrator shall screen all employees to the extent necessary to establish:
    a. Education or Training
    b. Skill and competency level of job tasks
    c. Current licenses and certifications
    d. Prior Disciplinary Actions against professional licenses
    e. Employment history and references
    f. Background Checks (Criminal, Sex Offender and OIG Excluded Party Sanction)
    g. Drug Screens (pre-employment and random)

7. **HR Files**: The clinic administrator or a designated HR employee shall keep an HR/Employment file on each employee which shall contain all the necessary information about the employee's job description, hiring process, qualification, education, health status and screenings.
    a. Personnel and Credentialing files shall be secured and safeguarded from unauthorized access at all times.
    b. Employee Health information shall be secured and safeguarded from unauthorized access at all times.
    c. Any negative findings shall be maintained in a separate Quality Assurance file for the purpose of peer review and performance improvement, if applicable.

**Specific Procedures**: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Employment Files | |
| | Quality Files | |
| | | |
| | | |

NIHD
RURAL HEALTH CLINIC

| COVID-19 Vaccination Policy | | |
|---|---|---|
| **J Tag References: J-0110, § References: 491.8(D)** | **Policy Type:** Human Resources and Employment | **Policy Number: 411.0** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purpose of this policy is to outline the policy and procedures related to the vaccination mandate required by CMS as found in 42 CFR 491.8(d).

Policy Statement: It is the intention of the clinic to remain in regulatory compliance as a Rural Health Clinic in respect to federal, state, and local laws which apply to the conditions of certification. More specifically, it is the intention of the clinic to adhere to the guidance in **Attachment M of QSO-22-07-ALL** and other guidance issues by the Center for Medicare and Medicaid Services (CMS) which requires all RHC staff are fully vaccinated for COVID-19. The clinic is identified asNorthern Inyo Rural Health Clinic.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: Provision of COVID-19 Vaccination/Immunization Requirements**

1. **Vaccination Definitions:** Below are the definitions of vaccination types.
    a. Primary vaccination series: The completion of the primary vaccination series for COVID-19 is defined as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.
    b. Fully Vaccinated: An individual who is at least two weeks or longer from completion of the primary vaccination series for COVID-19.
    c. Booster: per the Center of Disease Control (CDC), refers to a dose of vaccine administered when the initial sufficient immune response to the primary vaccination series is likely to have waned over time.

2. **Staff Definition:** Regardless of clinical responsibility or patient contact, this policy and the accompanying procedures and processes apply to the following clinic staff:
    a. All Rural Health Clinic Employees regardless of role or position or whether or not they provide direct patient care.
    b. All licensed practitioners and providers employed or contracted.
    c. All students, trainees, and volunteers.
    d. All other individuals who provide patient care, treatment, or other services to the clinic under contract or by other arrangement regardless of whether or not those services require direct patient care.
    e. **Except for the individuals in the categories listed above who either**:

i. Exclusively provide telehealth or telemedicine services outside of the clinic and never have direct contact with patients in the clinic or other RHC staff included above, or
ii. Provide remote support services for the clinic which are exclusively performed outside of the clinic and never have direct contact with patients in the clinic or other RHC staff included above.
iii. Remote staff are excluded from the staff required if 100% of their work is remote, outside the clinic, and they have not direct contact with RHC patients or RHC staff.

3. **COVID-19 Immunization Education:**
   a. The clinic shall provide educational resources to all RHC staff, as defined in Section 2 of this policy, for the purpose of providing information about:
      i. The Severe acute respiratory syndrome coronavirus 2 also known as SARS-CoV-2 or COVID-19 including the etiology, signs and symptoms, complications and risk factors and methods of transmission.
      ii. The role of immunizations in mitigating the spread of infection; and
      iii. The availability of immunizations.
   b. Educational resources shall be compiled from current information available from the Centers of Disease Control, state health departments, professional medical associations and other reliable sources of professional medical education.
   c. Educational resources may be distributed through any effective media including but not limited to, employee orientation training, annual staff training, clinic staff in-serve training, online modules, or other methods of instruction or distribution.

4. **Vaccination Accessibility and Administration:** The clinic shall make vaccine administration readily available to all RHC staff. Should vaccines not be available at the clinic, the clinic administration shall made vaccines available through other resources including but not limited to public health agencies, other local and regional healthcare providers or pharmacies. The clinic shall also accommodate staff members who experience side effects from the vaccinations.

5. **Verification of COVID-19 Vaccination Requirements for Staff**: The vaccine status of all staff requiring COVID-19 immunizations, except for those addressed in other sections of this policy as being qualified for an exemption or as requiring a delay in vaccination, shall be verified prior to the individual providing any care, treatment, or any other services for the clinic or its patients, directly or indirectly except where those individuals meet the 100% remote definition.
   a. Prior to hire or start date: The vaccination status of any new RHC staff, as defined above, who have **not** previously provided services for the clinic prior to the mandate implementation shall be verified prior to the individual reporting to work at the clinic. The vaccination status shall be verified by:
   Nursing Employee Health

i. Proof of vaccination shall be provided from a reliable and verifiable source. Sources may include the individual's COVID-19 vaccination card, the state's immunization database, a copy of clinical documentation substantiating the vaccine administration.
ii. A copy of the vaccine documentation, including any boosters, shall be retained by the clinic.
iii. The records can be located in
The NIHD EH
iv. Should the RHC doubt the validity of the proof, the clinic shall use a second source to verify and document the vaccination status.

b. Current and existing staff: The vaccination status of current or existing staff, as defined above, who have provided services for the clinic shall be verified as soon as possible after the issuance of the December 28, 2021, clarification provided by CMS in QSO-22-07-AA and related Attachment M if verification of vaccine status for existing staff had not been verified previously. The vaccination status shall be verified by: Nursing Employee Health

i. Proof of vaccination shall be provided from a reliable and verifiable source. Sources may include the individual's COVID-19 vaccination card, the state's immunization database, a copy of clinical documentation substantiating the vaccine administration.
ii. A copy of the vaccine documentation, including any boosters, shall be retained by the clinic.
iii. The records can be located in
The NIHD EH
iv. Should the RHC doubt the validity of the proof, the clinic shall use a second source to verify and document the vaccination status.

6. **Management of Employee for which vaccination has been delayed**: There may some situations where either new or existing staff are required to temporarily delay vaccination based on the recommendations of the CDC.
   a. The individual shall be identified along with the reason for the delayed vaccination and the estimated time of the delay.
   b. In these cases, for new and existing employees, respectively, the vaccination window (when the individual can be vaccinated) shall be monitored by the designated individual or department as referenced above in Section 3.
   c. The individual shall be notified when the temporary delay period has ended.
   d. Recordkeeping shall include the individual's name, the reason for the temporary delay in vaccination, and a copy of a COVID-19 vaccination record once it is available.
   e. The tracking, monitoring and recordkeeping of all COVID-19 vaccine data shall be safeguarded and securely stored as protected health information.

7. **Management of Exemption Requests**: The clinic shall receive requests for both medical and religious exemptions from individuals who are prevented from or object to COVID-19 vaccination on grounds which are recognized by applicable federal laws and

guidance from other agencies including but not limited to the Equal Employment Opportunity Commission (EEOC). Exemptions are granted by the clinic under the terms of this policy.

a. Medical Exemption Requests: Individuals may request a medical exemption when there is a clinical contraindication which precludes them from being vaccinated for COVID-19. The CDC maintains the document, *Summary Document for Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States* which can be accessed on the CDC website. The processes for requesting a medical exemption are:
    i. The staff member or job applicant shall use a request form that has been approved by the clinic.
    ii. The request shall include the following documentation:
        1. The authorized vaccine (manufacturer) that is contraindicated for the staff member
        2. The recognized clinical reasons for the contraindication
        3. A statement recommending that the individual be exempted from the RHC COVID-19 vaccination requirement based on the medical contraindication.
        4. The documentation supporting the request must be signed by a licensed practitioner acting within their scope of practice in accordance with all applicable state and local laws.
        5. The practitioner cannot sign their own request.

b. Religious Exemption Requests: Individuals may request vaccine-related religious accommodation in order to be excluded from the RHC COVID-19 vaccination requirement. The EEOC maintains a compliance manual of religious discrimination which can be accessed on the agency's website. The processes for requesting a non-medical or religious exemption are:
    i. The staff member or job applicant shall use a request form that has been approved by the clinic.
    ii. The staff member or job applicant must inform their employers if they seek an exception to an employer's COVID-19 vaccine requirement due to a sincerely held religious belief, practice, or observance. This shall be attested to on the request form.
    iii. Staff members and applicants are encouraged to familiarize themselves with the EEOC Title VII definitions of protected religious accommodation.
    iv. The request shall be signed and dated by the individual.

c. Granting of Exemptions: The clinic shall use the following criteria for receiving and granting exemption requests:
    i. Requests for either medical or religious exemption for the vaccine requirement shall be received by a designated member of clinic and forwarded as necessary to human resources, the clinic administrator or another designee.

ii. Submitted requests which are complete based on the current applicable federal regulations and guidance shall be considered on a case-by-case basis and granted when the reason for the request has been validated based on federal guidance such as EEOC or other internal administrative policies.

iii. Subcontractor Exemption Status: : The clinic shall honor any medical or religious exemption granted by a contractor to that contractor's employee or subcontractor who performs regularly occurring services within the clinic and who would otherwise be considered staff as defined in Section 2 of this policy. In this case:

   a. The clinic shall obtain the documentation of the contractor's policy concerning COVID-19 vaccination and proof that supports the granting of the exemption pursuant to the policy to any employees or subcontractors working within the rural health clinic.
   b. All other provisions of this policy shall apply to contractors, employees of contractors and subcontractors.

d. Exemption Recordkeeping: The clinic shall retain all exemption requests and the outcome of each request. The staff members who have been granted either medical or religious exemptions shall be tracked along with all other employees to ensure that RHC COVID-19 vaccination thresholds have been maintained and to demonstrate compliance with 42 CFR §491.8(D)

8. **Accommodation, Infection Prevention, and Infection Control:**
   a. The clinic shall adhere to national infection prevention and control standards in its reasonable accommodation of individual staff members who remain unvaccinated either as a result of a temporary delay or from the granting of an exemption for either medical or religious reasons. OSHA and CDC guidelines shall be considered. These standards could include, but are not limited to:
      **i.** Routine testing of unvaccinated staff
      **ii.** Employee screening processes for signs and symptoms
      **iii.** Self-reporting of a known exposure to the virus
      **iv.** Use of NIOSH N-95 masks or equivalent or higher-level respirators when unvaccinated staff are inside the clinic
      **v.** Use of additional PPE
      **vi.** Social distancing from other employees and patients
      **vii.** Use of physical barriers between workspaces
      **viii.** Reassignment of duties or work location
      **ix.** Hand hygiene
      **x.** Routine and frequent disinfecting of frequently touched surfaces
      **xi.** Other measures currently recommended by the CDC and OSHA
      **xii.** State requirements and recommendations
   b. Accommodation shall be made on an individual case-by-case basis depending on the staff member's job or role, the reason for the individual remaining

unvaccinated, direct exposure to patients and coworkers, and the physical layout of the staff member's workplace.

9. **RHC COVID-19 Vaccine Mandate Recordkeeping and Tracking:** The clinic shall keep complete records on the vaccination status of all RHC staff including the status of individuals who are temporarily delayed from being vaccinated and the status of individuals who have been granted medical or religious exemptions. The clinic shall develop tools, either electronic or hard copy, to facilitate in the tracking and recordkeeping. The designated stakeholders previously identified in this policy along with the RHC's compliance officer shall be responsible for identifying and correcting any area of non-compliance.

10. **Enforcement of Non-Compliance:** Should an individual incident of non-compliance with the RHC COVID-19 vaccine mandate not be able to be remedied by any of the terms of this policy, the staff member shall be subject to employment actions necessary to maintain the facility's compliance with the conditions of certification. The staff member shall be counseled according to other human resource management protocols prior to a final action.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Medical Exemption Form | 411-A |
| | Religious Exemption Form | 411-B |
| | Proof of Vaccination Record | |

NIHD
RURAL HEALTH CLINIC

| Periodic Performance Evaluation and Clinical Competency | | |
|---|---|---|
| **J Tag References: J-0011, J-0084, J-0085**<br>**§ References: 491.4, 491.8**<br>**Other References:** | **Policy Type: Human Resources and Employment** | **Policy Number: 415.0** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose**: This policy describes the processes for the periodic performance evaluation of employees and the processes for evaluating clinical competencies that will be used by the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Statement**: It is the intention for the clinic to conduct periodic performance evaluations to ensure: that employees are adequately performing the tasks within each respective job or role; that the job descriptions accurately reflect the present duties; and that clinical staff possesses the clinical competencies needed to perform nursing or direct patient care tasks.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: Performance Evaluation**

1. **Performance Evaluation**: The Clinic provides on-going performance evaluation of all employees which shall include any or all of these aspects of evaluation:
    a. Evaluation of individual employees during any provisional or probationary period of employment;
    b. On-going performance evaluation of employees to promote performance improvement and to promote pro-active education and training as needed;
    c. 360° team-building activities including peer and self-assessment;
    d. Formal performance evaluation, at least annually.
2. **Clinical Competencies**: The Clinic provides periodic evaluation of all licensed and unlicensed staff who performs direct patient care or nursing tasks.
    a. New skills: Whenever a new skill is required, due either to a change in job function or to the provision of a new service, the staff shall be in-serviced on the required task. Training and competency shall be documented at the point of training.
    b. Existing skills: At least annually, a licensed medical professional who is at least one supervision level or licensure level above each respective employee shall perform a clinical competency check-off to ensure that the individual employee possesses the skills needed to provide the patient care services.
    c. Retraining and Refreshment of Skills: As needed, employees shall receive training to refresh clinical skills.
3. **Performance Improvement or Action Plans**: Whenever an employee performance evaluation activity or employee action warrants a performance improvement plan (PIP) or a performance action plan, the employee shall be made aware of the

performance expectations, the plan stipulations, the required timeframe, and the prescribed outcomes based on improved or unimproved performance. The Clinic Administrator, supervisor or a HR representative shall discuss the PIP with the employee, document any actions in the personnel file. Both the employee and supervisor shall sign the PIP. The Clinic shall follow all written human resource policies and federal or state labor laws when implementing a performance improvement plan.

4. **Documentation of Evaluations and Training**: The Clinic shall maintain adequate records of all performance evaluation activities, clinical competency evaluations, and employee training. The records shall be maintained for the period of time required by the state for business record retention.

**Specific Procedures**: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Employment Files | |
| | Employee Training Records | |
| | | |
| | | |

NIHD
RURAL HEALTH CLINIC

| Program Evaluation Policy | | |
|---|---|---|
| **J Tag References: J-0100, J-0101, J-0102, J-0160, J-0161, J-0042 References: 491.9** | **Policy Type:** Administrative/QA | **Policy Number: 500.0** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purpose of this policy is to outline how the clinic will conduct the RHC Program Evaluation. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Statement:** The clinic shall conduct a biennial (every two years) evaluation of all aspects of the RHC program according to federal regulations and to state regulations, if they apply. The review shall either be conducted by a qualified third-party or by the clinic administrator and/or providers. Interperiodic reviews of focused areas may also be conducted. The review findings shall be presented at an organized meeting once every twenty-four (24 months). Data shall be compiled for each of the two 12-month periods.

**Policy Scope:** This policy is informational, regulatory and procedural in nature.

**Policy Body: Program Evaluation Policy**

1) **Purpose of the Evaluation:** The purpose of the evaluation is to determine if:
   a) Utilization of Services were appropriate for an RHC;
   b) Established policies and procedures were followed; and,
   c) To evaluate the need to change or revise the program of the clinic.
   d) Financial, demographic and operational data may also be reviewed to determine areas for improvement and to access community needs.

2) **Utilization:** The Clinic shall review the utilization of clinic services including:
   (1) The number of patients served;
   (2) The volume of services provided; and,
   (3) Any other measure of utilization that contributes to the review findings.

3) **Medical Records:** The clinic shall review a representative sample of both active and closed clinical records for completeness, accuracy and the utilization of services. The review of these records can be performed throughout the review period; however, a summary of these findings along with any additional focused record reviews shall be presented as part of the program evaluation. Additionally, medical record reviews or audits neccessary to comply with requirements of the medical board, state nursing board or any other 3rd parties shall be conducted as required to maintain total compliance. Results of those additional findings may be reported on interperiodically as needed.

4) **Policies and Procedures:** The clinic shall conduct a review the written policies and procedures at least biennially. The providers of the clinic--medical director, physicians, nurse practitioners and physician assistants, and other qualified RHC providers--shall participate in the review process.

One outside professional not employed by the RHC shall also participate in the biennial review of the written policies and procedures. All Federal and state regulatory guidelines will be considered during the review. The review shall be used to determine if:

(1) Services have been provided in accordance with the existing body of policies;
(2) Policy additions, deletions, or revisions are necessary to properly reflect current practice and ensure regulatory compliance.

5) **Biomedical Equipment:** As part of the program evaluation, records pertaining to preventive and periodic maintenance of essential equipment shall be reviewed. All equipment placed in service shall be placed on the equipment log. Any repairs to equipment or any equipment taken out of service shall be noted. Any changes to the equipment inventory shall be included in the program evaluation report.

6) **Program Evaluation Meeting:** The Clinic shall present the biennial program evaluation findings during an organized meeting at least once every 24 months. The meeting shall be attended by the RHC providers and appropriate staff as well as representatives from the RHC's parent entity and other stakeholders whose involvement would contribute to performance improvement, operational efficiencies, organizational strategy, and regulatory compliance. Minutes of the program evaluation meeting shall be maintained.

7) **QAPI:** The Clinic shall report on any quality assurance initiatives or performance improvement projects at the biennial meeting, as applicable to the biennial review process and 42 CRF §491.

8) **Consideration and Corrective Actions**: The Clinic staff shall consider the biennial review findings and any recommendations that result from the biennial meeting. Corrective actions, if necessary, to improve the program performance and compliance, shall be taken. The staff will be in-serviced on any changes which result from the biennial evaluation.

**Specific Procedures:** As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Program Evaluation Report | |
| | Inter-periodic Minutes or Studies | |

NIHD
RURAL HEALTH CLINIC

| Quality Assurance and Utilization Review | | |
|---|---|---|
| **J Tag References: J-0151, J-0152, J-0161, J-0162 § References: §491.8, 491.10, 491.11** | **Policy Type:** QA & UR | ***Policy Number:*** *510.00* |
| **Effective and Revision Date(s):** 1/31/2022 | | |

**Policy Purpose:** The purpose of this policy is to outline the objectives of Quality Assurance (QA) initiatives and Utilization Review (UR) functions of the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Statement**: The clinic is committed to compliance and quality patient care for which QA and UR activities are vital. The purpose of these activities is performance improvement and program integrity.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: Quality Assurance and Utilization Review**

1) **Quality Assurance:** The clinic shall conduct QA initiatives, studies, or projects which are deemed helpful in measuring the quality assurance of different aspects of the clinic's operations. Such projects might include, but are not limited to these areas:

   a. Patient Satisfaction
   b. Employee Satisfaction
   c. Employee Performance
   d. Other Clinical and/or Operational Functions

2) **Utilization Review:** The Clinic shall conduct utilization review activities which may include:

   a. Medical record review by the physician or medical director to establish appropriateness of care as provided by the mid-level providers.
   b. Medical record review by the physician(s) in accordance with federal or state requirements as stated in regulations, collaborative practice agreements, or other official guidelines. If no other governing board dictates a specific quantity of records to be reviewed or the frequency of review, the clinic shall defer to at least the minimum number established in the most recent version of the CMS, Appendix G, Interpretive Guidelines for Surveyors.
   c. Medical Record reviews by designated staff to determine the completeness of the medical records and the qualitative components of the records.
   d. Medical record reviews by other qualified third-parties as determined helpful by the clinic administration or as established in any written compliance plan or corrective action plan, if applicable at any given time.

3) Provider and Staff Involvement: The clinic shall encourage the participation of professional staff and employees in designing and conducting QA and UR activities.

   a. Quality initiatives shall be discussed at either routine staff meetings and/or during regular quality meetings as prescribed within the organization. Meeting minutes shall be kept for all meetings during which quality measures are discussed.
   b. Employees and providers shall be made aware of all on-going or new performance improvement (PI) projects;
   c. QA and UR activities shall be considered, evaluated or reviewed as part of the Annual Program Evaluation Process. The annual program evaluation findings shall serve as a source in the development of ongoing or future quality assurance/performance improvement (QAPI) initiatives.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

## RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Related Forms or Documentation, As Applicable | |

NIHD
RURAL HEALTH CLINIC

| Grievance Policy | | |
|---|---|---|
| **J Tag References: J-0010, J-1011, J-1062 § References: §491.4, 491.11** | **Policy Type: QA and UR** | **Policy Number: 520.0** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purposes of this policy are to clearly define the processes which employees or patients shall take in order to file a complaint or grievance against the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Statement**: It is the intention of the clinic to allow both employees and patients to freely express concerns, complaints and grievances in an effort to:

1. guarantee that individual civil rights are protected;
2. ensure that compliance with federal, state and local regulations and laws is maintained;
3. improve the quality of care and patient care experience;
4. improve the quality of the workplace; and
5. resolve failures or weaknesses within the existing policies and procedures.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: Grievance Policy**

1. **Patient Complaints**: The following steps shall be taken in handling a patient complaint.

   a. Patients may file a formal grievance by contacting the clinic by phone, by mail or electronic mail or in person.
   b. The employee receiving the complaint shall assist the complainant in completing the patient complaint form. The patient or patient representative may complete the form, if desired. The form may be given to the individual to return to the clinic later.
   c. All patient complaints are confidential in nature.
   d. Clinic staff should not hinder or deter the individual from making a complaint.
   e. All complaint forms shall be given to the clinic administrator or manager for the purposes of:

      1. Seeking resolution of the root problem;
      2. Clarifying Clinic policies and procedures with employees and/or patients;
      3. Taking Corrective actions, as needed;

   f. The administrator or manager shall research or investigate the complaint.
   g. The administrator or manager shall communicate with the patient for the purpose of further understanding the complaint and resolving the issue.

h. The administrator or manager shall communicate with staff and employees for purpose of further understanding the complaint and resolving the issue.
i. The administrator or manager shall document the investigation and resolution processes on the original Patient Complaint form.
j. Patients shall be given the contact information for the accreditation organization (AO) or state office for further reporting complaints which are not resolved through the internal process.

2. **Employee Complaints:** The following steps shall be taken concerning the resolution of an employee complaint or grievance.

   a. The employee should try to resolve any workplace conflict with co-workers or managers by discussing any problem as soon as possible.
   b. If informal conflict resolution is not successful or appropriate for the nature of the complaint, the employee may complete an Employee Complaint Form.
   c. The administrator or manager shall communicate directly with the employee concerning the grievance.
   d. The employee shall not be hindered or discouraged from voicing a complaint. No retaliatory actions shall result from an employee allegation of a grievance.
   e. The administrator or manager shall investigate the details of the complaint by interviewing other employees or individuals who may have knowledge of relevant facts.
   f. The administrator or manager shall seek to validate and resolve the employee complaint as quickly as possible.
   g. The administrator or manager shall document the investigation and resolution processes on the original Employee Complaint form.
   h. The administrator or manager shall take all necessary corrective actions related to any inappropriate personnel actions or behaviors discovered during the grievance resolution process.

3. **Quality Assurance/Performance Improvement:** All patient and employee complaints shall be taken seriously and considered an important part of the clinic's Quality Assurance and Performance Improvement (QAPI) activities.

   a. The original complaint forms shall be maintained as part of the clinic's regular record-keeping.
   b. The number of complaints and the nature of the complaints shall be included in the Clinic's annual review and QA evaluation or during inter-periodic reviews unless the nature of the complaint precludes disclosure due to federal or state law. The name of the complainant shall not be disclosed as part of the evaluation process.
   c. Grievances which suggest or substantiate non-compliance with local, state, or federal laws shall be reviewed by the organization's ownership and legal counsel as applicable to the situation.
   d. Performance Improvement activities shall be directed at correcting any trends or repeated issues that are brought to light through these grievance processes.
   e. Revision of written policies, handbooks, or procedural guides, if applicable, shall be made in response to grievance findings.

**Specific Procedures**: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS:** ***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Nondiscriminatory Policy | |
| | Patient Complaint Form | |
| | Employee Complaint Form | |
| | | |

NIHD
RURAL HEALTH CLINIC

| Risk Management Policy | | |
|---|---|---|
| **J Tag References: J-0041, J-0042, J-0010**<br>**§ References: §491.6, 491.4** | **Policy Type: QA and UR** | **Policy Number: 530.0** |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purposes of this policy are to clearly define the processes which employees or patients shall take in order to manage risk at the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Statement**: It is the intention of the clinic to manage the risk of injury to patients, employees, and property. Other policies in the Physical Plant section of this manual may augment this policy by providing more detailed guidance on how the clinic maintains a safe environment as more specifically related to patient and employee safety issues. The clinic's culture of compliance and quality assurance is a vital part of our risk management plan.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: Risk Management**

1. **Maintenance of Building & Grounds**: The Clinic shall maintain the building, grounds, and parking areas to prevent or minimize the risk of injury. This shall include:
    a. Removing, repairing, or replacing features which present a trip or fall hazard such as obstructions, uneven surfaces, or conditions which restrict access to entrances or exits;
    b. Maintaining appropriate signage for identification of hazards, directives, warnings, and other safety or environmental messages;
    c. Periodic inspection of the property and routine, scheduled maintenance;
    d. Safety meetings, as needed, with the employees and staff to help identify or mitigate potential areas of risk;
    e. Prompt repair of any hazardous condition.

2. **Injuries or Incidents**: If a patient, visitor or employee is injured while on clinic property, the administrator, manager or provider on-site shall:

    a. Immediately evaluate the need for first aid or emergency care and act appropriately;
    b. Complete an incident report to obtain details about the incident or injury and to record the occurrence;
    c. Obtain photographs, if applicable and authorized;

d. Report the incident to the ownership or management of the organization;
e. Assist in reporting the incident to the Clinic's insurance carriers;
f. Facilitate in any investigation, root cause analysis or corrective action required to manage or mitigate current or future risk.

3. **Insurance Coverage**: The Clinic shall secure and maintain adequate insurance coverage to include the following types of coverage, as appropriate or as required by state regulation, lenders, vendors, grantors, landlords, or any other third party or agency:

    a. Property and Casualty
    b. General Liability
    c. Automobile or Vehicle (comprehensive and/or liability)
    d. Worker's Compensation
    e. Malpractice Coverage
    f. Other professional errors and omissions coverage
    g. Any additional coverage needed for indemnification

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization

**RELATED POLICES AND SUPPLEMENTAL DOCUMENTS**
***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Other Policies in Section 200 | |
| | Incident Report Form | |
| | | |
| | | |

NIHD
RURAL HEALTH CLINIC

| Financial Policies | | |
|---|---|---|
| **J Tag References: J-0011, J-0160, J-0161 § References: 491.4, 491.11** | **Policy Type:** Administrative | ***Policy Number:*** *600.00* |
| Effective and Revision Date(s): 1/31/2022 | | |

**Policy Purpose:** The purpose of this policy is to establish the procedures for handling financial and patient accounting transactions of the Clinic.

Policy Statement: The clinic maintains policies and procedures for the financial operation of the RHC. These policies relate to patient account and business office functions. The clinic is identified as Northern Inyo Rural Health Clinic.

**Policy Scope**: This policy is informational, regulatory and procedural in nature.

**Policy Body: Financial and Patient Accounting Policies**

## A. Patient Registration

1. Verification of Insurance: The clinic shall demonstrate a prudent effort in verifying patient insurance coverage prior to the provision of services. The clinic shall use one or more of these methods to verify coverage:

    a. Tools or services available within the PM system;
    b. Payer websites and tools;
    c. Telephone verification between payer and the clinic front desk staff.

2. Patient Contact Information and Identity Verification: The clinic shall demonstrate a prudent effort in verifying patient identity and current contact information at the initiation of service and periodically thereafter. The clinic shall use one or more of these methods to verify patient information and update patient demographics.

    a. Scan or copy the patient's driver's license or state-issued identification card making sure that the name and information matches the information on the insurance card;
    b. Collect the patient contact information from the patient registration forms;
    c. Verify patient identification using another photo id card or government document;
    d. Re-validate patient contact information periodically to ensure correct demographics are captured.

e. Investigate any suspicion or discrepancy which puts the patient's identity into question. The clinic is committed to the prevention of medical identity fraud.

3. **HIPAA, Consent to Treat, and Reassignment of Benefits:** The clinic is committed to informing its patients of rights and responsibilities associated with receiving care and treatment. Notices, acknowledgments, consents and agreements shall be provided and executed between the practice and the patient. All agreements shall These documents shall include, as applicable:

   a. Posted notices of Non-discrimination
   b. Availability of language translation services
   c. Posted ownership statement
   d. Acknowledgement of receipt privacy and security practices
   e. General Consent to Treat
   f. Acknowledgment of Financial Responsibility and financial policies
   g. Reassignment of Benefits to provider
   h. Informed procedural consent, as needed
   i. Authorization of Release of PHI
   j. Patient Grievance Process

## B. Collection of Copays and Deductibles

1. **Deductibles:** The clinic shall make a prudent effort to collect deductible amounts according to the terms of the patient's insurance plan. The clinic shall not waive or write-off deductibles in violation of any managed care contract or as an incentive to reduce the patient's cost share of a service. The clinic as an RHC understands that the Part B deductible is due each calendar year for Medicare patients.

2. **Copayments:** The clinic shall make a prudent effort to collect patient copayments at the point of service to the extent that the patient liability is known and defined. Coinsurance amounts indicated on the patient's insurance card or verified with the payer shall be collected at the point of service. The clinic as an RHC understands that the co-insurance amount for Medicare patients is 20% of total charges. Coinsurance amounts shall not be waived in violation of any managed care contract or as an incentive to reduce the patient's cost share of a service.

## C. Charge Capture, Coding and Billing for Services

1. **Charge Capture:** The clinic shall make a prudent effort to correctly capture and report all services provided to patients. Administration shall be responsible for correctly setting up charges in the PM/EHR. Providers shall be trained on correct charge capture methodology. All employees shall be trained on the aspects of the corporate compliance plan which relate to charging for services.

2. **Fees:** The clinic shall establish a consistent methodology for fee-setting. The method shall consider a baseline either as the MPFS, published claims data amounts, or regional charge data to determine the reasonableness of the gross charges. Periodically, the fee schedules should be analyzed for accuracy and consistency. The clinic shall maintain only one fee schedule for all financial classes.

3. **Coding:** The clinic is committed to correctly assigning diagnosis and procedure codes under the official coding guidelines which are published annually. The diagnosis codes (ICD-10-CM) shall be reported using the highest specificity of the clinical documentation and follow the most recent official coding guidelines. CPT® and HCPCS® shall be used to report the appropriate procedure based on the actual service performed and the most recent official coding guidelines. All payer guidelines shall be followed when reporting services. CCI and MUE edits shall be followed to prevent reporting services which should not be billed during the same episode of care. The clinic shall follow the basic monitoring and auditing measures found in the corporate compliance plan. Providers and internal staff shall be periodically trained on coding updates and changes in official coding guidelines.

4. Billing and Claims Submission: The rural health clinic or its parent entity directly performs the billing functions. The clinic shall follow payer-specific guidelines for bill types, claim format, revenue codes, place of service codes, condition codes and modifiers. The clinic is responsible for billing RHC core services and non-RHC services. The clinic prepares bills and submits claims to payers and third-parties through one or more of these methods:

    a. Its practice management/EHR system and clearinghouse relationship
    b. Through the parent entity's hospital information system (provider-based RHC)
    c. Direct date entry through a payer's portal or website
    d. Submission of paper claims when permissible
    e. Direct submission to the patient or a non-payer third party

5. Rejections, Denials and Appeals: Designated billing or business office staff shall review clearinghouse rejections after each batch submission to determine the reason for the rejection. The clinic shall not repeatedly resubmit claims without investigating the reason for the rejection or the "return to provider" status. Likewise, denials or claims which process with a zero-payment amount shall be reviewed by designated billing or business office staff to determine why the claim did not pay. The clinic staff shall contact the payer to seek resolution. If an appeal is needed, the appropriate staff shall follow the payer's specific appeal guidelines in a timely manner.

## D. Payments, Posting and Account Follow-up

1. **Payments:** The following processes are followed concerning the receipt of payments:
    a. Upfront/Point of Sale Payments: Deductibles, copayments, and payments received for services in person shall be collected from the front desk staff and credited to the patient's account either through the practice management system or by paper receipt. The total amount collected for the day shall be reconciled to a daily system report and verified by the manager or administrator. Electronic payments are

encouraged for all types of transactions. Cash and check payments shall be processed through the system and reconciled daily. If the system report is not utilized, a manual reconciliation sheet shall be prepared.

b. Check payment received by mail: Checks received by mail shall be opened and logged by one person and the corresponding payments posted by another person if there is enough staff for adequate separation of duties. Check payments and posting activity shall be reconciled daily.
c. EFT payments: Electronic payments shall be reconciled to the system regularly. If electronic posting is also implemented, the billing staff shall verify that the payments and posting totals can be reconciled. Outstanding items shall be reconciled when transactions straddle the month-end.
d. Reconciliation of Payments and Posting Activity: There shall be standardized processes by which all payment types are reconciled to the patient account posting activity. Checks and balances shall be in place for adequate separation of duties to ensure that employees handling payments are not the same employees posting to patient accounts.

2. **Adjustments:** The following processes shall be followed when making or posting adjustments to patient accounts.
   a. Contractual Adjustments: Contractual adjustments shall be posted from the remittance advise. For an RHC, the contractual adjustment can be either a debit or a credit. Care should be taken to post the contractual correctly leaving the correct patient responsibility amount even if the payment is in excess of the charges. Should an employee have a question about how to post a specific adjustment, the manager should be consulted.
   b. Other Adjustments: The clinic shall have guidelines for making other adjustments to accounts for items such as sliding fee scale adjustments, prompt pay discounts or corrections to accounts. No employee shall make adjustments greater than 50% of the account balance without a supervisor's permission. Adjustments which are made to correct charges or a patient account balance shall be approved by a supervisor.

3. **Discounts:** No patient discounts shall violate the terms of a managed care contract. Furthermore, no patient discount shall result in the reimbursement for a particular service to be less than the average amount reimbursed by commercial payers for the same service unless created by a charity care policy based on patient income.

4. **Secondary or Corrected Claim Filing:** Payer-specific guidelines shall be followed when submitting secondary claims or when correcting original claims.

5. **Patient Billing:** Patients or the responsible party for the patient shall be billed for amounts deemed to be patient responsibility. Patient statements shall be sent promptly upon the determination of a patient balance and at repeated cycles until the account balance is resolved.

6. **Credit Balances:** Patient accounts with credit balances shall be reviewed at least quarterly to determine if a true credit balance exists and, if so, to determine the source of the overpayment. If the credit balance has been created by an overpayment or duplicate payment by CMS, the amount shall be reported to the MAC using either using the Quarterly Credit Balance Report (CMS 838) or the MAC's portal. Credit balances which

are due the patient shall be refunded in a timely manner. Credit balances which have resulted due to posting errors shall be corrected with a supervisor's approval.

7. **Bad Debt:** The clinic shall follow CMS guidelines for establishing that an account balance consisting of the patient's deductible and coinsurance amounts are considered to be a bad debt. The same guidelines for bad debt and collection efforts shall be applied to all financial classes. Bad debt should be reported according to the accounting policies of the organization and via cost reporting when appropriate.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

***Please refer to these other related policies or attachments for more specific information or procedures:***

| POLICY # | Policy or Document Name | Location |
|---|---|---|
| | Compliance Plan | |
| | Patient Registration Packet | |
| | Notice of Privacy Practices | |
| | Other Financial Policies | |

## Policy Addendum: Processes and Procedures

### *Policy # 130* Non-Discrimatory Policy

Addendum Effective Date: March 2022

**Policy Addendum Purpose:** The purpose of this policy addendum is to establish written processes and procedures which further define or discuss how the main policy provisions will be assimilated and implemented in respect to the normal operations of the rural health clinic.

**Additional Processes and Procedures:**

2. **Identification of Individuals with language barriers and impaired sensory skills**:

a) The clinic providers and staff will use a number of other resources in an effort to meet the communication needs of patients and other individuals for whom English is not the primary language:

i. Certified medical translators or internet-based services which allow face to face translation in person or via an audio/video application. The clinic has an agreement with NIHD Language Services Coordinator:

José Garcia
150 Pioneer Lane
Bishop, California 93514
Phone: (760) 873-2147, TTY 711
Email: jose_garcia@nih.org

5. **Questions or Comments: Questions from patients or from the public concerning the non-discriminatory practices and accommodation of the Clinic, may be directedto:**

Michael Leoz
Pacific Region
(800) 368-1019
Email: OCRMail@hhs.gov

OR

Northern Inyo Rural Health Clinic
Ashley Murray, Civil Rights Coordinator
150 Pioneer Lane, Bishop, California 93514
(760) 873-2145 TTY 711
Email: alison_murray@nih.org

NIHD
RURAL HEALTH CLINIC

**Northern Inyo RHC**

**Disinfection and Sterilization Policy**

**Addendum Policy #238**

The Northern Inyo RHC benefits from access to support from Northern Inyo Healthcare District (NIHD) Sterile Processing services via the Perioperative Department. Sterile instruments and supplies includes the use of non-disposable instruments.

Northern Inyo RHC has a process to pre-clean instruments, under the direction of the NIHD Sterile Processing team. The instruments are contained, soaked in District approved solutions per manufacturer's recommendations, washed and remain in a hard-sided container with a lid for transport to the NIHD Sterile Processing unit. The instruments are packaged and sterilized per current standards.

**REFERENCES:**

- IAHCSMM Central Service Technical Manual 8th Edition Chapter 6
- Amsco/Steris Technique Manual
- AORN RP for Sterilization
- AAMI ST79- 8, 9, 10
- Title 22 Standard 70833
- TJC: EC.02.04.03, IC.02.01.01

Developed: 2/2022

NIHD
RURAL HEALTH CLINIC

## Northern Inyo RHC

## Communication During Internal or External Situations

## Addendum Policy #291

Northern Inyo RHC works closely with Northern Inyo Healthcare District (NIHD) to manage all internal or external emergency situations. NIHD utilizes the Hospital Incident Command System (HICS). Should an internal or external situation arise, the House Supervisor (HS) is notified immediately. The HS determines the need to initiate the HICS and becomes the Incident Commander until the Administrator-On-Call arrives to assume the role. Staff call out happens at the direction of the Incident Command.

Northern Inyo RHC participates as a part of the response, playing an important role in the plan. Should the event occur specifically at the clinic, the District supports the RHC leadership in managing the response.

Communication with workforce from the Northern Inyo RHC is essential. The Internal communication plan is evidence 291-A. This is information is maintained within the NIHD Scheduling Software Program, which includes contact information for all RHC employees. An additional paper copy of the communication list is maintained within the Manager's Office at RHC.

Developed: 3/2022

# Policy Addendum: Processes and Procedures

## *Policy # 310* Medical Management Guidelines

Addendum Effective Date: March 2022

**Policy Addendum Purpose:** The purpose of this policy addendum is to establish written processes and procedures which further define or discuss how the main policy provisions will be assimilated and implemented in respect to the normal operations of the rural health clinic.

**Additional Processes and Procedures:**

Northern Inyo Healthcare District (NIHD) employs Nurse Practitioner(s) (NP), Certified Nurse Midwife (CNM) and Physician Assistants (PA) to work at Northern Inyo RHC. This group of professional providers is generally referred to as Advanced Practice Providers (APPs).

The APPs function at NIHD under Standardized Procedures if they are Registered Nurses (RN), which allows the NP and CNM to work beyond the scope of practice of the RN. This meets the California Board of Registered Nursing requirements.

The PA functions at NIHD under Standardized Procedure. The PA is licensed under the Medical Board of California.

Both the Standardized Procedures and Protocols are developed and revised utilizing an interdisciplinary approach, which includes professionals from nursing, medicine and administration, per the Medical Staff Bylaws. These foundational documents are reviewed via committees, including medical staff oversight. They are reviewed and/or revised biennially.

The Standardized Procedures and Protocols are maintained within the NIHD Policy and Procedure Management (PPM) software. They can be located via the NIHD Intranet>PPM link.

https://nihd.policytech.com/

# Policy Addendum: Processes and Procedures

## *Policy # 330* Patient-Provided or 3rd Party Pharmaceuticals

Addendum Effective Date: March 2022

**Policy Addendum Purpose:** The purpose of this policy addendum is to establish written processes and procedures which further define or discuss how the main policy provisions will be assimilated and implemented in respect to the normal operations of the rural health clinic.

**Additional Processes and Procedures:**

Northern Inyo RHC works closely with the Northern Inyo Healthcare District (NIHD) Pharmacy Department to provide medications and biologicals that are maintained to assure the products effectiveness is not altered.

3rd party pharmaceuticals may be shipped directly to the NIHD Pharmacy Department, where they will assure the packaging is intact and the drug has been stored properly during shipping. NIHD Pharmacy will deliver the medication to the clinic for administration to the patient.