June 15 2022 Regular Board Meeting

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AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

June 15, 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. Northern Inyo Healthcare District 2022 Community Heath Needs Assessment CHNA Update (*Board will receive this update)*

B. Northern Inyo Healthcare District Emergency Department Sexual Assault Response Update (*Board will receive this update)*

C. Approval of Operating and Capital Budget for Fiscal Year 2022-2023 (*Board will receive this presentation and consider the approval of the Operating and Capital Budget for Fiscal Year 2022-2023)*

4. Chief of Staff Report, Sierra Bourne MD:

A. Medical Staff Appointments (*Board will consider the approval of these Medical Staff Appointments)*
   1. Matt Irons, PA-C (*family practice*) – Advanced Practice Provider Staff
   2. Grant Meeker, MD (*anesthesiology*) – Active Staff
   3. Jennifer Meeker, MD (*anesthesiology*) – Active Staff

B. Changes in Medical Staff Category
The following Medical Staff members were recommended to be changed from Active Staff to Courtesy Staff (*Board will consider the approval of these changes in Medical Staff Category)*
   1. J. Daniel Cowan, MD – *anesthesiology*
   2. Michael Dillon, MD – *emergency medicine*
   3. Daniel Firer, MD – *emergency medicine*
   4. Casey Graves, MD – *emergency medicine*
   5. Curtis Schweizer, MD – *anesthesiology*
   6. Carolyn Tiernan, MD – *emergency medicine*

C. Medical Staff Resignations *(Board will consider the approval of these Medical Staff Resignations)*
   1. Kinsey Pillsbury, MD (*radiology*) – effective 05/18/22
   2. Milan Shah, MD (*urology*) – effective 05/19/22

D. Policies *(Board will consider the approval of these Policies)*
   1. *COVID-19 Vaccination for NIHD Workforce*
   2. *DI - Communication of Mammography Results to the Patient*
   3. *DI - MRI Safety Plan*
   4. *DI - NM P&P - Area Surveys and Wipe Tests*
   5. *DI - NM P&P - Daily Area Surveys*
   6. *DI - Reportable/Recordable Events in CT, Fluoroscopy, & Nuclear Medicine*
   7. *Diagnostic Imaging - Lead Interpreting Mammographer Responsibilities*
   8. *Diagnostic Imaging - Mammography Compliance Requirements*
   9. *Diagnostic Imaging - Self-Referral for Breast Screening Exams*
   10. *Gait Belt Policy*
   11. *Infection Prevention Recommendations for Avian Influenza, Novel Influenza, and Seasonal Flu*
   12. *Medical Staff Department Policy – Emergency Medicine*

13. *Mobile Intensive Care Nurse (MICN)*
14. *Nursing Chain of Command in Resolving Patient Care Issues*
15. *Pre- and Post-Operative Anesthesia Visits*
16. *Scope of Anesthesia Practice*
17. *Services for Swing Bed Patients*
18. *Standardized Procedure - Emergency Care for the Nurse Practitioner or Certified Nurse Midwife*
19. *Standardized Protocol - Emergency Care for the Physician Assistant*
20. *Standardized Procedure - Well Child Care Policy for the Nurse Practitioner*
21. *Standardized Protocol - Well Child Care Policy for the Physician Assistant*
22. *Swing Bed Patients Inter-Disciplinary Care Conference*

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

Consent Agenda

5. Approval of District Board Resolution 22-11, 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 April 26, 2022, Special Board Meeting (*Board will consider the approval of these minutes)*
7. Approval of minutes of the May 18, 2022 Regular Board Meeting *(Board will consider the approval of these minutes)*
8. Approval of minutes of the May 25, 2022 Special Board Meeting (*Board will consider the approval of these minutes)*
9. Approval of recently revised Northern Inyo Healthcare District Bylaws *(Board will consider the approval of the entire bylaws in their recently revised format)*
10. Approval of the Northern Inyo Healthcare District Governance Committee Charter *(Board will consider the approval of the NIHD Governance Committee Charter)*

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11. Reports from Board members (*Board will provide this information*).
12. Public comments on closed session items.
13. Adjournment to Closed Session to/for:
    A. 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)

    B. Public Employee Performance Evaluation (pursuant to Government Code Section 54957 (b)) Title: Chief Executive Officer

6/9/2022, 1:34 PM

14. Return to open session and report on any actions taken in closed session.
15. Adjournment

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

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

Date: June 1, 2022

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

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. The survey completion window ran from May 6th through June 3rd. The Board will receive an update on the number of completed surveys and next steps in the CHNA project.

Prepared by: ______________________
Sara Alves
Administrative Assistant to the CNO

Approved by: ______________________
Kelli Davis
CEO

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

Date: JUNE 1, 2022

Title: **NIHD SEXUAL ASSAULT RESPONSE WORKFLOW**

Synopsis: Northern Inyo Healthcare District (NIHD) compassionately recognizes sexual violence can affect many aspects of a survivor's life. To receive care and assistance, victims often must navigate a complex pathway of governmental and community agencies.

NIHD seeks to reduce these hardships and is actively involved in our community based sexual assault response multidisciplinary team meetings to ensure the creation and continued long-term improvements to our area systems, efforts and effectiveness in responding to sexual violence. As an area leader in health care, we remain committed to maximizing effectiveness of available resources and responses in conjunction with supportive relationships between law enforcement, victim services, prosecution and our neighboring hospitals.

While NIHD does not currently perform sexual assault exams, we strive to help survivors through the pathways of community services. The attached workflow serves as a guide to our caregivers when the victim of sexual violence presents to NIHD.

Prepared by: ______________________________

Allison Partridge, Chief Nursing Officer

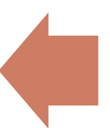
Approved by: Kelli Davis ______________________________

Kelli Davis, Chief Executive Officer

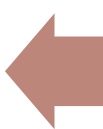
INYO-SART victim with law Enforcement

INYO SART Law enforcement officer will contact NIH Charge RN to inform them of a ETA for PEP.

SART INYO Law Enforcement officer will get on-call SART provider cell number from MH ED Clerk. INYO LE will call and speak with on-Call SART provider



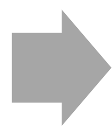
SART provider determins time of exam in Women's Health/Specialty Clinic



INYO LE will call

ED clerk and inform them of a SART exam occuring with the provider on call at the specified time. ED Ward clerk will register a "stand alone" encounter in cerner for Women's Health/Specialty clinic

SART victim with LE will present to Women Health/Specialty building when appt is scheduled.



After 1900-SART Provider/Assist will notify House Sup of SART being completed in Women's.

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

Date: June 3, 2022

Title: **FISCAL YEAR 2022/2023 NIHD OPERATING AND CAPITAL BUDGET**

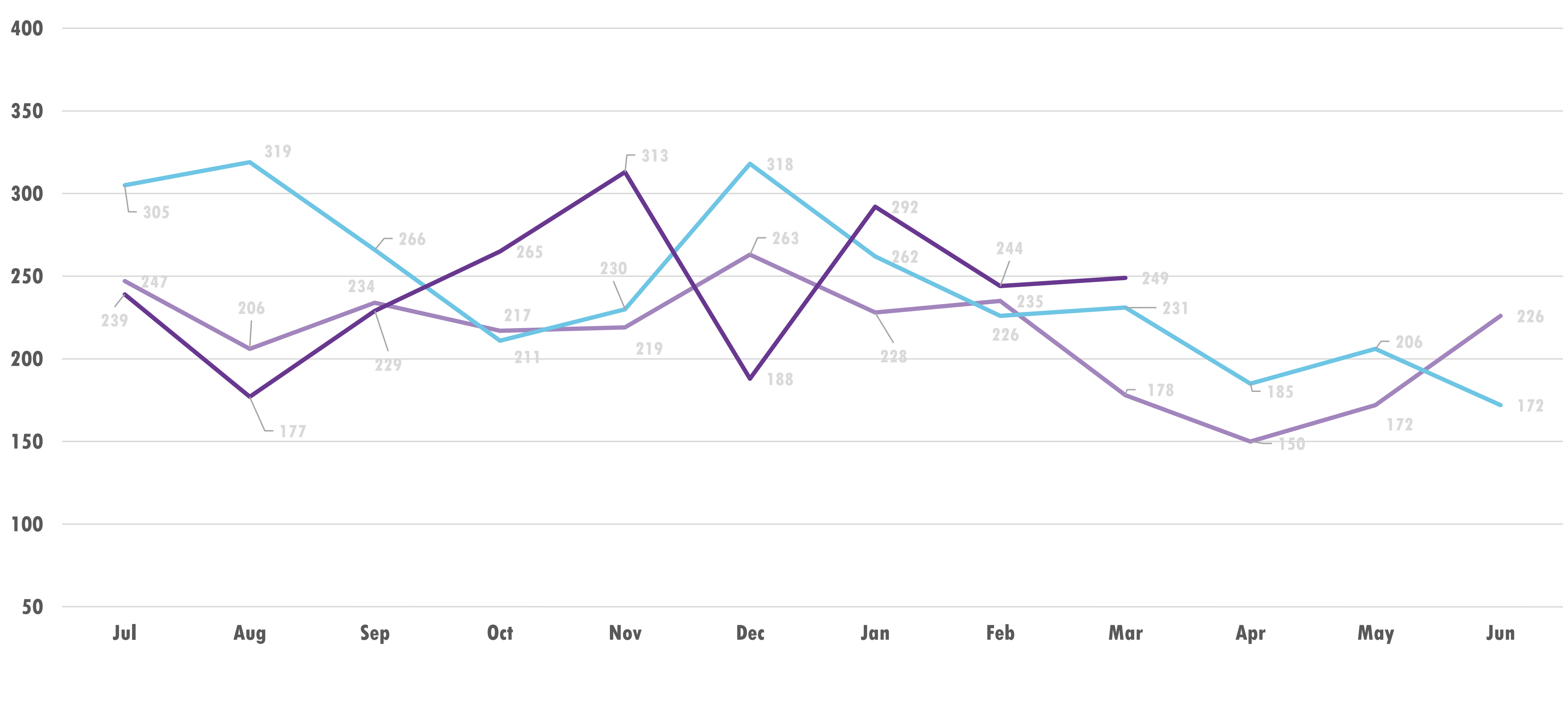
Synopsis: In preparation for the 2022/2023 Fiscal Year beginning July 1, 2022 and commencing June 30, 2023, the NIHD Board of Directors will receive a budget presentation from the Executive Team.
This financial presentation will provide a clear overview of the anticipated financial spend for the District in the coming year.
The District leadership team feels confident all budgetary planning efforts in recent months, convey the fiscal year primary goals and objectives, and they align with District mission and vision.
It is recommended our Board approve the budget as received during the presentation on June 15, 2022, during the scheduled Board Meeting.

Prepared by: ______________________
Sara Alves
Administrative Assistant – to the CNO

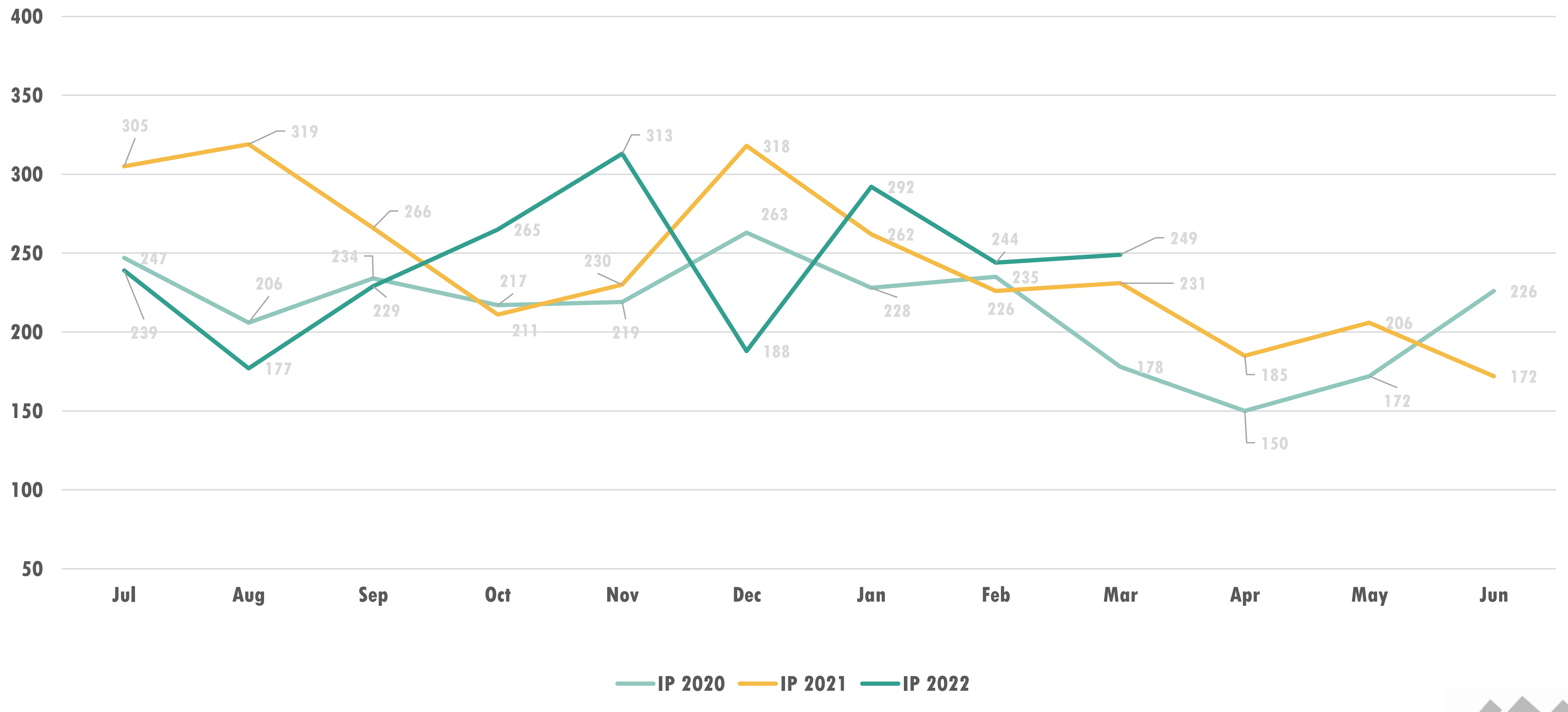
Approved by: Kelli Davis
Kelli Davis
CEO

NORTHERN INYO HEALTHCARE DISTRICT
FY 2023 Operating & Capital Budget
Presentation
June 8, 2022
NORTHERN INYO HOSPITAL

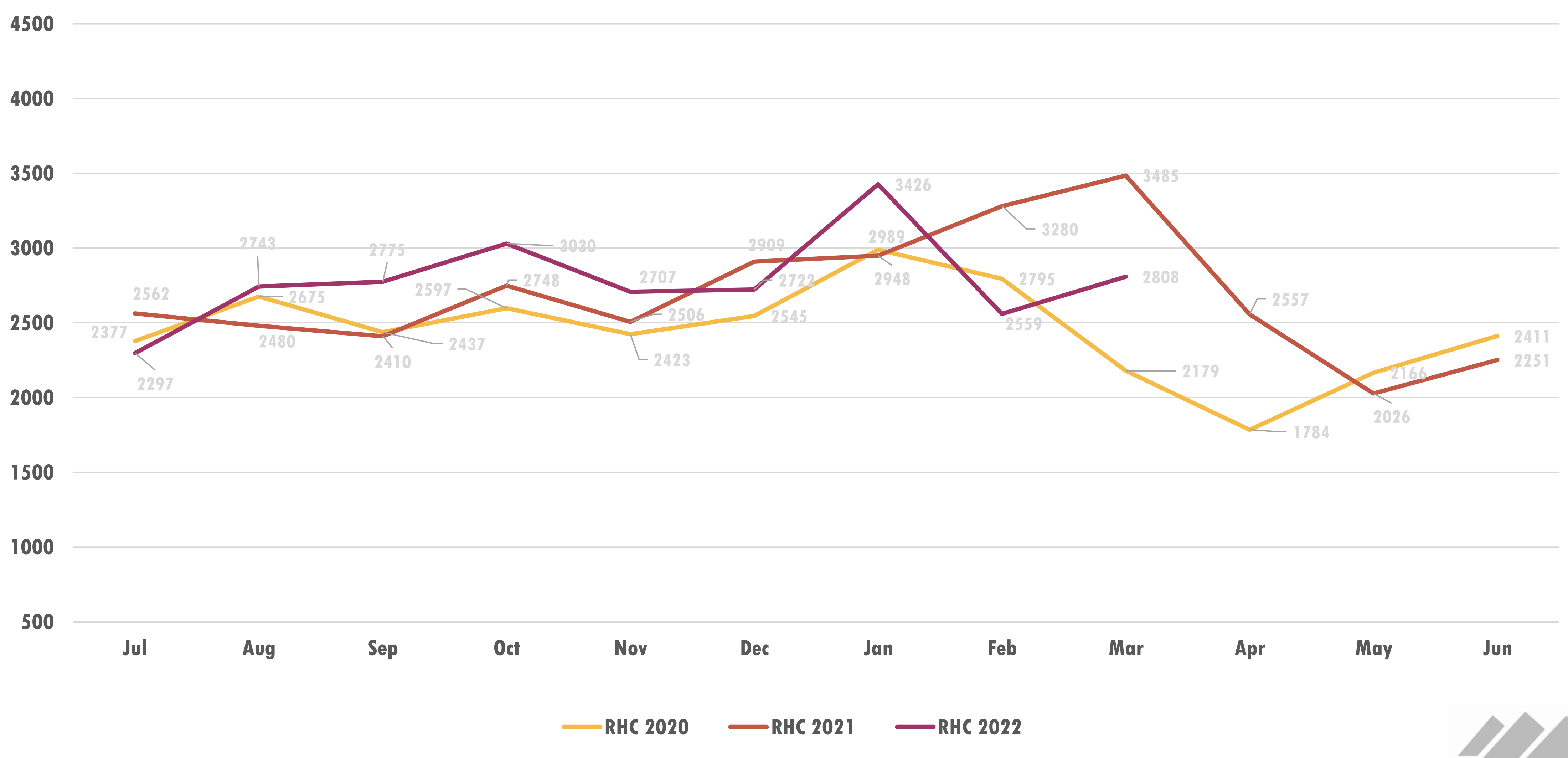
Inpatient Utilization



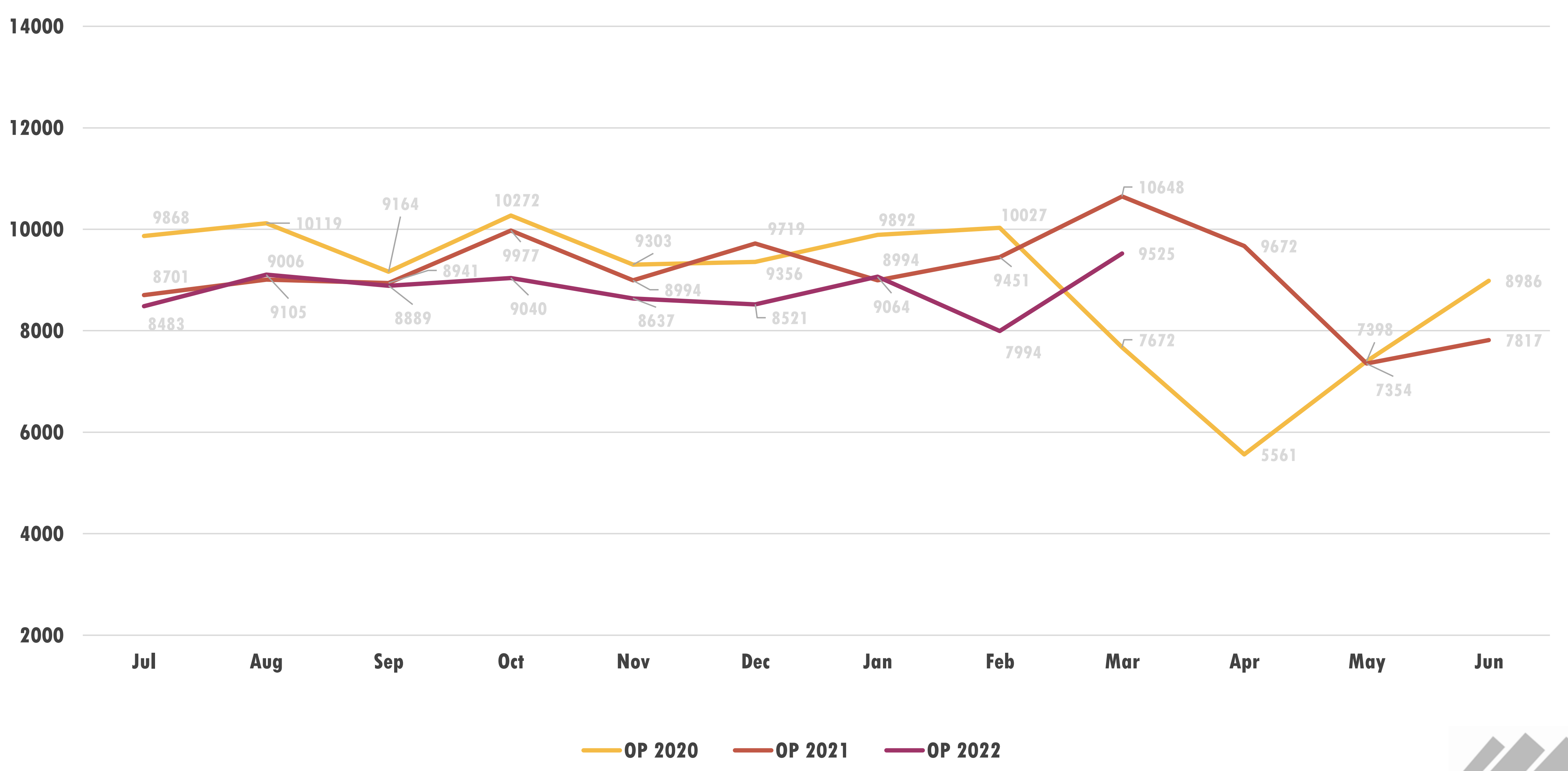
NIA Clinic Visits



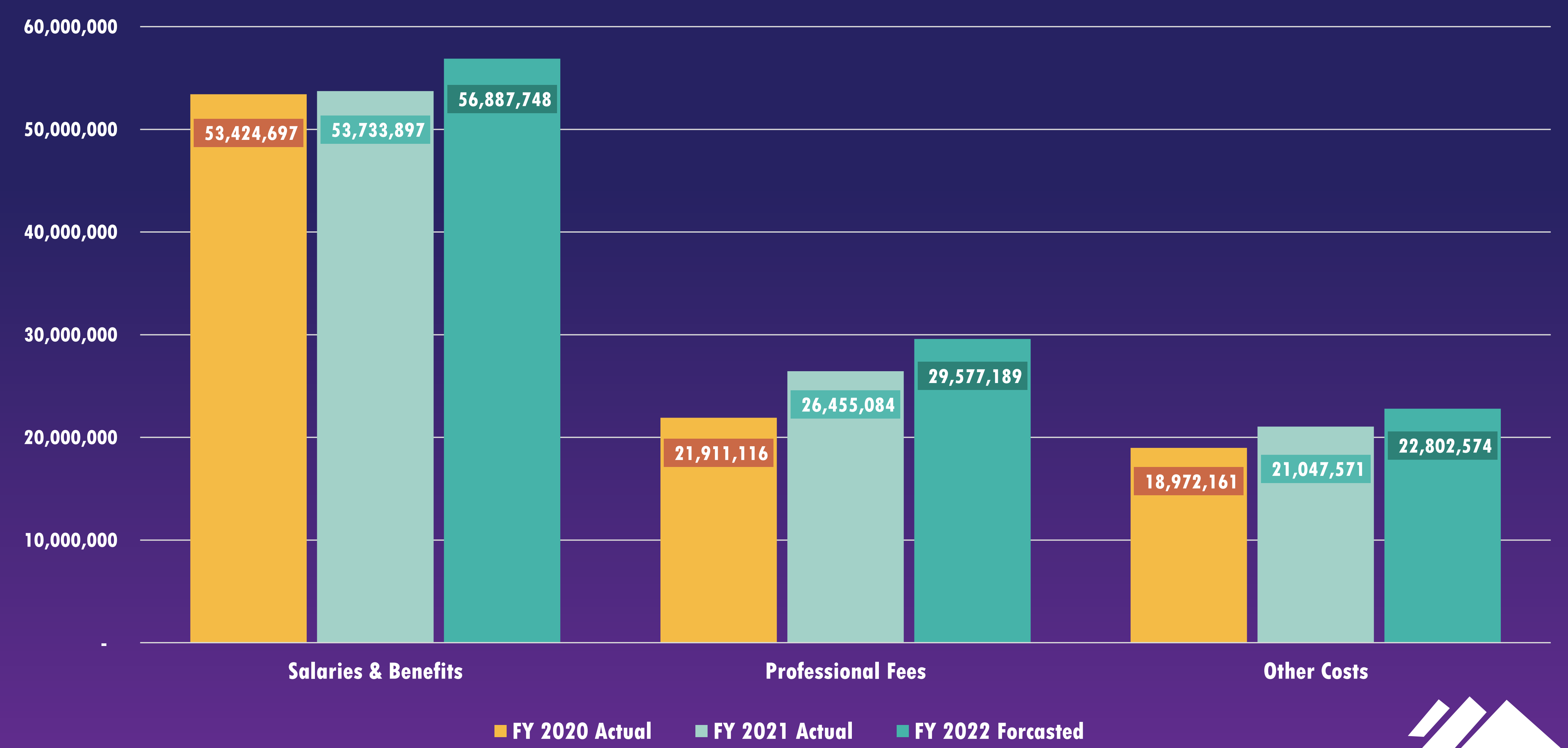
Rural Health Clinic Visits



Outpatient Visits



NIHD Operating Expense



Operating Expense

	FY 2022 (Annualized)	FY 2023 Budget
Cost of Direct Services		
Salaries	27,351,647	29,420,237
Benefits	22,683,739	23,329,204
Professional fee	24,661,021	28,016,167
Pharmacy	4,203,116	3,811,300
Medical Supplies	3,832,327	4,641,706
Hospice Operations	-	
Athena/Cerner EHR system	1,392,632	1,371,244
Other direct costs	7,496,500	7,446,372
Total Direct Costs	**91,620,982**	**98,036,2310**
General & Admin Expense		
Salaries	4,193,378	4,642,245
Benefits	3,797,321	3,979,975
Professional Fee	4,099,145	4,867,767
Depreciation	4,177,649	4,469,074
Other Overheads	1,931,686	2,148,444
Total Overheads	18,199,180	20,107,504
Total Expense	**109,820,162**	**118,143,736**

Expense Increase – Identified Causes

Wage Increases for All District Employees - October 2021

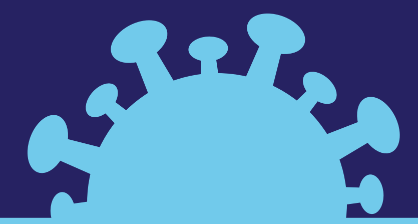
6% - 10% increase

for 450 Employees

National Labor Shortage – Increase In Traveler, Temporary, and Contract Employees

10% Increase

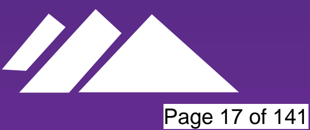
To Professional Fee & Contract Services Expense



Affects of Post-COVID and National Crises

Increase to Cost

Of Medical and Non-medical Supplies, Food, Freight & Shipping



Rising Cost of RN Travelers, Temp/Contract Employees

10,000,000
9,000,000
8,000,000
7,000,000
6,000,000
5,000,000
4,000,000
3,000,000
2,000,000
1,000,000
-

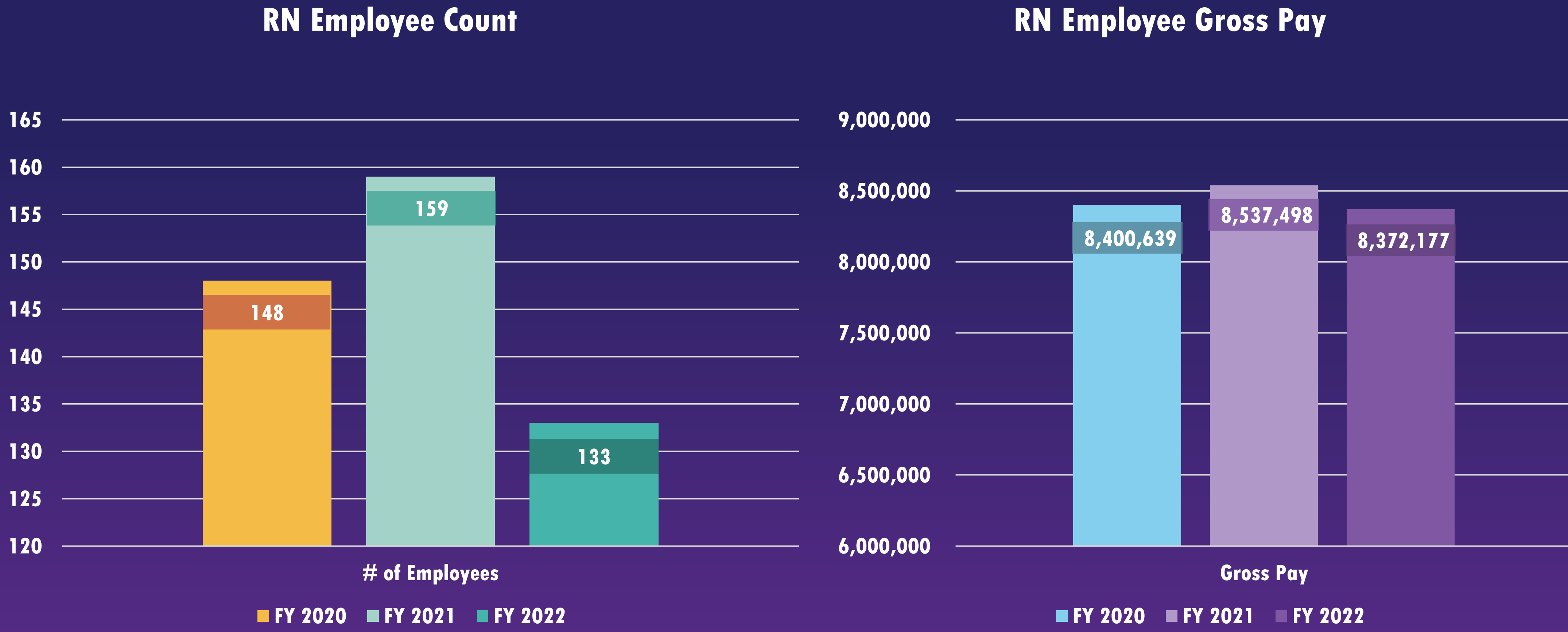
2,316,962
4,462,520
8,848,884

Contract/Temp/Travelers Expense

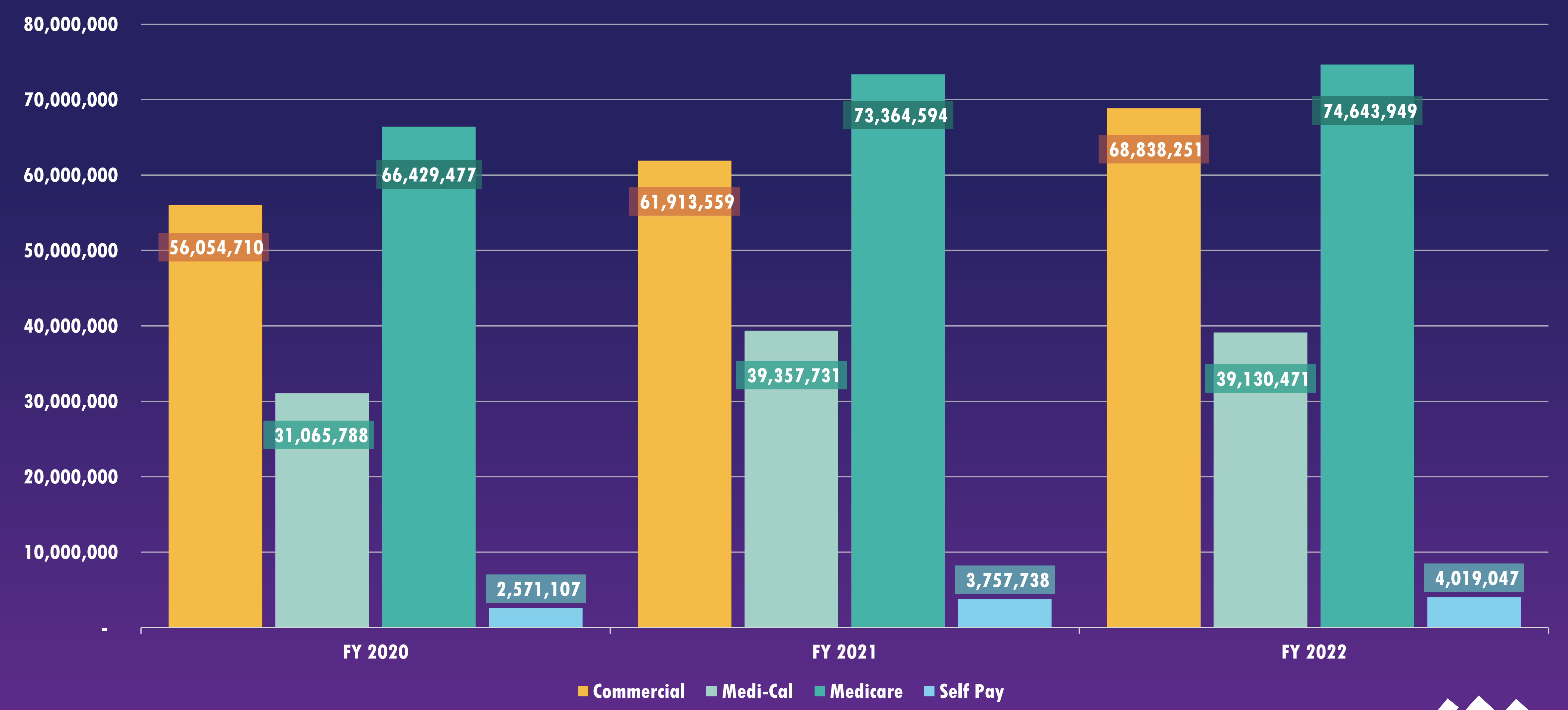
FY 2020 FY 2021 FY 2022

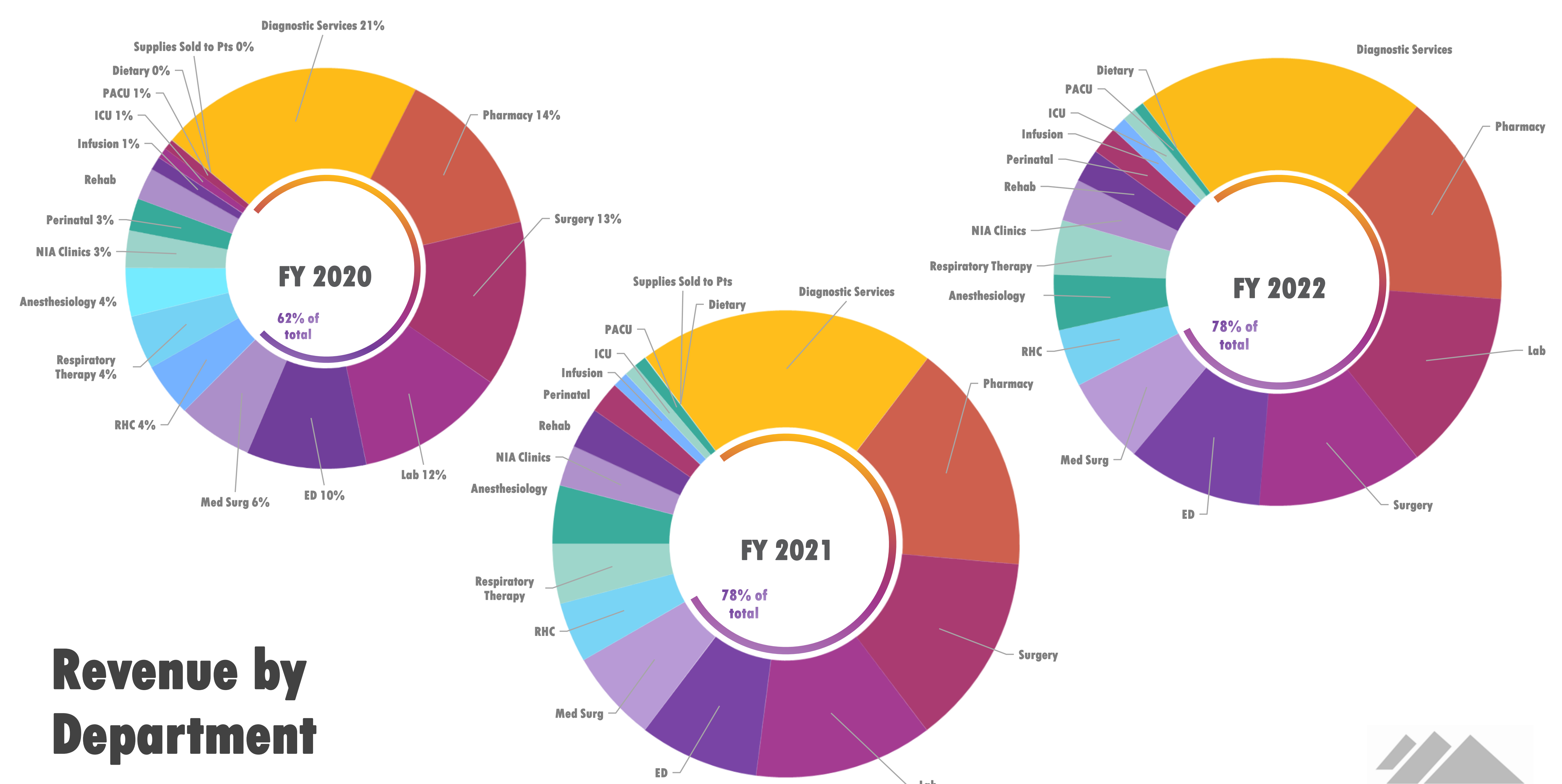
- Current Count of Traveler/Temp/Contractors = 42
- Accounts for 10% of the total staff at NIHD
- Cost continues to rise due to labor shortage in the Healthcare Industry

RN District Employee



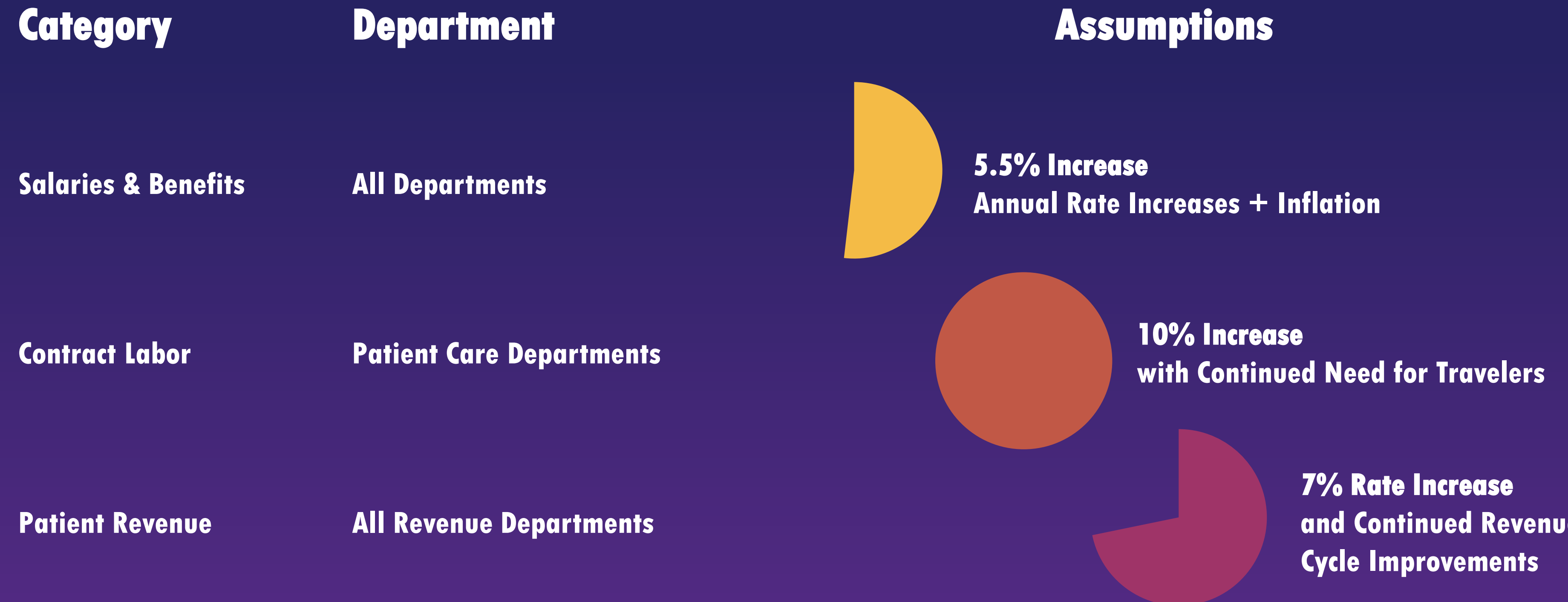
Revenue by Payor





Revenue by Department

Key Assumptions FY 2023



Category	Department	Assumptions
Salaries & Benefits	All Departments	5.5% Increase Annual Rate Increases + Inflation
Contract Labor	Patient Care Departments	10% Increase with Continued Need for Travelers
Patient Revenue	All Revenue Departments	7% Rate Increase and Continued Revenue Cycle Improvements

Workforce

Total Workforce		Employee Worker Category		Employee Job Class	
Employees	464	FTE	403	Advanced Practice	13
Travelers	26	Full Time	358	Aide & Orderly	31
Temporary Employees	8	Part Time	49	Clerical	98
Contractors	8	Per Diem	57	Environmental	53
Vacancies	56			LVN	12
Total	568			Management	43
				Registered Nurse	93
				Technical	120

**Some vacancies are currently filled by Travelers, Temps, or Contractors

New Positions FY 2023

Position	Department
Assistant Manager	Environmental Services
Director of Accounting	Finance
Patient Access Lead	Patient Access
Bi-lingual Content Specialist	Marketing
Clinical Education Specialist	Human Resources
ITS Manager	Information Technology Services
Perinatal LVN (2)	Perinatal
Perinatal Clerk (2)	Perinatal
Perinatal Assistant Manager	Perinatal
Medical Assistant Float (2)	RHC
LVN Float	RHC/NIA
Employee Health Clerk	Employee Health

Capital Purchase Requests FY 2023

Requesting Department	FY 2022	FY 2023	FY 2024	FY 2025
8462 PROJECT/PROPERTY MGMT	$2,957,195	$350,000	-	-
8450 PLANT OPERATIONS	$1,281,396	$298,465	$178,000	$55,000
7670 ULTRASOUND	-	$200,000	$200,000	-
6400 ALTERNATE BIRTHING ROOMS	-	$250,000	$34,305	-
8480 INFORMATION TECHNOLOGY	-	$77,000	$185,000	-
8640 Management Engineering	-	$250,000	-	-
7660 MRI	-	$93,000	$77,000	$18,200
7560 ECHO	-	-	$180,000	-
7420 Surgery	-	$208,755	-	-
8380 Sterile Processing	$140,801	-	-	-
8795 JOSEPH HOUSE	-	$20,000	-	$6,000
7590 EKG	-	-	-	$110,000
7590 EKG	-	-	-	$110,000
8390 PHARMACY	-	-	$27,400	-

Capital Purchase Requests FY 2023 (cont.)

Requesting Department	FY 2022	FY 2023	FY 2024	FY 2025
7450 ANETHESIOLOGY	-	$70,000	-	-
8350 LAUNDRY-LINEN	-	$65,000	-	-
6293 PED-NEONATAL	-	$53,712	-	-
7720 RESPIRATORY CARE	-	$45,000	-	-
6170 MED-SURG	-	$44,411	-	-
8420 SECURITY	-	$ 39,123	-	-
9512 NIA PEDIATRICS	-	$5,758	-	$30,000
9511 NIA SPECIALTY CLINIC	-	$21,000	$11,111	-
6010 ICU	-	-	$28,415	-
7509 CLINICAL LAB	-	$28,118	-	-
7010 ER	-	$21,754	-	-
8440 ENVIRONMENTAL SERV	-	$8,438	-	-
8320 KITCHEN	-	$4,000	-	-
Total	$4,379,392	$2,153,534	$921,231	$219,200

Board Operating Budget FY 2023

Professional Fees	FY 2022 Budget	FY 2023 Budget
Board Governance/Self Assessment/Retreat Consulting	30,000	50,000
Strategic Consulting		5,000
Legal Fees	91,000	70,000
Other Expense		
Education/Travel	5,000	5,000
Meeting Pay	6,000	6,000
Gallagher Billing 2 of 2	4,500	0
ACHD	0	6,250
Utilities	0	500
Total	**142,500**	**143,750**

Consolidated Income Statement

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
	Actual	Actual	Actual	Projected	Budget
Gross Patient Revenue	155,224,322	157,561,442	169,484,991	181,259,699	189,624,348
Contractual Adjustments	76,040,974	63,402,303	79,153,259	80,537,024	84,253,592
Bad Debt Adjustment	3,837,461	17,071,191	5,191,750	8,732,020	9,134,979
A/R Writeoffs	3,667,063	1,060,306	2,344,389	2,879,665	3,012,554
IGT	22,198,867	13,729,686	16,976,875	16,759,338	18,435,271
Other Revenue	760,073	201,485	1,038,280	105,571	116,128
Net Patient Revenue	**94,637,764**	**89,958,812**	**100,810,748**	**105,975,898**	**111,774,622**
Salaries	30,541,399	30,957,783	30,923,375	31,545,025	34,062,482
Benefits	22,329,285	22,466,914	22,810,522	26,481,060	27,309,179
Professional fee	21,376,594	21,911,116	26,455,084	29,577,189	32,883,933
Pharmacy	2,678,246	3.105,981	4,035,279	4,201,929	3,811,300
Medical Supplies	5,323,644	4,199,962	4,136,111	3,803,947	4,641,706
Hospice Operations	398,206	(505,000)	-	-	-
Athena/Cerner EHR system	-	4,813,483	1,480,088	1,443,268	1,371,244
Depreciation	4,267,098	4,275,662	4,146,504	4,135,741	4,469,074
Other direct costs	9,292,240	2,577,073	7,249,590	9,217,689	9,594,816
Total Expense	**96,206,712**	**93,802,973**	**101,236,553**	**110,405,848**	**118,143,736**
Financing expenses	2,911,643	2,363,056	3,874,346	2,440,758	1,690,758
Financing income	2,253,889	2,372,608	2,741,460	2,060,319	2,080,922
Investment Income	791,063	600,420	2,069,532	209,708	211,805
Miscellaneous Income	1,050,148	1,684,051	7,960,199	9,845,173	853,625
Grant Income	1,980,000	28,866	2,698	10,612	
Net Surplus/(Deficit)	**1,594,508**	**(2,531,273)**	**8,473,738**	**5,255,104**	**(4,913,520)**

Budget Deficit Financing

	Budget
Operating Deficit	(6,369,114)
Debt Service Payments	(1,690,758)
County Appropriation	2,080,922
Investment Income	211,805
Misc Income	853,625
CMS Rate Adjstment	2,456,760
Retained Reserves	2,456,760

Q & A

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: June 7, 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. Medical Staff Appointments (*action item*)
   1. Matt Irons, PA-C (*family practice*) – Advanced Practice Provider Staff
   2. Grant Meeker, MD (*anesthesiology*) – Active Staff
   3. Jennifer Meeker, MD (*anesthesiology*) – Active Staff

B. Change in Medical Staff Category (*action item*)
   The following Medical Staff members were recommended to be changed from Active Staff to Courtesy Staff:
   1. J. Daniel Cowan, MD – *anesthesiology*
   2. Michael Dillon, MD – *emergency medicine*
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C. Medical Staff Resignations (*action item*)
   1. Kinsey Pillsbury, MD (*radiology*) – effective 05/18/22
   2. Milan Shah, MD (*urology*) – effective 05/19/22

D. Policies (*action item*)
   1. *COVID-19 Vaccination for NIHD Workforce*
   2. *DI - Communication of Mammography Results to the Patient*
   3. *DI - MRI Safety Plan*
   4. *DI - NM P&P - Area Surveys and Wipe Tests*
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   6. *DI - Reportable/Recordable Events in CT, Fluoroscopy, & Nuclear Medicine*
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   15. *Pre- and Post-Operative Anesthesia Visits*
   16. *Scope of Anesthesia Practice*
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   22. *Swing Bed Patients Inter-Disciplinary Care Conference*

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

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: COVID-19 Vaccination for NIHD Workforce		
Owner: EMPLOYEE HEALTH INFECT PREV SPEC	Department: Employee Health	
Scope: District Wide		
Date Last Modified: 04/28/2022	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: Vaccination is a vital tool to reduce the presence and severity of COVID-19 cases in the workplace, in communities, and in the nation as a whole. To ensure patient safety and to minimize the spread of COVID-19 among vulnerable individuals, General Acute Care Hospitals (GACHs) in California are required to develop and implement processes for verifying the vaccination status of all healthcare workers, and for obtaining and tracking documentation of SARS-CoV-2 diagnostic screening testing of all unvaccinated exempt healthcare workers and booster-eligible healthcare workers who have not yet received their booster. Facilities and providers must maintain records demonstrating compliance with the vaccine and testing requirements for their healthcare workforce.

POLICY: This policy defines Northern Inyo Healthcare District (NIHD) COVID-19 vaccination requirements, documentation and tracking of all workers at NIHD. The workforce includes, but are not limited to, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, all contractual staff not employed by the health care facility, vendors, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the health care setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel). This policy complies with OSHA's Emergency Temporary Standard on Vaccination and Testing (29 CFR 1910.501), CMS 42 CFR 491.8 (d), California Department of Public Health (CDPH) AFL-21-27.3, California State Public Health Officer Order of February 22, 2022. Compliance with this policy is a condition of employment and ongoing employment.

DEFINITIONS:

1. Fully Vaccinated: A person is considered fully vaccinated two weeks after receiving the first dose in a single dose series or the second dose in a two dose series
2. Primary Vaccine: A primary vaccination series is either the first dose in a single dose series or the second dose in the two-dose series.
3. Medical Exemption: A written statement signed by a physician, nurse practitioner, or other licensed medical professional practicing under the license of a physician stating that the individual qualifies for the exemption (but the statement should not describe the underlying medical condition or disability) and indicating the probable duration of the worker's inability to receive the vaccine (or if the duration is unknown or permanent, so indicate).
4. Religious Exemption: The worker is declining vaccination based on sincerely held Religious Beliefs.
5. Contracted/Vendor Healthcare Personnel: Workers who provide direct or non-direct patient care duties regardless of clinical responsibilities or patient contact if they work at the facility on a regular (weekly) basis.

PROCEDURE:

COVID-19 VACCINE REQUIREMENT

1. Workers are required to be up to date with a primary vaccination series by September 30th, 2021, unless exempt.
2. All workers are required to receive the booster dose by March 1, 2022, or when eligible, unless exempt.
3. Workers who have completed their primary vaccination series and provide proof of COVID-19 infection may defer booster administration for up to 90 days from date of clinical diagnosis or first positive test.
4. Workers not yet eligible for boosters must be in compliance no later than 15 days after the recommended timeframe below for receiving the booster dose. Workers with a deferral due to a proven COVID-19 infection must be in compliance no later than 15 days after the expiration of their deferral.
5. Regardless of primary vaccine received, any of the COVID-19 vaccines authorized in the United States may be used for the booster dose, but either Moderna or Pfizer-BioNTech are preferred.
6. The requirement for new workers is the same as existing employees; that they have received either the first dose in a single dose series or the second dose in the two-dose series. They can begin work after their primary series is complete without delay, and there is no provision to allow an employee to work while they are getting their second dose.
7. Workers who are not fully vaccinated, or for whom vaccine status is unknown or documentation is not provided when eligible, are considered unvaccinated.

CALIFORNIA COVID-19 VACCINE OPTIONS TABLE

COVID-19 Vaccine	Primary vaccination series	Vaccine booster dose
Moderna or Pfizer-BioNTech	1st and 2nd doses	Booster dose at least 6 months after 2nd dose
Johnson and Johnson [J&J]/Janssen	1st dose	Booster dose at least 2 months after 1st dose
World Health Organization (WHO) emergency use listing COVID-19 vaccine	All recommended doses	Single booster dose of Pfizer-BioNTech COVID-19 vaccine at least 6 months after getting all recommended doses
A mix and match series composed of any combination of FDA-approved, FDA-authorized, or WHO-EUL COVID-19 vaccines	All recommended doses	Single booster dose of Pfizer-BioNTech COVID-19 vaccine at least 6 months after getting all recommended doses

State Public Health Officer order (02/22/2022)

PROOF OF COVID-19 VACCINATION

1. Proof of vaccination must be submitted to NIHD Employee Health Department by the due date as outlined in Covid-19 Vaccine Requirement.

2. Per the CDPH Guidance for Vaccine Records Guidelines & Standards, only the following modes may be used as proof of vaccination:
   - COVID-19 Vaccination Record Card (issued by the Department of Health and Human Services Centers for Disease Control & Prevention or WHO Yellow Card[ii]) which includes name of person vaccinated, type of vaccine provided, and date last dose administered); OR
   - a photo of a Vaccination Record Card as a separate document; OR
   - a photo of the client's Vaccination Record Card stored on a phone or electronic device; OR
   - documentation of COVID-19 vaccination from a healthcare provider; OR
   - digital record that includes a QR code that when scanned by a SMART Health Card reader displays to the reader client name, date of birth, vaccine dates and vaccine type. Workers may access their digital vaccination record by using the Digital COVID-19 Vaccine Record website; OR
   - documentation of vaccination from other contracted employers who follow these vaccination guidelines and standards.

COVID-19 VACCINE EXEMPTIONS AND TESTING

1. Workers may be exempt from the vaccination requirements only upon providing NIHD Employee Health Department an NIHD Exemption Form, signed by the individual stating either of the following:
   a. The worker is declining vaccination based on sincerely held Religious Beliefs, or
   b. The worker is excused from receiving any COVID-19 vaccine due to Qualifying Medical Reasons.
2. If a worker has submitted a completed exemption form or a booster eligible worker has not yet received their booster dose, the worker must meet the following requirements when working:
   a. Test for COVID-19 with either PCR or antigen test that either has Emergency Use Authorization by the U.S. Food and Drug Administration or be operating per the Laboratory Developed Test requirements by the U.S. Centers for Medicare and Medicaid Services.
   b. NIHD workforce weekly testing requirements are below:

      - **Twice-weekly testing is required for those in Acute Health Care settings**: Rehabilitation, Diagnostic Imaging, Laboratory Services, Inpatient Services, Emergency, Perioperative, Cardiopulmonary, Dietary, Environmental Services, Laundry, Facilities, Information Services, HIMS, Compliance, Human Resources, Employee Health/Infection Control, Informatics & Quality, Security, Administration, and Admission Services.
        - Healthcare Personnel (HCP) who are unvaccinated or incompletely vaccinated must undergo twice-weekly SARS-CoV-2 diagnostic screening testing
        - HCP who are unvaccinated or incompletely vaccinated and work no more than one shift per week must undergo once-weekly SARS-CoV-2 diagnostic screening testing
        - HCP who are unvaccinated or incompletely vaccinated and work less often than weekly must undergo SARS-CoV-2 diagnostic screening testing. Testing should occur within 48 hours before their shift but no later than end of shift.

      - **Once-weekly testing is required for those in other health care settings**: All Clinics, Rehabilitation front office, Accounting and Billing Departments
        - Healthcare Personnel (HCP) who are unvaccinated or incompletely vaccinated must undergo once weekly SARS-CoV-2 diagnostic screening testing.
        - HCP who are unvaccinated or incompletely vaccinated and work no more than one shift per week must undergo once weekly SARS-CoV-2 diagnostic screening testing

- HCP who are unvaccinated or incompletely vaccinated and work less often than weekly must undergo SARS-CoV-2 diagnostic screening testing. Testing should occur within 48 hours before their shift but no later than end of shift
- HCP who are unvaccinated or incompletely vaccinated and do not work in areas where care is provided to patients, or to which patients do not have access for any purpose, must undergo weekly SARS-CoV-2 diagnostic screening testing

c. NIHD workforce must wear a surgical mask or higher-level respirator approved by the National Institute of Occupational Safety and Health (NIOSH), such as an N95 filtering face piece respirator, at all times while on NIHD property until such time CDPH changes/updates recommendations for Acute Health Care facilities.

3. The exemption would not be appropriate for a new worker that is in the middle of the two-dose series, as it undermines the public health order. The public health order guidance steers away from this being a reasonable and true medical or religious exemption.

VACCINE DOCUMENTATION AND RECORD STORAGE

1. Compliance is met when the worker has submitted an authorized documentation of the vaccine or exemption to NIHD Employee Health Department.
2. Consistent with applicable privacy laws and regulations, NIHD Employee Health Department will maintain records of workers' vaccination or exemption status and testing.
3. NIHD Employee Health Department will maintain records pursuant to the CDPH Guidance for Vaccine Records Guidelines & Standards with the following information: (1) full name and date of birth; (2) vaccine manufacturer; and (3) date of vaccine administration for all eligible doses.
4. If the worker is exempt NIHD will also maintain records of the workers' testing results.
5. Records will be made available to the local or state Public Health Officer, the California Department of Social Services, or their designee promptly upon request, and in any event no later than the next business day after receiving the request.
6. Vendors or contractors must be able to provide proof of vaccination or approved exemption for their employee, when requested by NIHD designated representatives or regulatory surveyor as of September 30, 2021.

REFERENCES:

Aragon, T., MD, DrPH. (2022, February 22). *State public health officer order of February 22, 2022: Health care worker vaccine requirement*. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx

California Department of Public Health. (2022, February 22). *AFL 21-27.3: Coronavirus disease 2019 (COVID-19) testing, vaccination verification and personal protective equipment (PPE) for health care personnel (HCP) at general acute care hospitals (GACHs).* https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-27.aspx

California Department of Public Health. (2022, February 22). *AFL 21-34.3: Coronavirus disease 2019 (COVID-19) vaccine requirement for healthcare personnel (HCP).* https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-34.aspx

California Department of Public Health. (2021, August 25). *Vaccine record guidelines & standards.* https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Vaccine-Record-Guidelines-Standards.aspx

California Department of Public Health. (2021, November 2). *Weekly Facility COVID-19 Update Call.*

Legal Information Institute. (2021, November 5). *Staffing and staff responsibilities.* https://www.law.cornell.edu/cfr/text/42/491.8

Occupational Safety and Health Administration. (2022, January 26). *COVID-19 vaccination and testing; emergency temporary standard.* https://www.federalregister.gov/documents/2022/01/26/2022-01532/covid-19-vaccination-and-testing-emergency-temporary-standard

RECORD RETENTION AND DESTRUCTION:

Minimum of 10 years-max 30 years. *CDPH Recommendation is to discuss with our compliance team.*

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Northern Inyo Healthcare District: COVID-19 Prevention Program (CPP)
2. Health Care Worker Screening and Maintenance Requirements

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: DI - Communication of Mammography Results to the Patient		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Diagnostic Imaging		
Date Last Modified: 04/29/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/15/2016	

PURPOSE: To define how Northern Inyo Hospital (NIH) will communicate mammography results in lay terms to patients in less than 30 days.

DEFINITION:

1. BI-RADS – Breast Imaging – Reporting and Data System

POLICY:

1. All BI-RADS 1 and 2 (negative and benign) will have a patient lay letter generated and mailed within 96 hours of interpretation of the mammogram.
2. All BI-RADS 0 (needs additional work-up) will have a letter generated and mailed to the patient within 48 hours of interpretation. The Radiology Office staff will call BI-RADS 0 patients within 24 hours of interpretation to schedule follow up imaging.
3. All BI-RADS 3 (short term follow-up) will have a letter generated and mailed to the patient within 48 hours of interpretation. The Mammographer will discuss the results and recommendations from the diagnostic examination with the patient at the time of completion of the examination and will document that discussion in the report, a BIRADS 3 patient notification letter will be provided to patient and scanned into patient's chart. (This will need to be added once the BIRADS 3 letter is approved by forms)
4. All BI-RADS 4 and 5 (suspicious and highly suggestive of malignancy) will have a letter generated and mailed to the patient within 24 hours of interpretation of the diagnostic mammogram. The Mammographer will discuss results and recommendations with the patient at the conclusion of the diagnostic work up. If a biopsy is recommended, the patient will be scheduled for the first available appointment. The Mammographer will document the discussion with the patient in the report of the diagnostic exam.
5. All summary letters shall contain a description of the test results in lay terminology. All letters will contain a description of the next steps for additional examination (annual screening, 6 month follow up, immediate follow up). Each summary will contain the patient name, date of the procedure and the name and address of our facility. Summary letters also indicate that the original images will become part of the patient's permanent medical record and will be available for continuing care.

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6. For patients with dense breasts, summary letters shall include the statement required in SB1538, below.

"Your mammogram shows that your breast tissue is dense. Dense breast tissue is common and is not abnormal. However, dense breast tissue can make it harder to evaluate the results of your mammogram and may also be associated with an increased risk of breast cancer. This information about the results of your mammogram is given to you to raise your awareness and to inform your conversations with your doctor. Together, you can decide which screening options are right for you. A report of your results was sent to your physician."

REFERENCES: ACR Practice Parameters for the performance of Screening and Diagnostic Mammography

RECORD RETENTION AND DESTRUCTION:
Mammography reports will be stored in patient's medical record

CROSS REFERENCED POLICIES AND PROCEDURES:
1. DI – Communication of Mammography Results to the Patient
2. Diagnostic Imaging – Mammography Compliance Requirements
3. DI – Screening Mammography

Supersedes: v.1 DI - Communication of Mammography Results to the Patient

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NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: DI - MRI Safety Plan		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: All Hospital Staff		
Date Last Modified: 04/21/2022	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date: 07-25-2005	

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Introduction

MAGNETIC RESONANCE (MR) Safety Manual's purpose is to establish MR safe practices from a growing awareness of the MR environment's potential risks and adverse events involving patients, equipment, and personnel. The American College of Radiology (ACR) manual on MR Safety remains the key document on industry standards for safe and responsible guidelines in clinical MR environments. Northern Inyo Healthcare District (NIHD) MR department's intent is to follow ACR Guidance Document on MR Safe Practices from 2020. The intent of this plan and cross referenced procedures is to assist NIHD staff, physicians, and departments to help prevent adverse staff and patient outcomes relating to medical procedures in MRI.

A. Establish, Implement, and Maintain Current MR Safety Policies and Procedures:

1. NIHD's MR Department will maintain and implement safety procedures regarding our current GE Signa 1.5-tesla magnet. This MRI safety plan is directly associated with and inclusive of all MRI Safety Procedures listed in the cross referenced policy and procedures section of this plan.
2. Cross referenced procedures will be reviewed annually as part of this MRI Safety Plan.
3. Cross referenced procedures and MRI Safety Plan will be reviewed with the introduction of any significant changes in safety parameters of the MR site (e.g., adding faster or stronger gradient capabilities, higher RF duty cycle studies, etc.)
4. NIHD's Magnetic Resonance Medical Director(MRMD) is responsible for ensuring that MR safe guidelines and operations are established and maintained as current and appropriate for the site. The MRMD shall be responsible for the formulation and application of policies and procedures that ensure the safety of patients, MRI staff, and others in the MRI environment.
5. The MRMD is responsible to delegate MRI safety-related tasks to the Magnetic Resonance Safety Officer (MRSO) who is responsible for the day-to-day implementation of the site's safety policies.
6. The MRSO must be trained and experienced in MRI and MRI safety, but need not be a medical physician. It is the responsibility of the site's administration to ensure that the policies and procedures that result from these MR safe practice guidelines are implemented and adhered to at all times and by all of the site's personnel.

7. Procedures will be in place to ensure that any and all adverse events, MR safety incidents, or "near incidents" that occur in the MR suite are reported to the MRMD in a timely manner and used in continuous quality improvement efforts. MRI incidents will be reported to the Radiology Services Committee through the Radiation Safety / MR Safety Committee meeting.

REFERENCES:

MRI Safety References

1. ACR Manual on MRI Safety (2020 edition)
2. Dr. Kanal, Emmanual "Kanal's MRMD/MRSO MR Safety Training Course – Orlando, FL". Nov 3, 2019 – Nov 6, 2019. North West Imaging Forums, INC.
3. Kanal E, Barkovich AJ, Bell C, et al. ACR guidance document on MR safe practices: 2007. AJR AM J Roentgenol 2007;188:1447-1474
4. Kanal E, Barkovich AJ, Bell C, et al. ACR guidance document on MR safe practices:2013. J Magn Reson Imaging 2013;37;501-530.
5. U.S. Department of Health and Human Services Food and Drug Administration,
6. Center for Devices and Radiological Health. Criteria for significant risk investigations of magnetic resonance diagnostic devices.Guidance for industry and Food and Drug Administration staff.
7. International Commission on Non-Ionizing Radiation Protection. Guidelines on limits of exposure to static magnetic fields. Health Phys 2009;96:504–514.
8. The Joint Commission: Diagnostic imaging requirements, issued August 10, 2015. Available at https://www.jointcommission.org/diagnostic_imaging_standards/.
9. The ACR Guidance Statement on MR Safe Practice, issued 2013, 2018, 2019 https://www.acr.org/Clinical-Resources/Radiology-Safety/MR-Safety

CROSS REFERENCED POLICIES AND PROCEDURES:

- DI - MRI Safety - Burn/Thermal Incident Reduction Policy
- DI - MRI Safety – Special Patient Population Management
- DI – MRI Safety – Noise Protection
- DI – MRI Safety – Patient and Caretaker Screening
- DI – MRI Safety – MRI Access Control – NIHD Staff
- DI – MRI Safety – MRI Safety Organizational Structure
- DI – MRI Safety – NIHD Specific Zone Identification
- Cylinder Safe Handling

Supersedes: Not Set

review

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: DI - NM P & P - Area Surveys and Wipe Tests*		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Nuclear Medicine		
Date Last Modified: 04/21/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 01-19-2016	

PURPOSE:
The purpose of this guideline is to provide guidance for the nuclear medicine technologist to ensure that there are no areas of contamination (exposure level and removable contamination) in the nuclear medicine department on a regular basis.

POLICY:
Area surveys shall be performed with a GM survey meter in multiple areas of the nuclear medicine department to check for radiation exposure levels, weekly.
Wipe tests shall be taken in multiple areas of nuclear medicine to check for removable contamination, weekly.

PROCEDURE:
Area Surveys:
Using a GM survey meter, survey the designated areas in which radioactive materials are used or stored (see ASWT maps).
All surveys should be taken at waist height or 4" above the surface.
All surveys are recorded in mR/hr on the weekly ASWT form.
Surveys must be less than 0.05 mR/hr in unrestricted areas and less than 2.0 mR/hr in restricted areas.
Wipe Tests:
Using a cotton swab for each area, wipe the designated areas in which radioactive materials are used or stored (see ASWT maps).
The swabs are placed in plastic tubes and counted for activity in the well counter.
All results are recorded in dpm/cm2 on the ASWT form (located in nuclear medicine department). Any area with a wipe count over 2000 dpm/cm2 needs to be decontaminated and rewiped, repeating the process until the wipe test is less than 2000 dpm/cm2.

REFERENCES:
- Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf,
- 10 CFR 35

RECORD RETENTION AND DESTRUCTION: Duration of license +30 years

CROSS REFERENCED POLICIES AND PROCEDURES:
- Radiation Safety Plan
- DI – NM P&P – Daily ~~wipe tests~~Area Surveys

Supersedes: v.1 DI NM Area Surveys and Wipe Tests*

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NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: DI - NM P&P - Daily Area Surveys		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Nuclear Medicine		
Date Last Modified: 04/21/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 12-02-2015	

PURPOSE:
to provide guidance to the technologist to ensure that radiation exposure levels, in areas used by nuclear medicine, are checked daily.

POLICY:
Daily surveys shall be done, with a GM survey meter, at the end of each normal workday, when radioactive materials are in use, to check for areas of contamination.

PROCEDURE:
Using a GM survey meter, survey the hot lab, injection area and waiting area (BKG).
These surveys are recorded in mR/hr at the bottom of the dose dispensation log.
Areas outside the hot lab that are more than twice background should be checked for removable contamination (wipe test.) Areas of contamination should be cleaned and resurveyed.

REFERENCES:

- Guide for the Preparation of an Application for a Radioactive Materials License Authorizing Medical Use, Retrieved from: http://www.cdph.ca.gov/pubsforms/Guidelines/Documents/RHB-MedicalGuide.pdf,
- 10 CFR 35

RECORD RETENTION AND DESTRUCTION: Duration of license +30 years

CROSS REFERENCED POLICIES AND PROCEDURES:
- Radiation Safety Plan
- DI – NM P&P – Area Surveys and Wipe Tests

Supersedes: v.1 DI NM Daily Area Surveys

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NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: DI - Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine*		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Radiology Technologists		
Date Last Modified: 04/19/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 12-13-2016	

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PURPOSE: To define radiation events and radiation exposures in Computed Tomography (CT), Nuclear Medicine (NM), and fluoroscopy that are recordable or reportable to regulatory and accreditation bodies; To outline the process for investigation and reporting of these events

DEFINITIONS:

Action Plan - The product of the root cause analysis, which identifies the strategies that an organization intends to implement to reduce the risk of similar events occurring in the future.

Byproduct material – any radioactive material (except enriched uranium or plutonium) produced by a nuclear reactor; material that has been made radioactive through the use of a particle accelerator or any discrete source of radium-226 used for commercial, medical, or research activity.

CT scan - axial or helical acquisition acquired on computed tomography equipment

CT study – Scan(s) of a region of interest intentionally acquired for a single diagnosis, does not include repeat imaging due to operator or machine error; (CT Study and Examination are used interchangeably in CDPH RHB regulations)

Effective Dose – reflects the risk of a non-uniform exposure in terms of an equivalent whole body dose; quantity defined in ICRP Publication 60 as a weighted sum of equivalent doses to all relevant tissues and organ with the purpose "to indicate the combination of different doses to several different tissues in a way that is likely to correlate well with the total of the stochastic effects". This is, therefore, applicable even if the absorbed dose distribution over the human body is not homogeneous. The unit is the joule per kilogram ($J\ kg^{-1}$) and is given the special name sievert (Sv). Accepted industry practice is to report skin or organ dose in rads or Grays (Gy). For the reporting purposes, 1 rad = 1 rem and 1 Gy = 1 Sv.

Examination – One or more scans of a region of interest intentionally acquired for a single diagnosis, performed during a single visit/appointment, does not include repeat imaging due to operator or machine error (CT Study and Examination are used interchangeably in CDPH RHB regulations)

Organ dose - quantity defined in ICRP Publication 60 in relation to the probability of stochastic effects (mainly cancer induction) as the absorbed dose averaged over an organ, i.e., the quotient of the total energy imparted to the organ and the total mass of the organ. The unit is the joule per kilogram and is given the special name gray (Gy). Accepted industry practice is to report skin or organ dose in rads or Grays (Gy). For the reporting purposes, 1 rad = 1 rem and 1 Gy = 1 Sv.

Patient movement or interference – voluntary or involuntary movement by the patient; patient, patient family, or other caregiver interference interrupting or disrupting study; abnormal patient anatomy or injury requiring additional scan when routine procedures were followed but did not provide adequate imaging of area of interest

Radiology Report – formal documented interpretation of diagnostic test

Rad - One of the two units used to measure the amount of radiation absorbed by an object or person, known as the "absorbed dose" which reflects the amount of energy that radioactive sources deposit in materials through which they pass. The radiation-absorbed dose (rad) is the amount of energy (from any type of ionizing radiation) deposited in any medium (e.g., water, tissue, air). An absorbed dose of 1 rad means that 1 gram of material absorbed 100 ergs of energy (a small but measurable amount) as a result of exposure to radiation. The related international system unit is the gray (Gy), where 1 Gy is equivalent to 100 rad.

REM - One of the two standard units used to measure the dose equivalent (or effective dose), which combines the amount of energy (from any type of ionizing radiation that is deposited in human tissue), along with the medical effects of the given type of radiation. For beta and gamma radiation, the dose equivalent is the same as the absorbed dose. By contrast, the dose equivalent is larger than the absorbed dose for alpha and neutron radiation, because these types of radiation are more damaging to the human body. Thus, the dose equivalent (in rems) is equal to the absorbed dose (in rads) multiplied by the quality factor of the type of radiation [see Title 10, Section 20.1004, of the *Code of Federal Regulations* (10 CFR 20.1004), "Units of Radiation Dose"]. The related international system unit is the sievert (Sv), where 100 rem is equivalent to 1 Sv.

Recordable event – an event involving radiation or radioactive material where radiation or a radiopharmaceutical is administered without a written directive where a written directive is required; a radiopharmaceutical or radiation where a written directive is required without daily recording of each administered radiopharmaceutical dosage or radiation dose in the appropriate record; event is recorded, investigated, reviewed by Radiation Safety Committee and documentation maintained by facility

Reportable event – an event involving radiation or radioactive material where the dose or exposure meets the standards or is associated with significant deviation from the usual processes as outlined by regulatory and/or accreditation bodies; event is recorded, investigated, reviewed by Radiation Safety Committee; documentation maintained by facility and reported to regulatory and/or accreditation bodies

Root Cause Analysis - A root cause analysis is defined as a process for identifying the basic and casual factor(s) that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause is the most fundamental reason a problem (a situation where performance does not meet expectation) has occurred.

Sievert (Sv) = 100 rem

Single field – as it relates to fluoroscopy, single field refers to a location on the skin through which the stationary fluoroscopic beam is directed.

Shallow dose to skin - The external exposure dose equivalent to the skin or an extremity at a tissue depth of 0.007 centimeters (7 mg/cm^2) averaged over an area of 1 square centimeter. Accepted industry practice is to report skin or organ dose in rads or Grays (Gy). For the reporting purposes, 1 rad = 1 rem and 1 Gy = 1 Sv.

POLICY:

1. Except for an event that results from patient movement or interference, NIH shall report to the California Department of Public Health Radiologic Health Branch (CDPH RHB) an event in which the administration of radiation results in any of the following:

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A. Repeating of a CT examination, unless otherwise ordered by a physician or a radiologist, if one of the following dose values is exceeded:

a. 0.05 Sv (5 rem) effective dose.
b. 0.5 Sv (50 rem) to an organ or tissue.
c. 0.5 Sv (50 rem) shallow dose to the skin.

B. A CT examination for any individual for whom a physician did not provide approval for the examination if one of the following dose values is exceeded:

a. 0.05 Sv (5 rem) effective dose.
b. 0.5 Sv (50 rem) to an organ or tissue.
c. 0.5 Sv (50 rem) shallow dose to the skin.

C. A CT for an examination that does not include the area of the body that was intended to be imaged by the ordering physician or radiologist if one of the following dose values is exceeded:

a. 0.05 Sv (5 rem) effective dose.
b. 0.5 Sv (50 rem) to an organ or tissue.
c. 0.5 Sv (50 rem) shallow dose to the skin.

D. CT or fluoroscopic exposure that results in unanticipated permanent functional damage to an organ or a physiological system, hair loss, or erythema, as determined by a qualified physician.

E. A CT dose to an embryo or fetus that is greater than 50 mSv (5 rem) dose that is a result of radiation to a known pregnant individual unless the dose to the embryo or fetus was specifically approved, in advance, by a qualified physician.

NIH shall, no later than **five business days** after the discovery of an event described in section 1, paragraph E, and no later than **10 business days** after discovery of an event described in section 1, paragraphs A to D, provide notification of the event to the CDPH RHB and the referring physician of the person subject to the event and shall, no later than **15 business days** after discovery of an event, provide written notification to the person who is subject to the event.

2. NIH shall record any of the following events, except for an event that results from patient intervention, in which the administration of byproduct material or radiation from byproduct material *does not* result in a dose that exceeds 0.05 Sv (5 rem) effective dose equivalent, 0.5 Sv (50 rem) to an organ or tissue, or 0.5 Sv (50 rem) shallow dose equivalent to the skin:

A. An administration of a wrong radioactive drug containing byproduct material;
B. An administration of a radioactive drug containing byproduct material by the wrong route of administration;
C. An administration of a dose or dosage to the wrong individual
D. An administration of a dose or dosage delivered by the wrong mode of treatment; or
E. A leaking sealed source.

Recordable events involving byproduct material shall be documented as outlined in the procedure section of this policy. Recordable events shall be discussed and analyzed in the NIH Radiation Safety Committee. Discussion shall be documented in the minutes, as should actions taken, if any.

3. NIH shall report any event, except for an event that results from patient intervention, in which the administration of byproduct material or radiation from byproduct material results in a dose that exceeds 0.05 Sv (5 rem) effective dose equivalent, 0.5 Sv (50 rem) to an organ or tissue, or 0.5 Sv (50 rem) shallow dose equivalent to the skin from any of the following:

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A. An administration of a wrong radioactive drug containing byproduct material;
B. An administration of a radioactive drug containing byproduct material by the wrong route of administration;
C. An administration of a dose or dosage to the wrong individual
D. An administration of a dose or dosage delivered by the wrong mode of treatment; or
E. A leaking sealed source.

NIH shall report any event resulting from intervention of a patient in which the administration of byproduct material or radiation from byproduct material results or will result in unintended permanent functional damage to an organ or a physiological system, as determined by a qualified physician.

NIH shall notify by telephone the CDPH RHB **no later than the next calendar day** after discovery of the medical event described in section 3. NIH shall provide notification of the event described in section 3 to the referring physician and also notify the individual who is the subject of the medical event no later than **24 hours** after its discovery, unless the referring physician personally informs the licensee either that he or she will inform the individual or that, based on medical judgment, telling the individual would be harmful.

NIH shall submit a written report to the CDPH RHB (RAM section) within **15 days** of discovery of the medical event described in section 3. The written report may not contain the individual's name or any other information that could lead to the identification of the individual. NIH shall annotate the individual's name and identification number to the report and provide the annotated report to the referring physician within **15 days** of the discovery of the event.

4. Except for an event that results from patient movement or interference, NIH shall report to the California Department of Public Health Radiologic Health Branch (CDPH RHB) an event in which the administration of radiation results in any of the following:

A. A fluoroscopic exposure that results in unanticipated permanent functional damage to an organ or a physiological system, hair loss, or erythema, as determined by a qualified physician.

NIH shall, no later than **10 business days** after discovery of an event described in section 4 provide notification of the event to the CDPH RHB and the referring physician of the person subject to the event and shall, no later than **15 business days** after discovery of an event, provide written notification to the person who is subject to the event.

5. NIH shall report to the Joint Commission any cumulative fluoroscopic exposure of 1500 rads or more to a single field of skin. The Joint Commission defines "cumulative" for the purposes of this event as "dose over a period of six months to a year."

PROCEDURE:

1. Any potential reportable/recordable event is to be reported immediately to the Chief Performance Excellence Officer or Administrator. Upon notification, this individual, or designee, will direct an initial investigation to determine if the occurrence is indeed a reportable/recordable event as defined by this policy.

2. A Medical Radiation Physicist shall be consulted for dose and exposure calculations and methodology.

3. Upon determination that a reportable/recordable event has occurred, the Chief Performance Excellence Officer or Administrator will notify the Chief of Staff or his/her representative.

4. A team is to be formed to respond to a reportable/recordable event. The team should include, but not necessarily be limited to, the following:
    a. Appropriate representatives of Administration, Medical Staff, Safety, Performance Improvement, and departments directly involved in event.

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b. Those individuals directly involved in the event.

5. The team will undertake those actions necessary to remediate any immediate threat or likelihood of the sentinel event/unusual occurrence recurring.

6. The team will follow the actions outlined in the PA – Patient Safety: Sentinel Events, Unusual Occurrences Policy/Procedure.

7. Joint Commission shall be notified as deemed appropriate by the team and Administration.

8. Once a **recordable event** has been identified, the following steps shall be taken:

    a. The technologist involved in the recordable event shall complete a hospital incident report.
    b. The employee, supervisor and department director shall sign the incident report.
    c. Notify the Radiation Safety Officer immediately.
    d. Notify the ordering physician immediately.
    e. Make a copy of the following items to be placed in the "Recordable Events" file in the Nuclear Medicine Department:
        i. Signed physician order
        ii. Patient's facesheet
        iii. A description of the occurrence in full detail, including names of all involved
        iv. A description of what was done as follow-up to the incident
        v. Review action plan, if developed
    f. The Radiation Safety Committee shall analyze the situation at the quarterly meeting and document actions taken, if any.

9. Once a **reportable event** involving CT or fluoroscopy has been identified, the following steps shall be taken:
    a. NIH shall, no later than five business days after the discovery of an event described in section 1, paragraph 5, and no later than **10 business days** after discovery of an event described in section 1, paragraphs 1 to 4, provide notification of the event to the CDPH RHB and the referring physician of the person subject to the event and shall, no later than **15 business days** after discovery of an event, provide written notification to the person who is subject to the event.

    b. The information provided to the CDPH RHB should include the following:
        i. Radiation generating equipment specifics (i.e. manufacturer, model number, and software version)
        ii. Radiation generating equipment settings
        iii. Operator's name
        iv. Patient's physician name and contact information
        v. Copy of physician's order for CT or fluoroscopic exam
        vi. Explanation as to reason for reporting event
        vii. Prepared internal investigation reports (include cause and corrective action to prevent reoccurrence), as appropriate
        viii. Patient dose calculations (include methodology)
        ix. Copies of letters sent to the patient and physician

    c. Notify CDPH RHB of CT and fluoroscopic events via letter to the following address:
        i. Chief X-Ray ICE
        Event Notification
        Radiologic Health Branch
        California Department of Public Health
        P.O. Box 997414, MS 7610

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Sacramento, CA 95899-7414

ii. **Overnight address:**
Chief X-Ray ICE
Event Notification
Radiologic Health Branch
California Department of Public Health
1500 Capitol Avenue, MS 7610
Sacramento, CA 95814

d. The Radiation Safety Committee shall analyze the situation and action plan at the quarterly meeting and document actions taken, if any.

10. Once a **reportable event** involving byproduct material has been identified, the following steps shall be taken:

a. The technologist involved in the reportable event shall complete a hospital incident report.
b. The employee, supervisor and department director shall sign the incident report.
c. Notify the Radiation Safety Officer and NIH administration immediately.
d. Notify the CDPH RHB no later than the next calendar day following discovery.
e. Notify the ordering physician.
f. Submit, within **15 days,** a written report to CDPH RHB including:
   i. Facility's (licensee's) name
   ii. The name of the prescribing physician
   iii. A brief description of the event
   iv. Why the event occurred
   v. The effect, if any, on the individual(s) who received the administration
   vi. What actions, if any, have been taken or are planned to prevent recurrence
   vii. Certification that the licensee notified the individual (or the individual's responsible relative or guardian), and if not, why not.
   viii. The report may not contain the individual's name or any other information that could lead to identification of the individual.
g. NIH shall provide notification of the event to the referring physician and also notify the individual who is the subject of the medical event no later than **24 hours** after its discovery, unless the referring physician personally informs the licensee either that he or she will inform the individual or that, based on medical judgment, telling the individual would be harmful. The licensee is not required to notify the individual without first consulting the referring physician. If the referring physician or the affected individual cannot be reached within 24 hours, the licensee shall notify the individual as soon as possible thereafter. The licensee may not delay any appropriate medical care for the individual, including any necessary remedial care as a result of the medical event, because of any delay in notification. To meet the requirements of this paragraph, the notification of the individual (who is the subject of the medical event) may be made to that individual's responsible relative or guardian. If a verbal notification is made, the licensee shall inform the individual, or appropriate responsible relative or guardian, that a written description of the even can be obtained from the licensee upon request. The licensee shall provide such a written description if requested.
h. NIH shall:
   i. Annotate a copy of the report provided to the CDPH RHB with the:
      1. Name of the individual who is the subject of the event; and
      2. Social security number or other identification number, if one has been assigned, of the individual who is the subject of the event; and
      3. Provide a copy of the annotated report to the referring physician no later than **15 days after** the discovery of the event.
i. Notify CDPH RHB of RAM/byproduct material events via letter to the following address:
Department of Public Health

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Radiologic Health Branch
California Department of Public Health
500 S Kraemer Blvd.
Radioactive Materials, Suite 235
Brea, CA 92821

   j. The Radiation Safety Committee shall analyze the situation and action plan at the quarterly meeting and document actions taken, if any.

11. Records of reportable and recordable events shall be maintained at the facility in the custody of the Radiation Safety Committee for the life of the patient plus 10 years.

REFERENCES:

- CA SB 1237, Health and Safety Code Section 115113
- NRC Regulations, 10 CFR 35.3045
- The Joint Commission Sentinel Event Alert, Issue 47, August 24, 2011
- CA-RHB Radiologic Technology Certification Committee Meeting Minutes, October 23, 2013
- Russell, L. & Pizzutiello, B. Radiation Safety Webinar on California State Law and Joint Commission Sentinel Event Alert #47. CDPH-Radiologic Health Branch.
- CDPH RHB, Information Notice Regarding Senate Bill (SB) 1237, California Health and Safety (H & S) Code Section 115113. 14 Jan 2011.

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCE P&P:

- PA – Patient Safety: Sentinel Events, Unusual Occurrences Policy/Procedure
- DI – Radiation Safety Committee Charter
- DI – ALARA Program

Supersedes: v.1 DI - Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine*

review

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Diagnostic Imaging - Lead Interpreting Mammographer Responsibilities		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Radiologist		
Date Last Modified: 04/29/2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/18/2018	

PURPOSE: To establish the responsibilities of the Lead Interpreting Mammographer (radiologist) as required by the Mammography Quality Standards Act (MQSA 42CFR263(b)).

POLICY: The Lead Interpreting Mammographer shall be responsible for:

1. Establishment of a Mammography Policy and Procedure Manual
2. Bi-annual review and updating of the Mammography Policy and Procedure Manual
3. Maintain qualifications as outlined in the ACR Mammography Accreditation Program Requirements
4. Assure clinical image quality; Assure Quality Control is performed and documented as outlined in this manual. Review and verify Quality Assurance procedures are performed as outlined in this manual.
5. Assuring that technologists do not take x-rays without a specific order or a prescription by a licentiate of the healing arts, as defined by section 25661(i) of the Health and Safety Code, except for self-referred/self-requested screening mammography per policy "Diagnostic Imaging – Self- referral for Breast screening exams."
6. Observing the technologist performance bi-annually to assure that the technologists perform duties as identified in the Mammography Policy and Procedure Manual
7. Assuring that the technologists have successfully completed special training
8. Assuring the mean glandular dose for one contact craniocaudal view of a 4.5 cm (1.8 in) compressed breast composed of 50 percent adipose and 50 percent glandular tissue does not exceed 0.3 Rad.
9. Assuring that magnification mammography is performed only on dedicated mammographic x-ray equipment with a micro focal spot not greater than 0.3mm.

REFERENCES: ACR Practice Parameters for the performance of Screening and Diagnostic Mammography

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RECORD RETENTION AND DESTRUCTION:
Mammography reports will be stored in patient's medical record

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Mammography Compliance Requirements
2. Self-referral for Breast Screening Exams
3. Mammography Medical Audit Policy
4. Mammography Quality Control
5. Mammography Repeat Rate Analysis Policy
6. Qualifications for Mammography Technologists

Supersedes: v.2 Diagnostic Imaging - Lead Interpreting Mammographer Responsibilities

review

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Northern Inyo Healthcare District
One Team. One Goal. Your Health.

Title: Diagnostic Imaging - Mammography Compliance Requirements		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope: Diagnostic Imaging		
Date Last Modified: 04/29/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 09/17/2014	

PURPOSE: To document elements of the mammography program as required by Federal and State regulations (MQSA, 10 CFR 42)

POLICY:

Mammography X-ray equipment shall be registered with the Department of Public Health, Radiologic Health Branch. NIH registration number: 6593-03

1. NIH shall only use mammography equipment specifically designed for mammography.
2. Equipment installed at NIH is
    a. GE Senographe Essential/SenoClaire, Serial Number 545885BU6
    b. A Quality Assurance (QA) program is established and maintained.
3. All mammography is performed digitally and is reviewed on the radiologist workstation.
    a. The radiologist workstation is regulated and maintained in coordination with the complete QA program.
    b. All quality control is performed according to manufacturer's specifications.
4. Only diagnostic radiologic technologists who hold current and valid mammography certificates issued by the Department of Public Health, Radiologic Health Branch, and who are in compliance with all policies of this department are allowed to perform mammographic x-ray procedures.

REFERENCES:

1. ACR Practice Parameters for the performance of Screening and Diagnostic Mammography
2. MQSA , 10 CFR 42

RECORD RETENTION AND DESTRUCTION:

Mammography reports will be stored in patient's medical record

CROSS REFERENCED POLICIES AND PROCEDURES:

1. DI – Communication of Mammography Results to the Patient
2. Diagnostic Imaging – Mammography Compliance Requirements
3. DI – Screening Mammography

Supersedes: v.3 Diagnostic Imaging - Mammography Compliance Requirements

review

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Diagnostic Imaging - Self-referral for Breast Screening Exams		
Owner: DIRECTOR OF DIAGNOSTIC SERVICES	Department: Diagnostic Imaging	
Scope:		
Date Last Modified: 04/29/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/15/2015	

review

PURPOSE:

The purpose of this policy is to serve the patients in this community that need a mammogram but do not have a referring physician or do not have an order from their primary care provider.

DEFINITIONS:

1. **Self-referrals** – patients requesting a screening mammogram who do not have a referring physician
2. **Self-requests** – patients referring themselves for a screening mammogram who do have a primary care provider.
3. Screening Mammogram- mammogram on a patient who is asymptomatic and has not had previous breast cancer.

POLICY:

1. Self-referrals/self-requests will be scheduled for screening mammography
    a. Self-referrals/self-requests shall be accepted for a screening mammogram no more than once every 366 days.
    b. If the patient has any complaints or diagnoses other than screening, Northern Inyo Healthcare District (NIHD) staff will refer the patient to their provider or an available healthcare provider and will not schedule the self-referred exam until a physician order has been received.
2. NIHD staff will send the mammography report, in addition to the summary of report written in lay terms directly to the **self-referred** patient.
3. NIHD staff will send the self-requesting mammography report to their primary care physician. A summary of the written report in lay terms shall be sent to the patient.
    a. In the event that the healthcare provider declines to accept the mammography report, then we will treat the patient as a self-referred.
4. Self-referrals with abnormal results will be referred to the RHC care coordination department who will be responsible for identifying a provider that can work on behalf of the patient.
5. Follow-up contact will be made to self-referrals with abnormal results (BIRADS 0, 3, 4, 5) to determine that they have consulted a healthcare provider for follow-up care.
6. In the event that a self-referred or a self-requested patient is having a screening mammogram when the interpreting radiologist is onsite and determines a need for additional workup, the imaging department will contact either the healthcare provider who has agreed to accept the patient or primary healthcare provider provided by the patient to obtain an order for additional diagnostic workup.

REFERENCES: ACR Practice Parameters for the performance of Screening and Diagnostic Mammography

RECORD RETENTION AND DESTRUCTION:
Mammography reports will be stored in patient's medical record

CROSS REFERENCED POLICIES AND PROCEDURES:

1. DI – Communication of Mammography Results to the Patient
2. Diagnostic Imaging – Mammography Compliance Requirements
3. DI – Screening Mammography

Supersedes: v.3 Diagnostic Imaging - Self-referral for Breast Screening Exams*

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NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Gait Belt Policy		
Owner: Manager Acute/Subacute ICU	Department: Acute/Subacute Unit	
Scope: Manager Acute/Subacute ICU		
Date Last Modified: 04/28/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/18/2015	

PURPOSE:
To reinforce the use of gait belts for appropriate patients resulting in less strain on the back of the care giver and additional support for the patient, improving patient and staff safety during transfers

POLICY:
A gait belt will be used to at transfer and ambulation of all patients on fall prevention status as evidenced by the yellow slippers and falling star on the door. Continued assessment of the patient's mobility status and gait belt need is ongoing as patient's status changes.

1. The gait belt is to be worn around a patient's waist.
2. The gait belt is used to move a patient from a standing or seated position to a wheelchair or bedside chair.
3. The gait belt may be used to ambulate a patient as an assistive device to prevent falling.
4. The proper way to apply it is to keep two fingers between the belt and the patient's body. Tighten it until there is just enough room for the fingers.
5. If the belt is too loose you can either have it slip upward and injure the patient's chest (especially the female patient) or increase the risk for dropping the patient once the weight is put on the belt.
6. Gait belt education:
   - During orientation each new staff member will go through training on the following:
     a. The gait belt policy and procedure.
     b. The proper use of the gait belt.
     c. Ergonomic training by Physical Therapy.
     d. Patient population indicated for the use of the gait belt.
     e. Infection control policy as to cleaning and care.
7. Placement of the gait belt;
   - Nursing units will have gait belts available in a designated spot of their choice with staff education on where to locate a belt if needed.
   - Once used, the gait belt must be cleaned prior to use with another patient.
   - If the patient is an inpatient and a gait belt is used the belt stays with the patient until discharge.
   - At discharge the gait belt is cleaned by environmental services in accordance with the type of cleaning required for the room.

REFERENCES:

1. OSHA Health Care Facilities Gait belt training. www.osha.gov.
2. TJC (2005) Fall Prevention: http://www.rehabmart.com/PDFs/M6241-Posey-Falls-Management-Color-Gait-Belts.pdf

CROSS REFERENCED POLICIES AND PROCEDURES:
1. Fall prevention and Management

Supersedes: v.1 Gait Belt Policy*

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

Title: Infection Prevention Recommendations for Avian Influenza, Novel Influenza, and Seasonal Flu		
Owner: Director of Quality and Infection Prevention	Department: Nursing Administration	
Scope: All Clinical Staff		
Date Last Modified: 03/01/2022	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/13/2017	

PURPOSE:

To minimize exposure to patients, healthcare workers, and visitors by way of patients presenting with Avian, Novel and seasonal flu like symptoms or a confirmed diagnosis.

DEFINITIONS:

1. **Avian Influenza:** Influenza viruses that are different from currently circulating human influenza A virus subtypes and include viruses from predominantly avian and swine origin Novel and variant Influenza A viruses can infect and cause severe respiratory illness in humans e.g. H1N1, H5N1, and H7N9. Highly contagious. Avian flu viruses do not normally infect humans. However, sporadic human infections with avian flu viruses have occurred.
2. **Case Classification**
   - **Suspected:** A case meeting the clinical criteria, pending laboratory confirmation. Any case of human infection with an influenza A virus that is different from currently circulating human influenza viruses is classified as a suspected case until the confirmation process is complete.
   - **Probable:** A case meeting the clinical criteria, pending laboratory confirmation. Any case of human infection with an influenza A virus that is different from currently circulating human influenza viruses is classified as a suspected case until the confirmation process is complete.
   - **Confirmed:** A case of human infection with a novel influenza A virus confirmed by CDC's influenza laboratory or using methods agreed upon by CDC and CSTE as noted in Laboratory Criteria.
3. **Endemic:** Refers to the constant presence and/or usual prevalence of a disease or infectious agent in a population within a geographic area.
4. **Epidemic:** Refers to an increase, often sudden, in the number of cases of a disease above what is normally expected in that population in that area.
5. **Outbreak:** Carries the same definition of epidemic, but is often used for a more limited geographic area.
6. **Novel Influenza A Virus:** Refers to A virus that has caused human infection, but is different from current seasonal human influenza A viruses that circulate among people. Novel influenza A viruses are usually influenza to a virus that circulate among animals.
7. **Pandemic:** Refers to an epidemic that has spread over several countries or continents, usually affecting a large number of people.
8. **Seasonal Influenza Virus:** Seasonal influenza viruses are influenza A and B viruses that spread and cause illness in people during the time of year known as the "flu season." Seasonal influenza viruses cause annual U.S. influenza epidemics during fall, winter, and spring, and circulate among people

worldwide. Seasonal influenza A and B viruses are continually undergoing evolution in unpredictable ways.

9. **Sporadic:** Refers to a disease that occurs infrequently and irregularly.

POLICY:

1. Prompt screen and triage of symptomatic patients by a provider or Registered Nurse
2. Implement transmission based procedures on symptomatic and confirmed patients.
3. Notify Infection Preventionist, House Supervisor, or designee immediately of all patients admitted with suspected Avian or Novel Influenza.
4. Report all cases of suspected Avian and Novel Flu that meet the current case definition will be reported within one working day to the local health department.
5. Visitors will be limited to immediate family or caregiver for short period of time. Visitors to follow appropriate standard and transmission based precautions.
6. If able dedicate healthcare workers to care for confirmed or suspected patients, to minimize risk and exposure to other patients and healthcare workers.
7. Keep a list of all healthcare workers who care for or enter the room of the suspected or confirmed case of Avian Flu or Novel Influenza A Virus.
8. Infection Prevention team will complete a Pandemic and Seasonal Influenza Readiness Assessment Checklist annually.

PROCEDURE:

1. Screen all patients with influenza like illnesses.
    - Avian Flu
    - Novel Flu
    - Coronaviruses
    - Seasonal (Influenza A, B)
2. Institute Isolation Precautions as indicated: Droplet, Airborne, Contact, and Standard Precautions
    - Place surgical mask on every patient or during transport who has a cough or signs and symptoms of influenza.
    - Implement Respiratory Hygiene and Cough Etiquette.
    - Institute droplet precautions for suspected or confirmed cases of seasonal flu.
    - Place patient in Airborne Isolation if suspected or confirmed Avian or Novel A Influenza virus or performing aerosolizing producing procedures with any influenza type patient.
        - Option 1: Room 5, Medical surgical Unit;
        - Option 2: Room 1, ICU Unit;
        - Option 3: Place patient in surgical mask, staff to don N 95 mask, shut door and place Airborne Isolation signage on door. All family visitors must follow Northern Inyo Healthcare District (NIHD) infection prevention guidelines. Any aerosolizing producing treatments will be completed in an Airborne Infection Isolation Room if room available.
3. Don Personal Protective Equipment upon entering patient room.
    - Hand Hygiene
    - Gown
    - Gloves
    - Eye protection
    - N95 mask or PAPR

4. Avoid touching the eyes, mouth, and nose after touching any contaminated material while wearing PPE.
5. Provide education to patient, family, and visitors.

HEALTHCARE WORKER EXPOSURE: AVIAN AND NOVEL INFLUENZA

1. Healthcare workers (HCW) who have unprotected direct contact with an Avian or Novel A Influenza Flu patient must report the exposure to Infection Control or Employee Health. The HCW must complete the "HCW Contact with Case of an Aerosolized Transmissible Disease" screening form and be instructed to monitor their temperature in the morning and in the evening for at least 10 days.
2. All staff will be vigilant for the development of fever, respiratory symptoms and/or conjunctivitis for one (1) week after the last exposure to avian influenza-infected patients.
3. If a fever or cough develops, the HCW will be instructed to seek medical evaluation immediately.
4. Refer to Infection Prevention Recommendations for Avian Influenza, Novel Influenza, and Seasonal Flu policy and procedure.

HEALTHCARE WORKER EXPOSURE: SEASONAL FLU

1. Refer to Infection Prevention Recommendations for Avian Influenza, Novel Influenza, and Seasonal Flu policy and procedure.

HANDWASHING:

- Hands are to be washed prior to after patient contact. Follow the World Health Organization guidelines: Your 5 Moments for Hand Hygiene.
- If hands are not visibly soiled or the patient does not have C-diff or norovirus, alcohol-based rub can be used.

TRANSPORTING PATIENTS:

- Patients should not be transported to other areas of the hospital unless absolutely necessary.
- If patients must be transported, place a surgical mask over patient's nose and mouth.

PATIENT CARE EQUIPMENT:

- Patient care equipment (e.g., thermometers, blood pressure cuffs, stethoscopes and commodes) should be kept in the patient's room if able. Use disposable equipment whenever possible.
- Reusable equipment will be cleaned per protocol before re-use.

LINENS, WASTE AND ROOM CLEANING:

- All linen will be considered contaminated
- High touch surface areas will be cleaned more frequently
- Terminal clean will be completed at discharge

REFERENCES:

1. Centers for Disease Control and Prevention. (2014). Interim Guidance for Infection Control within Healthcare Settings When Caring for Confirmed Cases, Probable Cases, and Cases Under Investigation for Infection with Novel Influenza A Viruses Associated with Severe Disease. Retrieved from https://www.cdc.gov/flu/avianflu/novel-flu-infection-control.htm
2. Centers for Disease Control and Prevention. (2021) Prevention strategies for Seasonal Influenza in Healthcare Settings. Retrieved from https://www.cdc.gov/flu/professionals/infectioncontrol/healthcaresettings.htm
3. Centers for Disease Control and Prevention. (2017). Pandemic Influenza Plan 2017 Update. Retrieved from https://www.cdc.gov/flu/pandemic-resources/pdf/pan-flu-report-2017v2.pdf
4. Centers for Disease Control and Prevention (CDC). (2019. Interim Guidance for the use of Masks to Control Seasonal Influenza Virus Transmission. Retrieved from https://www.cdc.gov/flu/professionals/infectioncontrol/maskguidance.htmhttps://www.cdc.gov/flu/professionals/infectioncontrol/index.htm
5. Occupational Safety and Health Administration. (Retrieved August, 24th, 2017). Seasonal Flu: Employer Guidance Reducing Healthcare Worker's Exposures to Seasonal Flu Virus. Retrieved from https://www.osha.gov/dts/guidance/flu/healthcare.html
6. California Hospital Association. (2018), Record and Data Retention Schedule. Retrieved from file:///H:/Public/CHA/CHA%20Record%20and%20Data%20Retention%20Schedule%202018.pdf

RECORD RETENTION AND DESTRUCTION:

Medical Records for patients are managed by NIHD Medical Records Department per policy.
Employee Health Records are kept duration of employee, plus 30 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Aerosolized Transmissible Disease Plan
2. Airborne Precautions, Contact Precautions, Hand Hygiene, Droplet Precautions, Standard Precautions, Respiratory hygiene and cough etiquette, ambulatory care: Lippincott Procedures
3. Airborne Infection Isolation Rooms (AIIR)
4. Health Care Workers with Influenza like illness
5. Reportable Diseases: Lippincott Procedures
6. Personal Protective Equipment (PPE) Putting on, Personal Protective Equipment, Removal: Lippincott Procedures
7. Disinfection, noncritical patient care equipment, ambulatory care: Lippincott Procedures
8. Handling of Soiled Linen
9. Linen Laundry Processes AB 2679.
10. Infection Prevention Plan
11. Severe Acute Respiratory Syndrome (SARS-COV) or Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Infection Control Recommendations Hospitalized Patients

Supersedes: v.4 Infection Prevention Recommendations for Avian Influenza, Novel Influenza, and Seasonal Flu

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

<table>
<tr><td colspan="3">Title: Medical Staff Department Policy - Emergency Medicine</td></tr>
<tr><td colspan="2">Owner: MEDICAL STAFF DIRECTOR</td><td>Department: Medical Staff</td></tr>
<tr><td colspan="3">Scope: Practitioners with Privileges in Emergency Medicine</td></tr>
<tr><td>Date Last Modified: 05/12/2022</td><td>Last Review Date: No Review Date</td><td>Version: 1</td></tr>
<tr><td colspan="2">Final Approval by: NIHD Board of Directors</td><td>Original Approval Date:</td></tr>
</table>

PURPOSE: To delineate clear expectations for practitioners in the Department of Emergency Medicine within Northern Inyo Healthcare District (NIHD).

POLICY: All practitioners (physicians and Advanced Practice Providers) granted privileges in the Department of Emergency Medicine will adhere to the following procedures. The procedures outlined in this document should reflect and be congruent with the agreements in the Emergency Room Physician Service Agreements provided by Eastern Sierra Emergency Physicians.

PROCEDURE:

1. Patient Care Responsibilities
    a. Practitioners will provide 24-hour basic emergency services for patients of all ages whose emergent medical needs can be met within the capabilities of the hospital staff and facilities.
    b. Practitioners are to be present and ready to see patients in the Emergency Department or take sign-out from the outgoing provider at the time of their scheduled shifts. Unexcused tardiness will result in disciplinary action.
    c. Practitioners performing Emergency Services are required to be in-house at all times while on shift. Practitioners are required to respond to all emergencies/codes as outlined in existing hospital policies. Practitioners first responsibility is to their patient's in the Emergency Department but every effort should be made to assist with emergencies/codes called outside of the Emergency Department but within the hospital.
    d. Practitioners will provide a medical screening exam on all patients, regardless of the ability to pay.
    e. Practitioners will be familiar with and abide by Emergency Medical Treatment and Labor Act (EMTALA) at all times and during all patient encounters.
2. Documentation:
    a. The practitioner shall be responsible for developing the ability to use the electronic health record of NIHD. It is expected that the practitioner will maintain their individual passwords and login information. It is expected that the practitioner will maintain a level of familiarity with the electronic health record that will allow them to safely and efficiently care for patients in the Emergency Department.
    b. Informed consent is to be obtained by the physician and properly documented for applicable procedures as described in the *Informed Consent – Practitioner's Responsibility* policy.
    c. Verbal and/or phone orders are to be authenticated within the timeframe specified as per the *Verbal and/or Phone Medical Staff Practitioner Orders* policy.

   d. It is a requirement for all practitioners to participate in any training provided by the District or recommend by the Emergency Department Medical Director that involves charting. This includes but is not limited to: billing, coding, electronic health record training.
   e. All patient charts are to be completed in a timely manner with the goal for patient charts to be completed within 24 hours of the patient encounter.
3. Credentialing:
   a. Physician practitioners in the Department of Emergency Medicine must be board certified or board eligible by the American Board of Emergency Medicine or the American Board of Family Medicine or AOA (American Osteopathic Association) equivalent.
4. Meeting Attendance:
   a. Practitioners are to attend meetings of the Medical Staff per Medical Staff Bylaws requirements.
5. Focused Professional Practice Evaluation (FPPE):
   a. Practitioners new to NIHD will be expected to complete FPPE as per policy and as delineated during the privileging process.
6. Ongoing Professional Practice Evaluation (OPPE):
   a. Practitioners will be expected to participate in all requirements of OPPE as per Medical Staff policy.
7. Peer Review:
   a. All charts identified by critical indicators will be peer reviewed by a physician with privileges in Emergency Medicine. Selected cases will be reviewed at the Emergency Services committee at its next scheduled meeting. Records are confidential and will be kept by the Medical Staff Office.
8. Re-Entry:
   a. Applicants to the Department of Emergency Medicine are not eligible for Re-entry.

REFERENCES:

1. N/A

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Northern Inyo Healthcare District Medical Staff Bylaws
2. *Informed Consent – Practitioner's Responsibility*
3. *Verbal and/or Phone Medical Staff Practitioner Orders*
4. *Focused and Ongoing Professional Practice Evaluation Policy*
5. *Practitioner Re-Entry Policy*

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Mobile Intensive Care Nurse (MICN)		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: Emergency Department RNs		
Date Last Modified: 03/01/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/1995	

PURPOSE:

To allow the MICN to give immediate direction by radio to the Advanced Life Support (ALS) provider following the protocols as set forth by the California State Emergency Medical Authority (EMS), administered locally by the Inland Counties Emergency Medical Agency (ICEMA), and approved as described by ICEMA.

POLICY:

The ALS providers are responsible for giving a patient care report for any patient contact. The MICN on duty at Northern Inyo Hospital emergency department (ED) shall have the necessary authority to give direction to the ALS providers by radio as outlined in the protocols. This policy allows that the MICN at Northern Inyo Hospital will have the necessary authority to follow current protocols as outlined by this policy to give direction to the ALS providers by radio.

The emergency department nurse manager, pre-hospital liaison nurse (PLN) and the base station hospital director (BSD) or designee will review the protocols prior to being instituted. If the BSD, or ED physician has concern over a particular protocol that issue will be addressed in the Emergency Services Committee, and the committee's decision will be forwarded to ICEMA. If agreed upon, that concern will be noted as an exception to the protocols for the MICN to follow. This exception will be placed in the appropriate place in the protocol manual for direction in the ED, and all MICN's will be notified of the exception.

PROCEDURE:

MICN's will have current understanding of approved protocols and will refer to the protocol manual located in the ED when any question about protocol direction arises. All MICNs will complete the requirements for MICN certification or recertification. The protocol manual will be updated as new protocols are approved, and a copy of the current protocols will be available in the main ED, near the radio at all times. This book will be updated as protocols and exceptions to protocols are made.

DOCUMENTATION:

MICN shall document all ALS contacts on the MICN run sheet and pre-hospital log. The MICN shall also be responsible for any other pertinent paperwork relating to ICEMA policy.

REFERENCE:

1. LALS/ALS ICEMA (EMS Agency) Protocol, Base Hospital Designation, Health and Safety Code Division 2.5 1797.56

RECORD RETENTION AND DESTRUCTION: Record retention will be maintained for 6 years as per California Hospital Association recommendations.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Pre-Hospital Care Policy
2. ICEMA Policy Procedure and Protocol Manual

Supersedes: v.3 MICN Guidelines

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Nursing Chain of Command in Resolving Patient Care Issues		
Owner: Chief Nursing Officer	Department: Nursing Administration	
Scope: Nursing – District Wide		
Date Last Modified: 05/03/2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/2014	

PURPOSE:

To define nursing actions when a nurse has concerns regarding a medical care or has difficulty contacting the attending/consulting provider.

POLICY:

1. A nursing chain of command will be in place to support the nurse in the delivery of care and resolution of clinical issues.
2. If a Hospital RN cannot reach the Attending Medical Staff Provider or has any reason to doubt or question the care provided to any patient or believes that additional consultation is needed and has not been obtained, the RN is to discuss the situation with the House Supervisor (HS).
   a. The HS will review the information and may in turn contact the Attending Physician.
   b. If the HS is unable to resolve the situation, the chain of command will be followed
3. Hospital Nursing Chain of Command:
   a. CNA/LVN →RN
   b. RN→HS
   c. HS→Manager/Assistant Manager (days)→CNO (days) and/or Administrator on Call (AOC) (off shifts, week-ends and holidays)
4. Clinics Nursing Chain of Command:
   a. MA/LVN→RN
   b. RN→Manager→Clinical Director
   c. Clinical Director→Medical Director
5. Under no circumstances may an RN write orders on behalf of a Medical Staff Provider if he/she cannot locate the Medical Staff Provider.
6. If an RN receives an order for a medication in unusual circumstances, or the medication dosage is beyond the usual amount prescribed, or in excess of that dosage listed in reference books or package inserts, the nurse will verify the order with the Pharmacist or Medical Staff Provider prior to administering.

PROCEDURE:

When unable to reach provider for Hospital Patients-

1. If an RN is unable to reach the Attending/Consulting/Covering Medical Staff Provider, the RN will discuss the situation with the HS. The HS will review the situation and will attempt to contact the Medical Staff Provider

2. If the HS is unable to reach the Medical Staff Provider, the HS will call the Chief of Service for direction.
3. If the HS is unable to reach the Chief of Service, the HS will call the Chief of Staff (or covering physician for the Chief of Staff) for direction.
4. If the RN or HS has concerns about the patient condition, the Rapid Response Team (RRT) may be activated.

When unable to reach provider for Clinic Patient-

1. If MA/LVN or RN have a question, need for an order or to notify a provider of concerns with a clinic patient and the primary care provider is unavailable in the clinic, on-duty provider staff will be consulted.
2. In clinics where no provider is not present to address the patient concern, attempts will be made to contact the on-call physician. In the event that a specialist is unavailable, attempts will be made to contact the primary care provider.

For care concern/conflict for Hospitalized Patients-

1. If an RN has concerns regarding the medical care, and has contacted the Attending Medical Staff Provider for clarification without satisfaction, the nurse shall call the House Supervisor or Manager.
    a. The HS/Manager will review the medical care/orders
    b. If in the opinion of the HS/Manager, the care is questionable, the Attending Medical Staff Provider will be re-contacted.
    c. If no clarification or resolution is received by the HS/Manager, the HS/Manager will call the Department Medical Director.
    d. If no resolution by the Department Medical Director, the HS/Manager will notify the Chief Nursing Officer (CNO) or Administrator on Call (AOC) on the off shifts, week-ends and holidays.
    e. The CNO or AOC will contact the Chief of Staff for further action.
2. If an RN has doubts regarding a medication order, the RN may verify the order with the hospital Pharmacist.
    a. The Pharmacist will consult the Medical Staff Provider if the order is questionable
    b. If the Medical Staff Provider does not change the order, the RN will notify the HS/Manager.
    c. The HS/Manager/Pharmacist will follow the chain of command in resolving the order.
    d. If the order is not resolved, the Medical Staff Provider will be informed that nursing will not administer the medication.
3. The Chain of Command for resolving patient care situations should always be followed:
    a. RN contacts Medical Staff Provider
    b. RN contacts HS/Manager
    c. HS/Manager re-contacts the Medical Staff Provider
    d. HS/Manager contacts the Department Medical Director
    e. HS/Manager contacts the CNO or AOC
    f. CNO or AOC contacts the Chief of Staff
4. Proper documentation must be done on the Unusual Occurrence Report (UOR).

For care concern/conflict for Clinic Patients-

1. If an RN has doubts concerns regarding the medical care, and has contacted the Primary Provider for clarification without satisfaction, the nurse shall call the Manager or Clinical Director.
    a. The Manager or Clinical Director will review the medical care/orders

b. If in the opinion of the Manager/Clinical Director, the care is questionable, the Primary Provider will be re-contacted.
c. If no clarification or resolution is received by Manager/Clinical Director, the Manager/Clinical Director will call the Clinic Medical Director.
d. If no resolution by the Clinic Medical Director, the Manager/Clinical Director will notify the Chief Nursing Officer (CNO) or Administrator on Call (AOC) on the off shifts, week-ends and holidays.
e. The CNO or AOC will contact the Chief of Staff for further action.

2. If an MA/LVN or RN has doubts regarding a medication order, after discussion with an available Clinic RN, the Clinic RN may verify the order with the hospital Pharmacist.
   e. The Pharmacist will consult the Provider if the order is questionable
   f. If the Provider does not change the order, the RN will notify the Manager/Director.
   g. The Manager/Director/Pharmacist will follow the chain of command in resolving the order.
   h. If the order is not resolved, the Medical Staff Provider will be informed that nursing (MA/LVN or RN) will not administer the medication.
3. The Chain of Command for resolving patient care situations should always be followed:
   g. MA/LVN or RN discusses concern with Provider
   h. RN contacts Manager/Clinical Director
   i. Manager/Clinical Director re-contacts the Provider
   j. Manager/Clinical Director contacts the Clinic Medical Director
   k. Manager/Clinical Director contacts the CNO or AOC
   l. CNO or AOC contacts the Chief of Staff
4. Unusual Occurrence Report (UOR) is completed by the staff with the concern.

REFERENCES:

1. TJC (January 2022) CAMCAH. Functional Chapter Leadership, LD030401, Oakbrook Terrace, Illinois.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Nursing Chain of Command in Resolving Patient Care Issues
2. Medical Staff Rules and Regulations

RECORD RETENTION AND DESTRUCTION:
Items documented within the patient medical record are maintained by the Northern Inyo Healthcare District Medical Records Department.
UORs are maintained for a minimum of ten (10) years.

Supersedes: v.2 Nursing Chain of Command in Resolving Patient Care Issues

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Pre- and Post-Operative Anesthesia Visits		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Practitioners Privileged in Anesthesia		
Date Last Modified: 03/07/2022	Last Review Date: No Review Date	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/03/2013	

PURPOSE:
To clarify requirements for pre- and post-operative anesthesia visits.

POLICY:

1. Pre-Anesthesia
   a. The preoperative visit shall be conducted personally, whenever possible, by the anesthesiologist who is scheduled to provide care for the patient.
   b. The pre-operative visit shall include a disclosure of risks and options, a formulation of the plan of anesthesia and informed consent given to the patient and or patient representative, if the patient is not competent.
   c. A pre-operative note of the findings relating to anesthesia including the plan of anesthesia, and the patient's informed consent shall be placed in the medical record.
   d. A history and physical examination will be available in the patient's medical record at the time of the anesthesiologist's visit. This document shall not replace the anesthesiologist's responsibility for personally evaluating the patient.
2. Post-Operative
   a. Post-operative visits are recorded on the evaluation form or progress notes.
   b. At least one note will describe the presence or absence of anesthesia related complications.
   c. The number and timing of post-anesthesia visits will be determined by the status of the patient. It is recommended that a visit be made early in the post-operative period and after complete recovery from anesthesia.
   d. Post-anesthesia notes should specify time and date and be completed within 48 hours after surgery.
   e. Post-anesthetic assessment by an anesthesiologist shall be performed and entered in the medical records of all patients discharged directly from the PACU.

~~**DOCUMENTATION:**~~
~~Documentation of pertinent patient information as designated above in the medical record~~

REFERENCES:

1. CMS Conditions of Participation: Anesthesia Services 482.52(b)1,3.

RECORD RETENTION AND DESTRUCTION:

draft

1. Life of policy, plus 6 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. *Anesthesia Clinical Standards and Professional Conduct*
2. *Anesthesia in Ancillary Departments*
3. *Medical Staff Department Policy – Anesthesia*
4. *Scope of Anesthesia Practice*

Supersedes: v.5 Pre and Post Operative Anesthesia Visits

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Scope of Anesthesia Practice		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Practitioners Privileged in Anesthesia		
Date Last Modified: 03/07/2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/20/2018	

PURPOSE:
To delineate the practice of anesthesia, which is a recognized medical and advanced practice nursing specialty unified by the same standard of care

POLICY:
1. The scope anesthesia practice at Northern Inyo Healthcare District includes, but is not limited to:
    a. The preoperative, intraoperative and postoperative evaluation and treatment of patients who are rendered unconscious and/or insensible to pain and emotional stress during surgical, obstetrical, radiological therapeutic and diagnostic or other medical procedures and participation in the overall coordination of care;
    b. The protection and maintenance of life functions and vital organs (e.g., brain, heart, lungs, kidneys, liver, endocrine, skin integrity, nerve [sensory and muscular]) under the stress of anesthetic, surgical and other medical procedures;
    c. Monitoring and maintenance of acceptable physiology during the perioperative period;
    d. Diagnosis and treatment of acute, chronic and cancer-related pain;
    e. Clinical management of cardiac and pulmonary resuscitation;
    f. Evaluation of respiratory function and application of respiratory therapy;
    g. Management of critically ill patients;
    h. Conduct of clinical, translational, basic science and outcomes/best practice research;
    i. Supervision, teaching and evaluation of performance of both medical and paramedical personnel involved in perioperative care and cardiac and pulmonary resuscitation;
    j. Management and preservation of patient safety;
    k. Communication of patient-care concerns with the surgeon/proceduralist and other members of the healthcare team whenever indicated.
2. The anesthesia provider's responsibilities to patients include:
    a. Assessment of, consultation for and preparation of patients for anesthesia;
    b. Management of patients and the anesthetic for the planned procedures;
    c. Post anesthetic evaluation and treatment;
    d. Perioperative pain management.

REFERENCES:

1. "Guidelines for Patient Care in Anesthesiology." American Society of Anesthesiologists. October 26, 2016 edition.

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2. “Scope of Nurse Anesthesia Practice.” American Association of Nurse Anesthetists 2013.

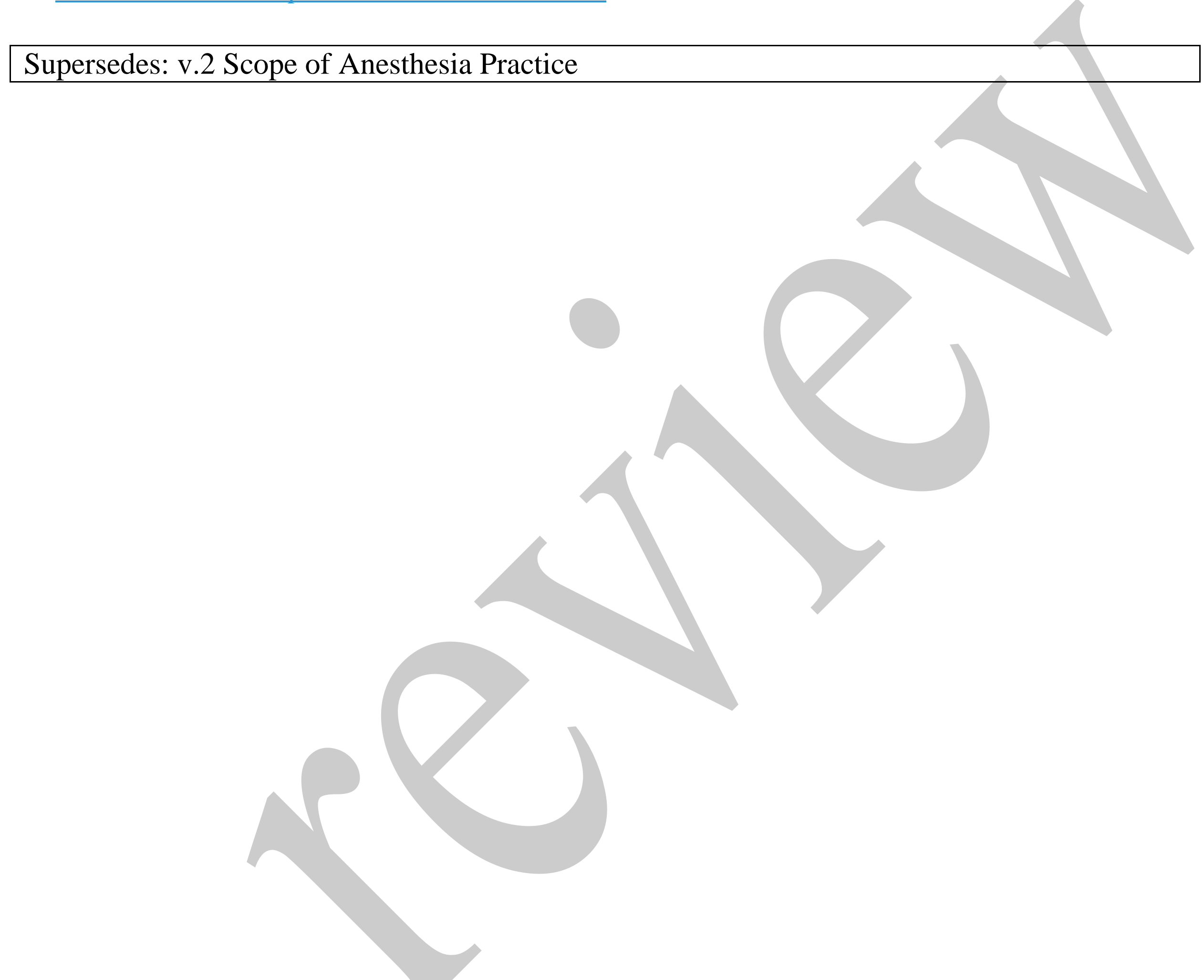
RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. *Anesthesia Clinical Standards and Professional Conduct*
2. *Anesthesia in Ancillary Departments*
3. *Medical Staff Department Policy – Anesthesia*
4. *Pre and Post Operative Anesthesia Visits*

Supersedes: v.2 Scope of Anesthesia Practice



NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Services for Swing-Bed Patients		
Owner: Manager Acute/Subacute ICU	Department: Acute/Subacute Unit	
Scope:		
Date Last Modified: 06/01/2022	Last Review Date: No Review Date	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
An interdisciplinary team will coordinate the support care activities for the Resident including rehabilitation services, activities plan, case management, mental health and dental services.

POLICY:
1. An ongoing program of activities will be designed for each Resident to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each swing-bed patient.

2. At the primary nurse's request, the social worker will assess and support the psychosocial well being of the resident.

3. Rehabilitative services are either provided by NIHD employees or through contracted services. Patients requiring services that cannot be provided by direct or contract service are transferred to another facility.

4. Case Management will assess patients for emotional or behavioral disorders, and in collaboration with the physician determine the appropriate treatment plan including discharge/transfer to appropriate care setting.

5. Every Resident shall receive daily oral care to support oral health and function.

Activities:
1. The Activities Coordinator will visit all new swing-bed patients to inform them of available activities and to assess them for activities that are medically appropriate.
2. The Department Clerk will notify the Activities Coordinator of the Swing admission.
    a. An activities care plan will be developed for each Resident.
    b. An activities calendar, if indicated, is kept in the swing-bed patient's room and in plain sight at the nursing station.
    c. Activities can occur at anytime and are not limited to formal activities being provided by activity staff. Others involved may be any facility staff, volunteers, and visitors.
    d. Clergy visits will be arranged according to the patient's wishes.

Case Management:
1. Case Management visits every swing-bed patient to assess the patient for potential needs.
2. The medically related social services needed by each swing-bed patient are discussed at the interdisciplinary team meetings.

3. Each visit is documented in the EHR.

Rehabilitation Services:

1. Speech Therapy (ST), Occupational Therapy (OT), and Physical Therapy (PT) will complete an assessment on the swing-bed patient as appropriate.
2. A ST, OT, PT plan of care will be developed based on the swing-bed patient needs.
    a. A physician order is obtained for rehabilitation services.
3. Rehabilitation Services interventions are documented in the Electronic Health Record (EHR).
4. The PT collaborates with nursing staff for activity orders to occur outside routine therapy.
    a. Nursing patient activity goals are marked on the white board in the patient room and progress documented in the EHR.
5. If the patient requests or needs divisional activity, therapeutic work can be used to occupy the patient. The OT will devise activity that is patient-specific as a way to relieve boredom or promote physical activity. The work is not to replace actual work necessary to the hospital functioning but "made-up" work for the sole purpose of diverting the resident. Residents are never hired for "paid work.'

Mental Health:

1. Local mental health services will be contacted to provide services when needed.

Dental Services:

1. NIHD will assist residents in obtaining routine and 24-hour emergency dental care.
2. Oral care is performed on residents as part of AM/PM care.
    a. The RN will report any problems the Resident indicates to the physician.
3. When dental care by a dentist is required, an order is obtained and the Department Clerk or Case Management makes arrangements with the dentist of the Resident.
    a. If the patient is unable to travel easily, an appointment will be made for an on-site dentist visit.

REFERENCES:

1. Survey Protocol, Regulations and Interpretive Guidelines for CAH and Swing-Beds in CAHs, Rev. 5/21/04 C-0385---483.15(F) C-0836---483.15(g) C040---483.45(a)

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Swing-Bed Interdisciplinary Care Conference

Supersedes: v.5 Services for Swing-Bed Patients

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

<table>
<tr><td colspan="4">Title: Standardized Procedure - Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife</td></tr>
<tr><td colspan="2">Owner: MEDICAL STAFF DIRECTOR</td><td colspan="2">Department: Medical Staff</td></tr>
<tr><td colspan="4">Scope: Nurse Practitioner, Certified Nurse Midwife</td></tr>
<tr><td>Date Last Modified: 04/20/2022</td><td colspan="2">Last Review Date: No Review Date</td><td>Version: 4</td></tr>
<tr><td colspan="2">Final Approval by: NIHD Board of Directors</td><td colspan="2">Original Approval Date: 04/15/2020</td></tr>
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PURPOSE:
This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines for the management of emergency care conditions.

POLICY:
1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. Circumstances:
   a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
   b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
   c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROCEDURE:
1. Database:
   a. Subjective
      i. Obtain pertinent history related to emergency symptoms.
      ii. Collect appropriate information, including past medical history, review of systems, allergies, immunizations, and medications.
   b. Objective
      i. Perform limited physical examination pertinent to the emergency illness or injury, including any possible involved organ systems.
      ii. Obtain appropriate evaluative studies, including but not limited to, lab work and x-rays. (See *Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife*).
2. Assessment:
   a. Formulate diagnosis consistent with the data base collected.
   b. Document diagnosis in the patient chart.
3. Treatment Plan – Medical Regimen:
   a. Patients requiring emergency care will be stabilized to the best of the capabilities of the setting and transferred to or referred to an appropriate provider. The supervising physician will be involved if needed and the care of the patient transferred to the NIHD hospitalist or appropriate

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practitioner from the emergency department for care or to an accepting outside physician if transfer to another facility is warranted.

i. Emergent referral will usually require transport to NIHD emergency department. This may be accomplished by use of the 911 system and ALS ambulance if indicated by the patient condition. If in the opinion of the NP or CNM the patient can tolerate transfer by wheel chair, an RN must accompany the patient to the emergency department.
ii. Emergent transfers will be managed per NIHD Emergent Transfer Policy. All EMTALA regulations will be followed and appropriate forms, including consent for transfer, will be utilized.
iii. Emergent referrals to facilities other than NIHD will be managed per NIHD policy.

b. The NP or CNM may, whenever necessary, attempt to sustain life. This includes, but is not limited to:
   i. Establishing and maintaining an airway
   ii. Cardiopulmonary resuscitation
   iii. Control of hemorrhage by external pressure or tourniquet
   iv. Establishing an intravenous line
   v. Administration of epinephrine for symptoms of anaphylaxis
   vi. Administration of oxygen for acute dyspnea
   vii. Splint skeletal injuries
   viii. Irrigate wounds
   ix. Apply heat or cold for exposure
   x. Administration of Narcan for suspected narcotic overdose
   xi. Administration of intravenous or oral glucose for suspected hypoglycemia
   xii. Follow resuscitation guidelines as appropriate
c. Physician Consultation: As described in the General Policy Standardized Procedure.
d. Referral to Physician: Conditions for which diagnosis and/or treatment are beyond the scope of the NP's or CNM's knowledge and/or skills, or for those conditions that require consultation.
e. Furnishing Medications – Medical Regimen:
   i. Follow *Furnishing Medications/Devices Standardized Procedur*e, utilizing formulary.

4. Documentation:
   a. All emergency care provided will be recorded in the patient chart.

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REFERENCES:

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

ATTACHMENTS:

1. List of Authorized Nurse Practitioners or Certified Nurse Midwives

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.3 Standardized Procedure - Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROTOCOL

Title: Standardized Protocol - Emergency Care Policy for the Physician Assistant		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Physician Assistants		
Date Last Modified: 04/20/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/15/2020	

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PURPOSE:
This standardized protocol developed for use by the Physician Assistant (PA) is designed to establish guidelines for the management of emergency care conditions.

POLICY:

1. This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the General Policy for the Physician Assistant.
2. Circumstances:
    a. Patient population: pediatric and adult patients.
    b. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in Delegation of Services Agreement.

PROTOCOL:

1. Definition: this protocol covers the management of Emergency Care conditions which may present to NIHD and its affiliated locations.
2. Database:
    a. Subjective
        i. Obtain pertinent history related to emergency symptoms.
        ii. Collect appropriate information, including past medical history, review of systems, allergies, immunizations, and medications.
    b. Objective
        i. Perform limited physical examination pertinent to the emergency illness or injury, including any possible involved organ systems.
        ii. Obtain appropriate evaluative studies, including but not limited to, lab work and imaging studies.
3. Assessment:
    a. Formulate diagnosis consistent with the data base collected.
    b. Document diagnosis in the patient chart.
4. Treatment Plan – medical regimen:
    a. Patients requiring emergency care will be stabilized to the best of the capabilities of the setting and transferred to or referred to an appropriate provider. The supervising physician will be involved if needed and the care of the patient transferred to the NIHD hospitalist or appropriate

practitioner from the emergency department for inpatient care or to an accepting outside physician if transfer to another facility is warranted.

    i. Emergent referral will usually require transport to NIHD emergency department. This may be accomplished by use of the 911 system and ALS ambulance if indicated by the patient condition. If in the opinion of the PA, the patient can tolerate transfer by wheelchair, an RN must accompany the patient to the emergency department.
    ii. Emergent transfers will be managed per NIHD Emergent Transfer Policy. All EMTALA regulations will be followed and appropriate forms, including consent for transfer, will be utilized.
    iii. Emergent referrals to facilities other than NIHD will be managed per NIHD policy.

  b. The Physician assistant(s) may, whenever necessary, attempt to sustain life. This includes, but is not limited to:
    i. Establishing and maintaining an airway
    ii. Cardiopulmonary resuscitation
    iii. Control of hemorrhage by external pressure or tourniquet
    iv. Establishing an intravenous line
    v. Administration of epinephrine for symptoms of anaphylaxis
    vi. Administration of oxygen for acute dyspnea
    vii. Splint or reduce skeletal injuries
    viii. Incision and drainage of abscesses
    ix. Irrigate and repair wounds
    x. Apply heat or cold for exposure
    xi. Administration of Narcan for suspected narcotic overdose
    xii. Administration of intravenous or oral glucose for suspected hypoglycemia
    xiii. Follow resuscitation guidelines as appropriate
  c. Physician Consultation: As described in the *General Policy Standardized Protoco*l.
  d. Consult specialty physician or transfer care of patient.
  e. Refer to Physician: Diagnosis and/or treatment are beyond the scope of the PA's knowledge and/or skills, or for those conditions that require consultation.
  f. Medications – see Delegation of Services Agreement and *Medication/Device Policy for Emergency Department Physician Assistant*

5. Documentation
  a. All emergency care provided will be recorded in the patient chart.

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REFERENCES:

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

ATTACHMENTS:

1. List of Authorized Physician Assistants and Supervising Physicians

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.3 Standardized Protocol - Emergency Care Policy for the Physician Assistant

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure – Well Child Care Policy for the Nurse Practitioner		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Nurse Practitioners		
Date Last Modified: 05/11/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/20/2020	

PURPOSE:

1. This standardized procedure developed for the use by the Family Nurse Practitioner (FNP) or Pediatric Nurse Practitioner (PNP) is designed to establish guidelines that will allow the FNP or PNP to manage well child care.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. This standardized procedure is designed to establish guidelines that will allow the PNP or FNP to perform health maintenance, health promotion and disease prevention activities which promote the physical, psychosocial and developmental well-being of children.
3. Circumstances:
   a. Patient population: neonatal and pediatric patients
   b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations
   c. Supervision: Physicians indicated in the supervisory agreements for the NP

PROCEDURE:

1. Data Base
   a. Subjective
      i. Obtain complete histories on all first time patients; interval histories on subsequent visits.
   b. Objective
      i. See schedule of well child care. Gather and review information as indicated on periodicity schedule.
2. Plan
   a. Diagnosis
      i. Well child
      ii. Acute illness
      iii. Current assessment of chronic illness
   b. Therapeutic regimen
      i. Diet as appropriate for age/nutritional status
      ii. Medications

review

1. Vitamins/mineral supplements
2. Immunizations as indicated
3. Medication as indicated for chronic or acute illness

iii. Activity/exercise as appropriate for age
iv. Health education and anticipatory guidance related to developmental level
v. Treatment of acute illness as indicated (see *Management of Acute Illness Standardized Procedure*).

c. Consultation/referral
   i. Physician consult to be obtained under the following circumstances:
      1. Unexplained history, physical or laboratory finding
      2. Problem which is not resolving as anticipated
      3. Emergency conditions requiring prompt medical intervention
      4. Upon request of patient/family or supervising physician
   ii. Refer to specialist or other community resource as indicated.

d. Follow-up
   i. According to well child schedule or sooner as indicated

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

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

REFERENCES:

1. California Code of Regulations. Title 16, Section 1474. Standardized Procedure Guidelines.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.3 Standardized Procedure – Well Child Care Policy for the Nurse Practitioner

review

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROTOCOL

Title: Standardized Protocol – Well Child Care Policy for the Physician Assistant		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Physician Assistants		
Date Last Modified: 05/11/2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/20/2020	

review

PURPOSE:

1. This standardized protocol is designed to establish guidelines that will allow the Physician Assistant (PA) to manage well child care.

POLICY:

1. This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the *General Policy for the Physician Assistant.*
2. Circumstances:
   a. Patient populations: neonatal and pediatric patients
   b. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations
   c. Supervision: Physicians indicated in the Delegation of Services Agreement

PROTOCOL:

1. Definition: health maintenance, health promotion and disease prevention activities which promote the physical, psychosocial and developmental well-being of children. Includes health assessments, appropriate laboratory tests, and disease prevention through immunizations, developmental screening, and health education.
2. Data Base:
   a. Subjective:
      i. Obtain complete histories on all first time patients; interval histories on subsequent visits.
   b. Objective:
      i. See schedule of well child care. Gather and review information as indicated on periodicity schedule.
3. Plan:
   a. Diagnosis:
      i. Well child
      ii. Acute illness
      iii. Current assessment of chronic illness
   b. Therapeutic regimen:
      i. Diet as appropriate for age/nutritional status
      ii. Medications

1. Vitamins/mineral supplements
2. Immunizations as indicated
3. Medication as indicated for chronic or acute illness

iii. Activity/ exercise as appropriate for age
iv. Health education and anticipatory guidance related to developmental level
v. Treatment of acute illness as indicated (see Acute Illness Protocol).

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

d. Referral
  i. Refer to specialist or other community resource as indicated

e. Follow-up
  i. According to well child schedule or sooner as indicated

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

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

REFERENCES:

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

ATTACHMENTS:

1. List of Authorized Physician Assistants and Supervising Physicians

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.2 Standardized Protocol – Well Child Care Policy for the Physician Assistant

review

Title: Swing Bed Patients Inter-disciplinary Care Conference		
Owner: Manager Acute/Subacute ICU	Department: Acute/Subacute Unit	
Scope: District Wide		
Date Last Modified: 04/28/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/2008	

PURPOSE:
The goal of the Inter-disciplinary care conference for the Swing Bed Patient is to establish a comprehensive treatment plan for the swing bed patient, representing the identified needs from all members of the health care team. Each team member is responsible to provide information on each patient to establish a quality health care plan while hospitalized and upon discharge. The Swing bed patient/Family must be an integral part of this conference.

POLICY:
When a patient's status is changed to a Swing Bed, the patient and family will be informed, with a written letter given to the patient and family during a face to face discussion, that they are invited to participate in an inter-disciplinary care conference to allow them to participate in their plan of care. The conference members who will be asked to participate with the swing bed patient will be all those listed below if specific to their care as well as their primary care doctor. This involvement of the swing bed patient should be as early as possible in their stay and again prior to their discharge or transfer or every 30 days, whichever comes first.

Health Care Team Members Typically Present:

- The Swing Bed Patient /SO/Family
- Physician
- Patient's Nurse
- Hospitalist
- Unit manager/assistant manager
- House Supervisor/Case manager (HS)
- Pharmacy
- Nutritional Services
- Respiratory Therapy
- Physical Therapy
- Occupational therapy

Ancillary Services based on need include:

- Interpretive Services
- Infection Surveillance

The following clarifies the information each health care team member may provide at the conference to ensure a comprehensive treatment and discharge plan is developed for each NIHD Swing bed patient:

The Swing bed patient/Family members:

1. May discuss their wishes for their stay and what they feel are the most important areas of concern and what their goals are for this stay.
2. These concerns and goals will then be incorporated into their plan of care.
3. This will also give the patient an opportunity to discuss their care with all members of the team at one time so that the plan of care is consistent with their goals.

Hospitalist

1. The medical goals they may develop for this patient.
2. The physician discharge goals for this patient.
3. Expected length of stay to accomplish goals.

Medical Surgical RN:

1. Prior to report obtain any specific information related to the patient care.
2. Provide specific medical information related to daily care needs if indicated.
3. Provide specific information related to physical care needs.
4. Inform team of specific lab and x-ray reports including pending cultures.
5. State concerns of patient's mental health status, family interactions and any patient issue pertinent to delivery of care.

House Supervisor/Case Manager (HS):

1. Mental Health Status Report.
2. Social Resources currently available to patient.
3. Family Involvement in patient care.
4. Financial Resources available.
5. Recommended Agency Referrals.
6. Discharge Plan.
7. Facilitates the Inter-Disciplinary Patient care conference.
8. To relay any concerns that may be specific to how patient is progressing and meeting the specific goals to maintain the swing bed criteria.
9. Make notation that patient was informed in writing and verbally of their impending transfer and discharge.

Nutritional Services:

1. Relay information on patient's nutrition, nutritional needs and goals for each patient.
2. Ask questions related to nursing compliance to nutritional goals.

Pharmacy:

1. Describe specific drug interactions.

2. Medication information for take home use and face-to-face discussion with patient on medicine management.
3. Antibiotic information as to length of time needed to be on medications and the best antibiotics to use. IV vs. PO?

Physical Therapy:

1. Discuss any concerns related to patient physical therapy.
2. How the patient is progressing and are goals being met.
3. What they would like nursing to do for each individual patient and physical therapy goals.

Respiratory Therapy:

1. Relate specific information concerning 02 therapies and respiratory needs.

Interpretive Services Manager:

1. Provide input on cultural characteristics team needs to be aware of when treating patient.
2. Interpret treatment and discharge plan to patient.

Infection Surveillance:

1. Inform team of all precautions needed to take for self and patient in preventing the transmission of illnesses.
2. Discuss isolation concerns on specific patients and anything that might be required to confirm a need for precautions other than standard precautions.

Documentation:

1. Documentation of the interdisciplinary care conference will take place by case management or the house supervisor within the patient's medical record.
2. Members of the interdisciplinary team will update their plan of care based on needs presented at the interdisciplinary care conference.

REFERENCES:

1. The Joint Commission CAMCAH Manual, Jan. 2022; Standard PC.02.02.01 & RI01.06.03.
2. State Operations Manual: Appendix W – Special Requirements for CAH Providers of Long–Term Care Services.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Scope of Service Swing Bed
2. Standards of Care for the Swing Bed Resident
3. Rights of Swing Bed Patients

Supersedes: v.3 Swing Bed Patients Inter-disciplinary Care Conference
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

RESOLUTION NO. 22-11

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 15th day of June, 2022 by the following roll call vote:

AYES:
NOES:
ABSENT:

____
Jody Veenker, Chair
Board of Directors

ATTEST:

____
Name:
Title: Administrative Assistant

CALL TO ORDER	The meeting was called to order at 6:00 pm by Jody Veenker, District Board Chair.
PRESENT	Jody Veenker, Chair Mary Mae Kilpatrick, Vice Chair Topah Spoonhunter, Secretary Jean Turner, Treasurer Robert Sharp, Member-At-Large Kelli Davis, Chief Executive Officer Allison Partridge, Chief Nursing Officer (via Zoom)
ABSENT	Joy Engblade, Chief Medical Officer Vinay Behl, Interim Chief Financial Officer
PIONEER HOME HEALTH CARE BOARD OF DIRECTORS	Randall VanTassell, President Marga Foote, Secretary Lynda Salcido, Treasurer Thomas Boo, Member Kelli Davis, Member Mary Mae Kilpatrick, Member
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Veenker reported at this time, members of the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the Notice for this meeting. No comments were heard.
NORTHERN INYO HEALTHCARE DISTRICT AND PIONEER HOME HEALTH CARE MEET AND GREET	Kelli Davis, Chief Executive Officer, called attention and explained that the purpose of the meeting is to allow the Board of Directors for Northern Inyo Healthcare District (NIHD) and Pioneer Home Health Care (PHHC) to reintroduce and provide an overview of the partnership between the two agencies. The two Board of Directors provided a brief self-introduction. Ms. Davis then introduced PHHC Administrator, Ruby Allen. Ms. Allen provided an overview of the services and programs provided by PHHC for over 30 years throughout the local communities of the Eastern Sierra. The programs include the following: - Home Health Care - Hospice - Personal Care Ms. Allen reported that PHHC spent approximately $400,000.00 in preparation to becoming a certified hospice agency, she explained that in 2018 PHHC had to seek financial assistance from NIHD. Ms. Allen

expressed her gratitude to NIHD for their willingness to help PHHC during this time.

Ms. Allen additionally reported that the partnership between PHHC and NIHD, has allows both agencies to be able to collaborate together and provide discharge options to elderly patients. She also explained that PHHC understands that they must participate in the NIHD financial audit every year, due to the partnership with NIHD.

Ms. Allen also reported that PHHC is challenged with meeting the needs of the community and operating with minimal staff. Ms. Allen explained that PHHC is also working to collaberate with other local agencies. Ms. Davis explained that the District will be launching a 2022 Community Health Needs Assessment and she plans to share the results with PHHC to help identify the needs of the community and help improve these areas to ensure that the partnership between the two agencies continues to grow.

ADJOURNMENT The meeting was adjourned at 7:07 pm.

____
Jody Veenker, Chair

Attest: ____________________________________
Topah Spoonhunter, Secretary

CALL TO ORDER

The meeting was called to order at 5:30 pm by Jody Veenker, District Board Chair.

PRESENT

Jody Veenker, Chair
Mary Mae Kilpatrick, Vice Chair
Topah Spoonhunter, Secretary
Jean Turner, Treasurer
Robert Sharp, Member-at-Large
Kelli Davis MBA, Chief Executive Officer and Chief Operating Officer
Allison Partridge RN, MSN, Chief Nursing Officer (via zoom)
Keith Collins, General Legal Counsel (Jones & Mayer)

ABSENT

Vinay Behl, Interim Chief Financial Officer

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 (NIHD) 2022 YEARS OF SERVICE, HOSPITAL WEEK & NURSES WEEK CELEBRATION

Chief Executive Officer, Kelli Davis, introduced Northern Inyo Healthcare District (NIHD) Strategic Communications Specialist, Barbara Laughon. Ms. Laughon provided an overview of the activities that took place during the NIHD Nurses Week and Hospital Week, and presented a brief slide show to highlight these two events. The Board of Directors expressed their appreciation for this report.

NIHD 2022 COMMUNITY HEALTH NEEDS ASSESSMENT UPDATE

Ms. Davis introduced Scot Swan, NIHD Digital Marketing Specialist. Mr. Swan reported that NIHD successfully launched the 2022 Community Health Needs Assessment (CHNA) Survey on May 2, 2022 and closing on June 3, 2022. He also provided a brief presentation to explain the different ways the District is encouraging the public to take the survey. Mr. Swan additionally reported that NIHD is working to provide copies of CHNA survey information to local agencies.

NIHD GOVERNANCE COMMITTEE UPDATE	Ms. Davis provided an update on the recent Governance Committee meeting that took place in the recent months. She explained that the Governance Committee would like the Board to consider the approval of a few draft documents created by this committee and allow a discussion to take place about upcoming projects and focus areas. She additionally reported that a Special Board Meeting has been scheduled for May 25, 2022 at 6:00 pm, to allow the consideration of these items to take place.
APPROVAL OF THE DISTRICT BOARD RESOLUTION 22-07, AMENDING THE NIHD BYLAWS TO CREATE CURRENT STANDING COMMITTEE AD HOC COMMITTEE AND WITH ONLY THE GOVERNANCE COMMITTEE AS A STANDING COMMITTEE OR, ALTERNATIVELY APPROVAL OF DISTRICT BOARD RESOLUTION 22-08, AMENDING THE NIHD BYLAWS TO CREATE ALL CURRENT STANDING COMMITTEE AD HOC COMMITTEES	Keith Collins, General Legal Counsel, called attention to proposed District Board Resolution 22-07, amending the NIHD Bylaws to create current Standing Committees Ad Hoc Committees with only the Governance Committee as a Standing Committee, or alternatively approve the District Board Resolution 22-08, amending the NIHD Bylaws to create all current Ad Hoc Committees Standing Committees. An open discussion took place to approve one of the two District Board Resolutions. Mr. Collins clarified questions for the Board. It was moved by Robert Sharp, seconded by Jean Turner, and unanimously passed to table the approval of District Board Resolution 22-07 and District Board Resolution 22-08; the Board will consider the approval of these two items at the Special Board Meeting, May 25, 2022 as requested.
NORTHERN INYO HEALTHCARE DISTRICT CEO ABSENCE FROM THE JULY 20, 2022 BOARD OF DIRECTORS MEETING	Ms. Davis explained that she will be absent from the July 20, 2022 Regular Board of Directors Meeting. She asked that the Board consider approval to appoint another member of the NIHD Executive Team to sit in the place of the CEO for the July Regular Board Meeting or alternatively select another date to hold the July Regular Board Meeting. It was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve for Ms. Davis to appoint another member of the NIHD Executive Team to sit in the place of the CEO for the July 20, 2022 Regular Board meeting as requested.
DISTRICT BOARD RESOLUTION 22-09, CONSOLIDATION OF ELECTION	Ms. Davis called attention to proposed District Board Resolution 22-09, which would allow the NIHD Board of Directors November Election to be combined with the November 8, 2022 General Election. It was moved by Ms. Turner, seconded by Mary Mae Kilpatrick, and unanimously passed to approve District Board Resolution 22-09 as presented.
CHIEF OF STAFF REPORT	
MEDICAL STAFF APPOINTMENTS	Chief of Staff, Sierra Bourne, MD reported, following review and consideration, the Medical Executive Committee recommends approval of

the following Medical Staff Appointments:

1. *Paul Kim, MD (anesthesiology) – Active Staff*
2. *Carolyn Saba, MD (anesthesiology) – Courtesy Staff*
3. *Leena Sumitra, MD (psychiatry) – Telemedicine Staff*

It was moved by Ms. Turner, seconded by Topah Spoonhunter, and unanimously passed to approve all three (3) Medical Staff Appointments as requested.

CHANGES IN MEDICAL STAFF CATEGORY

Doctor Bourne reported, following review, consideration and approval by the appropriate Committees, the Medical Executive Committee recommends approval of the following Changes in Medical Staff Category:

1. *Farres Ahmed, MD (radiology) – requested to be changed from Courtesy Staff to Active Staff*

It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve the one (1) Change in Medical Staff Category as requested.

MEDICAL STAFF PRIVILEGE FORM

Doctor Bourne additionally reported the Medical Executive Committee recommends approval of the following Medical Staff Privilege Form:

1. *Cardiovascular Disease*

It was moved by Mr. Spoonhunter, seconded by Mr. Sharp, and unanimously passed to approve the one (1) Medical Staff Privilege Form as requested.

MEDICAL STAFF RESIGNATIONS

Doctor Bourne reported the Medical Executive Committee recommends approval of the following Medical Staff Resignations:

1. *Edmund Pillsbury, MD (radiology) – effective 2/23/22 – in good standing*
2. *Matthew Wise, MD (obstetrics & gynecology) – effective 2/24/22 – in good standing*
3. *Felix Karp, MD (hospitalist) – effective 4/12/22 – in good standing*

It was moved by Ms. Turner, seconded by Mr. Spoonhunter, and unanimously passed to approve all three (3) Medical Staff Resignations as requested.

POLICIES

Doctor Bourne reported the Medical Executive Committee recommends approval of the following District-Wide Policies:

1. *Access to Medications in the Absence of the Pharmacist*
2. *Barcode Medication Administration*
3. *Cardiac Arrest in the OR*
4. *Cleaning and Care of Surgical Instruments*
5. *Diet Texture Ordering*
6. *Focused and Ongoing Professional Practice Evaluation*
7. *High Alert Medications: Preparation, Dispensing, Storage*
8. *Laser Safety*
9. *Medical Staff Professional Conduct Policy*
10. *Quality Assurance and Performance Improvement Plan*
11. *Safe Patient Handling – Minimal Lift Program*
12. *Sentinel Event/Serious Harm Reporting and Prevention*
13. *Single-Dose vs. Multi-Dose Vial Policy*
14. *Surgeries Requiring An Assistant*

It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve all fourteen (14) Policies as presented.

MEDICAL EXECUTIVE COMMITTEE REPORT

Doctor Bourne provided a report on the Medical Executive Committee meeting and clarified questions. Mr. Sharp expressed that he would like the Board to receive an information update about the workflow regarding the NIHD emergency department sexual assault exams.

____.

CONSENT AGENDA

Ms. Veenker called attention to the Consent Agenda for this meeting which contained the following items:

1. *Approval of District Board Resolution 22-10, to continue to allow Board meetings to be held virtually.*
2. *Approval of minutes of the April 20, 2022 Regular Board Meeting*
3. *Approval of minutes of the April 26, 2022 Special Board Meeting*
4. *Chief Executive Officer Report*
5. *Chief Medical Officer Report*
6. *Chief Nursing Officer Report*
7. *Financial and Statistical reports as of March 31, 2022*
8. *Approval of Policies and Procedures*
   - A. *Password Policy*
   - B. *ITS Service Desk Work Order*
   - C. *Licensure of Nursing Personnel*

Ms. Veenker requested that the Board consider removing the April 26, 2022 Special Board Meeting Minutes for some revisions and consider the approval of these minutes at the next Regular Board Meeting.

It was moved by Mr. Sharp, seconded by Mr. Spoonhunter, and unanimously passed to remove the minutes from the April 26, 2022 Special Board Meeting and approve the remaining seven (7) Consent

Agenda items as presented.

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. Ms. Turner reported on the webinar from ACHD regarding the 2022 Legislative highlights. Ms. Kilpatrick reported that she attended the activities and events that took place during NIHD Nurses and Hospital week.

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 6:33 pm Ms. Veenker announced the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. PUBLIC EMPLOYEE PERFORMANCE EVALUATION
   Title: District Legal Counsel, Gov. Code. 54957(b) (1).
B. Conference with legal counsel, anticipated litigation. Significant exposure to litigation (pursuant to paragraph (2) of subdivision (d) of Government Code Section 54956.9); one case.

RETURN TO OPEN SESSION AND REPORT OF ANY ACTION TAKEN

At 8:03 pm, the meeting returned to Open Session. Ms. Veenker reported that the Board took no reportable action.

ADJOURNMENT

The meeting adjourned at 8:04 pm.

____
Jody Veenker, Chair

Attest: ______________________________
Topah Spoonhunter, Secretary

CALL TO ORDER

The meeting was called to order at 6:03 pm by Jody Veenker, District Board Chair.

PRESENT

Jody Veenker, Chair
Mary Mae Kilpatrick, Vice Chair
Topah Spoonhunter, Secretary
Jean Turner, Treasurer
Kelli Davis, Chief Executive Officer
Allison Partridge, Chief Nursing Officer (via Zoom)
Joy Engblade, Chief Medical Officer (via Zoom)

ABSENT

Robert Sharp, Member-At-Large
Vinay Behl, Interim Chief Financial Officer

OPPORTUNITY FOR PUBLIC COMMENT

Ms. Veenker reported at this time, members of the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the Notice for this meeting. No comments were heard.

APPROVAL OF THE DISTRICT BOARD RESOLUTION 22-07, AMENDING THE NORTHERN INYO HEALTCARE DISTRICT (NIHD) BYLAWS TO CREATE CURRENT STANDING COMMITTEE AD HOC COMMITTEE WITH ONLY THE GOVERNANCE COMMITTEE STANDING AS A STANDING COMMITTEE OR ALTERNATIVELY, APROVAL OF DISTRICT BOARD RESOLUTION 22-08, AMEMDING THE NIHD BYLAWS TO CREATE ALL CURRENT STANDING COMMITTEES AD HOC COMMITTEES

Ms. Veenker called attention the proposed District Board Resolution 22-07, to amend the Northern Inyo Healthcare District (NIHD) Bylaws to create current Standing Committee Ad Hoc Committee with only the Governance Committee as a Standing Committee, and alternatively District Board Resolution 22-08, to amend the NIHD Bylaws to create all current Standing Committees Ad Hoc Committees. A discussion took place to approve one of these two District Board Resolutions. Topah Spoonhunter requested that the District Board Resolution 22-07, be updated with corrections changing the word “President” to “Chair”.

It was moved by Topah Spoonhunter, seconded by Mary Mae Kilpatrick, and passed with a 4 to 0 vote to approve the District Board Resolution 22-07, amending the NIHD Bylaws to create current Standing Committee Ad Hoc Committee with only the Governance Committee as a Standing Committee with the correction as requested by Mr. Spoonhunter.

AYES: Jean Turner, Mary Mae Kilpatrick, Jody Veenker, Topah Spoonhunter
ABSENT: Robert Sharp

It was moved by Jean Turner, seconded by Ms. Kilpatrick, and passed with a 4 to 0 vote to reject the adoption of District Board Resolution 22-08, amending the NIHD Bylaws to create all current Standing Committees Ad Hoc Committees as presented.
AYES: Jean Turner, Mary Mae Kilpatrick, Jody Veenker, Topah Spoonhunter

ABSENT: Robert Sharp

APPROVAL OF NIHD GOVERNANCE COMMITTEE CHARTER

Ms. Davis called attention the proposed NIHD Governance Committee Charter. A discussion took place about the approval of this document. A decision was made to modify this document under the following sections:

- Purpose
- Responsibilities

It was moved by Ms. Turner, seconded by Mr. Spoonhunter, and passed with a 4-0 to table approval of the NIHD Governance Committee Charter with the recommended modifications, the Board will consider approval of this item at next Regular Board Meeting as requested.

AYES: Jean Turner, Mary Mae Kilpatrick, Jody Veenker, Topah Spoonhunter
ABSENT: Robert Sharp

APPROVAL OF THE POLICY AND PROCEDURE, GUIDELINES FOR BUSINESS BY THE NIHD BOARD OF DIRECTORS

Ms. Davis called attention to the proposed NIHD Board Policy and Procedure title: *Guidelines for Business by the Northern Inyo Healthcare District Board of Directors*.

It was moved by Ms. Kilpatrick, seconded by Mr. Spoonhunter, and passed with a 4-0 vote to approve the NIHD Board Policy and Procedure title: *Guidelines for Business by the Northern Inyo Healthcare District Board of Directors* as presented.

AYES: Jean Turner, Mary Mae Kilpatrick, Jody Veenker, Topah Spoonhunter
ABSENT: Robert Sharp

PUBLIC COMMENT 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.

ADJOURMENT TO CLOSED SESSION

At 7:07 pm Ms. Veenker announced the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. Public Employee Performance Evaluation (pursuant to Government Code Section 54957 (b)) Title: Chief Executive Officer.
B. Public Employee Performance Evaluation
Title: District Legal Counsel, Gov. Code. 54957(b) (1).

RETURN TO OPEN SESSION AND REPORT ON ANY ACTION TAKEN IN CLOSED SESSION

At 8:00 pm, the meeting returned to Open Session. Ms. Veenker reported that the Board took no reportable action.

ADJOURNMENT	Adjournment 8:01 pm

____
Jody Veenker, Chair

Attest: ______________________________
Topah Spoonhunter, Secretary

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ADOPTED BY THE BOARD OF DIRECTORS

NORTHERN INYO HEALTHCARE DISTRICT

REVISED AND ADOPTED IN CONFORMANCE WITH DIVISION 23, SECTION 32000 ET SEQ. OF THE CALIFORNIA HEALTH AND SAFETY CODE ON ~~NOVEMBER 17, 2021~~JUNE 15, 2022

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

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NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE I

NAME, AUTHORITY AND OFFICES

Section 1. NAME

The name of this non-profit health care district organization shall be the Northern Inyo Healthcare District, hereinafter "the District".

Section 2. AUTHORITY

a) This District, having been established January 11, 1946, by vote of the residents of the District under the provisions of Division 23, Section 32000 et seq, of the Health and Safety Code of the State of California, otherwise known and referred to herein as "The Local Health Care District Law," and ever since said time having been operated thereunder, these bylaws are adopted in conformance therewith, and subject to the provisions thereof.

b) In the event of any conflict between these bylaws and "The Local Health Care District Law," the latter shall prevail. To the extent they are not in conflict with these bylaws, the proceedings of the District Board shall be guided by the most recent edition of Robert's Rules of Order.

Section 3. OFFICES

The principal office for the transaction of business of the District is hereby fixed within the boundaries of the District as determined by the Board of Directors.

Section 4. TITLE OF PROPERTY

The title to all property of the District shall be vested in the District, and the signature of the ~~President~~Chair and/or Secretary**,** or any officer designated by the Directors, as authorized at any meeting of the Directors, shall constitute the proper authority for the purchase or sale of property, or for the investment or other disposal of funds which are subject to the control of the District.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE II

PURPOSES AND SCOPE

Section 1. PURPOSES

The purposes of the Northern Inyo Healthcare District shall include, but not be limited to the following:

a) Within available resources, to provide facilities and health services for quality acute and continued care of the injured and ill, inducing health maintenance and education, regardless of sex, race, creed, cultural or national origin.

b) To coordinate, wherever possible and feasible, the activities of the District with health agencies and other health facilities providing specialized as well as comprehensive care.

c) To conduct educational and research activities essential to the attainment of its purposes.

d) To do any and all other acts necessary to carry out the provisions of the Health Care District Act.

Section 2. SCOPE OF BYLAWS

a) These bylaws shall govern the Northern Inyo Healthcare District, its Board of Directors and its relationship to affiliated or subordinate organizations. The primary purpose of these bylaws is to provide rules for the self-governance of the District and the Board of Directors, to provide a structure for the Board of Directors to fulfill its functions and responsibilities with respect to an organized self-governing Medical Staff, and to provide a structure for Administration of the licensed healthcare inpatient and outpatient facilities operated by the District (specifically Northern Inyo Hospital, 1206 D and 1206 B clinics).

b) The Board of Directors may delegate certain powers to the Authority of the Board's committees, the Medical Staff, and to other affiliated and subordinate organizations and groups governed by the District, such powers to be exercised in accordance with the respective bylaws or guidelines of such groups. All powers and functions not expressly delegated to such affiliated or subordinate organizations or groups are to be considered residual powers vested in the Board of Directors of this District.

c) The Bylaws, Rules and Regulations of the Medical Staff and other affiliated and subordinate organizations and groups governed by the District, and any amendments to such bylaws, shall not be effective until the same are approved by the Board of Directors of the Northern Inyo Healthcare District. The provisions of these District bylaws shall be construed to be consistent with the Medical Staff's bylaws. Except that these Bylaws shall not conflict with the bylaws of the Medical Staff as approved by the Board of Directors, the Board of Directors may review these Bylaws and revise them as it deems appropriate.

Section 3. NOT FOR PROFIT STATUS

There shall be no contemplation of profit or pecuniary gain, and no distribution of profits to any individual, under any guise whatsoever; nor shall there by any distribution of assets or surpluses to any individual on the dissolution of this District.

Section 4. DISPOSITION OF SURPLUS

Should the operation of the District result in a surplus of revenue over expenses during any particular period, such surplus may be used and dealt with by the Directors for charitable District purposes or for improvements hospital's facilities for the care of the sick, injured, or disabled, or for other purposes not inconsistent with the Local Health Care District Act, or these bylaws. The Board of Directors may authorize the disposition of any surplus property of the District by any method determined appropriate by the Board.

Section 5. INDEMNIFICATION

a) Any person made or threatened to be made a party to any action or proceeding, whether civil or criminal, administrative or investigative, by reason of the fact that he/she, his/her estate, or his/her personal representative is or was a Director, officer or employee of the District, or an individual (including a medical staff appointee) acting as an agent of the District, or serves or served any other corporation or other entity or organization in any capacity at the request of the District while acting as a Director, officer, employee or agent of the District shall be and hereby is indemnified by the District, as provided in Sections 825 *et.seq.* of the California Government Code.

b) Indemnification shall be against all judgments, fines, amounts paid in settlement and reasonable expenses, including attorney's fees actually and necessarily incurred, as a result of any such action or proceeding, or any appeal therein, to the fullest extent permitted and in the manner prescribed by the laws of the State of California, as they may be amended from time to time, or such other law or laws as may be applicable to the extent such other law or laws is not inconsistent with the law of California, including Sections 825 *et.seq.* of the California Government Code.

c) Nothing contained herein shall be construed as providing indemnification to any person in any malpractice action or proceeding arising out of or in any way connected with such person's practice of his or her profession.

Section 6. FISCAL YEAR

The fiscal year of the District shall commence on the first day of July and each year shall end on the last day of June of each year.

Section 6 Annual Audit removed see section see VI Section, 2, b.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE III

BOARD OF DIRECTORS

Section 1. ELECTION

The Board of Directors shall be elected as provided in "The Local Healthcare District Law," which shall also govern eligibility for election to the Board of Directors.

Section 2. POWERS

The Board of Directors shall have and exercise all the powers of a Healthcare District as set forth in the Healthcare District Act. Specifically, the Board of Directors shall be empowered as follows:

a) To control and be responsible for the overall governance of the District, including the provision of management and planning.

b) To make and enforce all rules and regulations necessary for the administration, government, protection and maintenance of hospitals and other facilities under District jurisdiction and to ensure compliance with all applicable laws.

c) To appoint a Chief Executive Officer and to define the powers and duties of such appointee, and to delegate to such person overall responsibility for operations of the District, the Hospital, and affiliated entities as specified herein and consistent with Board of Directors' Policies. The Board shall also retain legal counsel and independent auditors as needed for District and Hospital operations.

d) To authorize the formation of other affiliated or subordinate organizations which they may deem necessary to carry out the purposes of the District.

e) To periodically review and develop a strategic plan for the District and the Hospital.

f) To determine policies and approve procedures for the overall operation and affairs of this District and its facilities according to the best interests of the public health and to assure the maintenance of quality patient care.

g) To enter into Joint Powers Agreements with other public entities, and to carry out the District's responsibilities in regard to such Joint Powers Authority as prescribed by law.

h) To evaluate the performance of the Hospital in relation to its vision, mission and goals.

i) To provide for coordination and integration among the Hospital's leaders to establish policy, maintain quality care and patient safety, and provide for necessary resources.

j) To be ultimately accountable for the safety and quality of care, treatment and services.

k) All powers of the Board of Directors, which are not restricted by statute, may be delegated by an employment agreement, policies, and by direction of the Board to the Chief Executive Officer or to others employed by or with responsibilities to the District, to be exercised in accordance with that delegation.

l) In the event of a vacancy in any Board office established by Article V of these Bylaws (Chair, Vice Chair, etc.), the Board of Directors shall select someone to fill such vacancy and to serve until the next regular election of officers, unless such person earlier resigns or is removed in accordance with said Article.

m) To do any and all other act and things necessary to carry out the provisions of these bylaws or of the provisions of the Local Healthcare District Law.

Section 3. COMPENSATION

The Board of Directors shall serve without compensation except that the Board of Directors, by a majority vote of the members of the Board, may authorize payment not to exceed one hundred dollars ($100) per meeting, or for each committee meeting or other meeting authorized by Board or Chair of the Board, and not to exceed five (5) meetings a month as compensation to each member of the Board of Directors, in accordance with Section 32103 of the California Health and Safety Code, as amended.

Each member of the Board of Directors shall be allowed his/her necessary traveling and incidental expenses incurred in the performance of official business of the District pursuant to the Board's policy.

A budget for the Board of Directors educational expenses is developed each year. At least annually, the entire Board will review their travel and incidental expenses.

Section 4. VACANCIES

Any vacancy upon the Board of Directors shall be filled by the methods prescribed in Section 1780 of the Government Code.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE IV

MEETINGS OF DIRECTORS

Section 1. REGULAR MEETINGS

The regular meetings of the Board of Directors of the Northern Inyo Healthcare District shall be held monthly, or as periodically determined by the Board, on such day and at such time as the Board of Directors shall from time-to-time establish by resolution and/or motion.

Section 2. SPECIAL MEETINGS

Special meetings of the Board of Directors may be called by the Chair or three (3) Directors, and notice of the holding thereof shall be received by each member of the Board of Directors at least twenty-four hours (24) before said meeting.

Section 3. QUORUM

A majority of the members of the Board of Directors shall constitute a quorum for the transaction of business, and motions and resolutions shall be passed if affirmatively voted upon by a majority of those voting at the time the vote is taken. If a member has a conflict of interest and may not vote they may not be counted towards a quorum.

Section 4. ADJOURNMENT

A quorum of the Board of Directors may adjourn any Directors' meeting to meet again at a stated day and hour; provided, however, that in the absence of a quorum, a majority of the Directors present at any Directors' meeting, either regular or special, may adjourn until the time fixed for the next regular meeting of the Board of Directors. An adjourned meeting can consider only the business of the meeting which was adjourned. An adjourned meeting must be completed prior to the convening of a new meeting.

Section 5. PUBLIC MEETINGS

All meetings of the Board of Directors whether regular, special or adjourned, shall be open to the public in accordance with Government Code Sections 54950 through 54961, commonly known as the Ralph M. Brown Act provided, however, that the foregoing shall not be construed to prevent the Board of Directors from holding executive sessions to consider the appointment,

employment, promotion, demotion or dismissal of an employee or public officer, as the term is defined by law, or to hear complaints or charges brought against such officer or employee, to discuss labor negotiations, or to consult with legal counsel concerning litigation to which the District is a party, and prospective and probably litigation, as provided in Sections 54956.7 through 54957 of the Government Code. In addition, closed sessions may be held to discuss trade secrets as defined in Government Code Section 54956.7, and provided in Section 32106 of the Health and Safety Code. To the extent not in violation with the Ralph M. Brown Act or the California Public Records Act, and California Health and Safety Code Section 32155, any information and reports protected from discovery by California Evidence Code Section 1157 that are provided to the Board of Directors by the Medical Staff shall be presented and discussed in closed sessions, maintained as confidential and not released except as required by applicable laws.

Section 6. MINUTES

A book of minutes of all public meetings of the Board of Directors shall be kept at the principal office of the District and shall be open for public inspection upon request.

Section 7. SCOPE OF MOTIONS AND RESOLUTIONS

The decisions of the Board establishing general rules or procedures of the District and/or procedures affecting the Directors shall be by motion or resolution. All motions or resolutions become effective at the time voted upon affirmatively by a majority of the Directors voting at the time the vote is taken.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE V

OFFICERS AND THEIR DUTIES

Section 1. OFFICERS

The officers of the Board of Directors of the Northern Inyo Healthcare District shall be a ~~President~~Chair, Vice ~~President~~Chair and a Secretary, a Treasurer, and “Member at Large”.

Section 2. ELECTION OF OFFICERS

a) The officers of the Board of Directors shall be chosen every year by the Board of Directors at the December meeting of every calendar year; and each officer shall hold office for one year, or until a successor shall be elected and qualified, or until the officer is otherwise disqualified to serve.

b) If an officer of the Board, other than the ~~President~~Chair, is unable to act, the Board may appoint some other member of the Board of Directors to do so, and such person shall be vested temporarily with all the functions and duties of the office.

c) Any officer on the Board of Directors may resign at any time or be removed as a Board officer by the majority vote of the other Directors then in office at any regular or special meeting of the Board of Directors. In the event of a resignation or removal of an officer, the Board of Directors shall elect a successor to serve for the balance of that officer's unexpired term.

Section 3. DUTIES

a) ~~President~~Chair: The Board of Directors shall elect one of their members to act as ~~President~~Chair. If at any time the ~~President~~Chair shall be unable to act, the Vice ~~President~~Chair shall assume office and perform the duties of the office. If the Vice ~~President~~Chair shall also be unable to act, then the Secretary/Treasurer shall assume the office and shall immediately conduct a Board election to appoint a ~~President~~Chair, and such person shall be vested temporarily with all the functions and duties of the ~~President~~Chair.

The ~~President~~Chair, or member of the Board of Directors acting as such, as above

provided:

(1) Shall preside over all meetings of the Board of Directors, and shall review all requested agenda items submitted to the ~~President~~Chair and the ~~President~~Chair & Chief Executive Officer pursuant to the Board's written policies;

(2) Shall sign as ~~President~~Chair on behalf of the District all instruments in writing that the ~~President~~Chair has been specifically authorized by the Board to sign;

(3) Shall act as the main liaison between the Board and management for communications and oversight purposes. It is expected that the Chair will discuss District business with the Chief Executive Officer and Vice Chair on a regular basis;

(4) Shall appoint or remove members of committees subject to approval by the Board of Directors.

(5) Shall have, subject to the advice and control of the Board of Directors, general responsibility for the affairs of the District and generally shall discharge all other duties which shall be required of the ~~President~~Chair by the Bylaws of the District.

b) Vice ~~President~~Chair: The Vice Chair shall, in the event of death, absence, or other inability of the Chair, exercise all the powers and perform all the duties herein given to the Chair. It is expected that the Vice Chair will participate in regular discussions with the Chair and Chief Executive Officer regarding District business.

c) Secretary:

(1) The member of the Board who is elected to the position of Secretary shall act in this capacity for both the District and the Board of Directors;

(2) Shall be responsible for seeing that records of all actions, proceedings and minutes of meetings of the Board of Directors are properly kept and are maintained at the District offices;

(3) Shall serve, or cause to be served, all notices required either by law or these bylaws, and in the event of absence, inability, refusal or neglect to do so, such notices may be served by any person thereunto directed by the ~~President~~Chair of the Board of Directors of this District;

(4) Shall be responsible for seeing that the seal of this District is in safekeeping at the District and shall use it under the direction of the Board of Directors;

(5) Shall perform such other duties as pertains to the office and as are prescribed by the Board of Directors. The Secretary may delegate his or her duties to appropriate management personnel.

d) Member at Large: The Member at Large shall have all the powers and duties of the Secretary in the absence of the Secretary, and shall perform such other duties as may from time to time be prescribed by the Board of Directors.

e) Treasurer:

(1) Shall have the responsibility for the safekeeping and disbursal of funds in the treasury of the District in accordance with the provisions of the "Local Healthcare District Law" and in accordance with resolutions, procedures and directions as the Board of Directors may adopt;

(2) Shall receive monthly reports from management with respect to the financial condition of the District and shall present such reports to the Board of Directors as directed by the Board of Directors;

(3) Shall perform such other duties as they pertain to this office and as prescribed by the Board of Directors. The Treasurer may delegate his or her duties to appropriate management personnel.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE VI

COMMITTEES

Section 1. COMMITTEES

a) 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.

b) The duties of these committees shall be to develop and make policy recommendations to the Board and to perform such other functions as shall be stated in these bylaws or in the resolution or motion creating the committee. Each Standing Committee will include two Board members, one of whom shall act as ~~President~~Chair of the Standing Committee. The ~~President~~Chair and Board members of each Standing Committee shall be appointed by the ~~President~~Chair of the Board and approved by the Board at the ~~second meeting of January of~~earliest possible time at the beginning of each calendar year and shall serve for one year, or until a successor has been appointed and approved. Other members of each standing committee are automatically members with one year terms, or until a successor has been appointed and approved. The two Board members shall be the only voting members of each Standing Committee, unless otherwise provided for in these Bylaws.

c) Special or ad hoc committees may be appointed by the ~~President~~Chair with the approval of the Board of Directors for such specific tasks as circumstances warrant. Special committees may consist only of Board members, or they may include individuals not on the Board. Voting rights on special committees shall be specified by the Board of Directors at the time the committee is created. No committee so appointed shall have any power or authority to commit the Board of Directors or the District in any manner; however, the Board may direct the particular committee to act for and on its behalf, by special vote.

d) All committees shall keep minutes of each meeting and shall maintain their minutes at the District offices and shall submit reports to the Board as requested.

e) Aside from committees upon which the ~~President~~Chair is appointed as a voting member, the ~~President~~Chair of the Board shall be an ex officio member of each committee, without being a voting member. The ~~President~~Chair shall be notified of all committee meetings.

~~f) 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~~
~~2. Finance Committee~~
~~3. Governance Committee~~
~~4. Community Benefit Committee~~

Section 2. STANDING COMMITTTEES

Governance Committee: Members of this standing 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. The function of this Committee is to recommend amendments or changes to the District bylaws and Board policies. This Committee shall commence an on-going review of the Bylaws to ensure that the Bylaws are maintained current and consistent with the Board's and the District's functions and operations. This Committee shall also review the Board Policy Manual, at least every four years, and make recommendations to the Board on any additions or deletions of policies. The Committee shall also be responsible for development of a format for the evaluation of the Chief Executive Officer, and for the conduct of a periodic evaluation. This Committee shall also be responsible for developing a format and administering the Board of Directors' periodic self-evaluations. Such Board evaluation shall include an annual assessment of resolution of safety and quality issues and initiatives.

Section ~~2~~3. AD HOC ~~STANDING~~ COMMITTEES

As needed, and from time to time, the Board shall create the following ad hoc committees as follows:

a) Quality and Safety Committee: Two members of ~~T~~the Board shall comprise the ~~sit as a~~ Quality and Safety Committee ~~of the Whole on all quality and safety issues~~, being advised by the ~~President~~Chair, ~~and~~ Chief Executive Officer, the Medical Executive Committee, the Chief of Staff, and Medical Staff members from time to time. The ~~Board~~ Quality and Safety Committee shall:

(1) Analyze data regarding safety and quality of care, treatment and services and establish priorities for performance improvement.

(2) Oversee the Medical staff's fulfillment of its responsibilities in accordance with the Medical Staff Bylaws, applicable law and regulation, and accreditation standards.

(3) Ensure that recommendations from the Medical Executive Committee and Medical Staff are made in accordance with the standards and requirements of the Medical Staff Bylaws, Rules and Regulations with regard to:

- completed applications for initial staff appointment, initial staff category assignment, initial department/divisional affiliation, membership prerogatives and initial clinical privileges;
- completed applications for reappointment of medical staff, staff category, clinical privileges;
- establishment of categories of Allied Health Professionals permitted to practice at the hospital, the appointment and reappointment of Allied Health Professionals and privileges granted to Allied Health Professionals.

(4) Provide a system for resolving conflicts that could adversely affect safety or quality of care among individuals working within the hospital environment.

(5) Ensure that adequate resources are allocated for maintaining safety and quality care, treatment and services.

(6) Analyze findings and recommendations from the Hospital's administrative review and evaluation activities, including system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.

(7) Assess the effectiveness and results of the quality review, utilization review, performance improvement, and risk management programs.

(8) Perform such other duties concerning safety and quality of care matters as may be necessary.

b) Finance Committee: ~~The~~ Two members of the Board shall ~~sit as a~~comprise the Finance Committee~~ of the Whole on matters pertaining to the finances of the District and its oversight role pursuant to the JPA Agreement~~. The Finance Committee in consultation with the Chief Executive Officer ~~and upon the recommendation of the Authority~~ shall be responsible for reviewing~~, adopting,~~ and monitoring the annual budget and, as appropriate, its long term capital expenditure plan. The Finance Committee shall oversee retention of auditors and approve audits, and business plans pursuant to subsidiary organizations.

~~c) 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. The function of this Committee is to recommend amendments or changes to the District bylaws and Board policies. This Committee shall commence an on-going review of the Bylaws to ensure that the Bylaws are maintained current and consistent with the Board's and the District's functions and operations. This Committee shall also review the Board Policy Manual, at least every four years, and make recommendations to the Board on any additions or deletions of policies. The Committee shall also be responsible for~~

~~development of a format for the evaluation of the Chief Executive Officer, and for the conduct of a periodic evaluation. This Committee shall also be responsible for developing a format and administering the Board of Directors' periodic self-evaluations. Such Board evaluation shall include an annual assessment of resolution of safety and quality issues and initiatives.~~

~~d~~c) Community Benefit Committee: The members of this Committee shall be two members of the Board of Directors. The Committee shall be assisted, as needed, by the Chief Executive Officer and the Director of Community and Government Affairs, along with any other staff or representatives designated by the Committee. The two members of the Board of Directors shall be the only members of the Committee with voting privileges. This Committee shall have general responsibility for development and implementation of an achievable Community Benefit Initiative, including identification of a process by which the initiative can be pursued, achieved, and sustained. The Committee will assess and marshal resources available to the District to advance the Initiative in a manner responsive to community health needs, prioritized based on a balance of need and outcome attainability, and, where helpful, in partnership with District and community stakeholders.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE VII

CHIEF EXECUTIVE OFFICER

Section 1 GENERAL PROVISIONS

The Board of Directors shall have the authority to employ and discharge the Chief Executive Officer and shall specify the terms and conditions of the person's employment. The performance of the Chief Executive Officer will be evaluated on an annual basis by the Board of Directors based on performance criteria established from time to time by the Board of Directors.

The Chief Executive Officer shall be responsible for the overall management of the Hospital and District, and has the necessary and full authority to effect this responsibility subject to the Board's oversight, any policies and directives issued by the Board, and as called upon pursuant to the JPA Agreement. Chief Executive Officer is directly responsible to the Board of Directors and the Authority, for the management of the Hospital and all of its departments and activities.

Section 2. QUALIFICATIONS, DUTIES AND RESPONSIBILITIES

Qualifications, specific duties and responsibilities of the Chief Executive Officer shall be set forth in the appropriate section of the Policy Manual and any employment agreement with the Chief Executive Officer.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE VIII

MEDICAL ADMINISTRATION IN THE HOSPITAL

Section 1. ESTABLISHMENT OF A MEDICAL STAFF

There shall be a Medical Staff for the Hospital established in accordance with the requirements of the Local Healthcare District Law (H. & Safety Code 32000, *et.seq*.), whose membership shall be comprised of all physicians, dentists and podiatrists who are duly licensed and privileged to admit and care for patients in the Hospital. The Board of Directors shall appoint the Medical Staff, which shall be an integral part of the Hospital. The Medical Staff derives its authority from the Board of Directors and shall function in accordance with the Medical Staff Bylaws, Rules and Regulations and Policies that have been approved by the Medical Staff and by the Board.

The Medical Staff shall be represented before the Board of Directors by the Chief of Staff or his/her designee and shall be afforded full access to the Board through the Board's regular meetings and committees as described herein. The Medical Staff, through its officers, department chiefs, and committees, shall be responsible and accountable to the Board of Directors for the discharge of those duties and responsibilities set forth in the Medical Staff's Bylaws, Rules and Regulations, and Policies, and as delegated by the Board of Directors from time to time.

Section 2. BYLAWS, RULES AND REGULATIONS

The Medical Staff is responsible for the development, adoption, and periodic review of the Medical Staff Bylaws and Rules and Regulations, consistent with these District Bylaws, applicable laws, government regulation, and accreditation standards. The Medical Staff Bylaws, Rules and Regulations and all amendments thereto, shall become effective upon approval by the Medical Staff and the Board of Directors.

Section 3. BOARD ACTION ON MEMBERSHIP AND CLINICAL PRIVILEGES

(a) Medical Staff Responsibilities: The Medical Staff is responsible to the Board of Directors for the quality of care, treatment and services rendered to patients in the Hospital. The Board of Directors shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff membership status, clinical privileges, and corrective action, except as

provided in Section 3(d). The Medical Staff adopt and forward to the Board or committee of the Board specific written recommendations, with appropriate supporting documentation, that will allow the Board of Directors to take informed action. When the Board of Directors does not concur with a Medical Staff recommendation, the matter shall be processed in accordance with the Medical Staff Bylaws and applicable law before the Board renders a final decision. The Board of Directors shall act on recommendations of the Medical Staff within the period of time specified in the Medical Staff Bylaws or Rules and Regulations, or if no time is specified, then within a reasonable period of time. However, at all times the final authority for appointment to membership on the Medical Staff of the Hospital remains the sole responsibility and authority of the Board of Directors.

(b) Criteria for Board Action: The process and criteria for acting on matters affecting Medical Staff membership status and clinical privileges shall be as specified in the Medical Staff Bylaws.

(c) Terms and Conditions of Staff Membership and Clinical Privileges: The terms and conditions of membership status in the Medical Staff, and the scope and exercise of clinical privileges, shall be as specified in the Medical Staff bylaws unless otherwise specified in the notice of individual appointment following a determination in accordance with the Medical Staff Bylaws.

(d) Initiation of Corrective Action and Suspension: Where in the best interests of patient safety, quality of care, or the Hospital staff, and after consultation with the Chief of Staff, the Board of Directors shall have the authority to take any action that it deems appropriate with respect to any individual applying for or appointed to the Medical Staff or who is seeking or exercising clinical privileges or the right to practice in the Hospital. Action taken by the Board of Directors in such matters shall follow the procedures for corrective action outlined in the Medical Staff Bylaws, Rules and Regulations. The Board shall notify the Executive Committee immediately of any such action.

Chief Executive Officer may summarily suspend or restrict clinical privileges of any Medical Staff member where failure to take action may result in imminent danger to the health of any individual and when no person authorized to take such action by the Medical Staff is available, provided that the Chief Executive Officer has made reasonable documented attempts to contact the person or persons so authorized. A suspension by the Chief Executive Officer that has not been ratified by the Medical Executive Committee within two working days, excluding weekends and holidays, shall terminate automatically.

(e) Fair Hearing and Appellate Procedures: The Medical Staff Bylaws shall establish fair hearing and appellate review mechanisms in connection with Staff recommendations for the denial of Staff appointments, as well as denial of reappointments, or the curtailment suspension or revocation of privileges. The

hearing and appellate procedures employed by the Board of Directors upon referral of such matters shall be consistent with the Local Healthcare District Law at Section 32150 *et. seq*. of the Health & Safety Code, and those specified in the Medical Staff Bylaws, Rules and Regulations to the extent not inconsistent therewith. Any doctor or other practitioner who feels aggrieved by any adverse recommendation or deprivation of Medical Staff status or clinical privileges shall be required, as a condition to exercising his or her right of appeal to the Board, to pursue his or her appeal through orderly channels of appeal and at the proper time and in the manner prescribed by the Bylaws and procedures of the Medical Staff of this hospital. When the Medical Staff has made its final ruling and decision concerning the appeal of any aggrieved doctor or practitioner in accordance with the Bylaws of the Medical Staff, and such doctor or practitioner then desires to appeal to the Board, he or she shall give notice in writing to the Hospital Administrator within ten (10) days next following the date of the entry of the final order of the Medical Staff. Said notices must state in substance the grievance made and complained of, and must be given in the time and manner herein specified, or the Board shall not take cognizance thereof except at its discretion. If said notice is so given within said time, then it shall be the duty of the Board to then consider such grievance in its entirety and render the decision of the Board in writing, and deliver a copy of its decision and findings to the aggrieved doctor or practitioner. Such decision shall be final.

The Medical Staff shall have the right to be heard, through its Chief of Staff or designee at meetings of the Board.

Section 4. ACCOUNTABILITY TO THE BOARD

The Medical Staff shall conduct and be accountable to the Board for conducting activities that contribute to the preservation and improvement of quality patient care and safety in the Hospital.

Section 5. DOCUMENTATION

The Board shall receive and act upon the findings and recommendations emanating from the activities required by Section 4. All such findings and recommendations shall be in writing and supported and accompanied by appropriate documentation upon which the Board can take appropriate action.

Section 6. COMPENSATED MEDICAL DIRECTOR POSITIONS

Compensated Medical Director positions shall be responsible to the Chief Executive Officer and the Medical Staff for documentation of activities related to their assignment. Compensated Medical Directors shall be approved by the Chief Executive Officer and for fit and compensation amount. Medical Staff may appoint Service Directors, the slate of Service Directors must be approved by the Board of Directors.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE IX

AMENDMENT

These Bylaws may be amended by affirmative vote of a majority of the total number of members of the Board of Directors at any regular or special meeting of the Board of Directors, provided a full statement of such proposed amendment shall have been sent to each Board member not less than forty-eight (48) hours prior to the meeting.

Affirmative action may be taken to amend these Bylaws by unanimous vote of the entire Board membership at any regular or special meeting of the Board of Directors, in which event the provision for forty-eight (48) hours notice shall not apply.

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~~President~~Chair, Board of Directors
~~November 17~~ June 15, 202~~1~~2

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ADOPTED BY THE BOARD OF DIRECTORS

NORTHERN INYO HEALTHCARE DISTRICT

REVISED AND ADOPTED IN CONFORMANCE WITH DIVISION 23, SECTION 32000 ET SEQ. OF THE CALIFORNIA HEALTH AND SAFETY CODE ON JUNE 15, 2022

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

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NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE I

NAME, AUTHORITY AND OFFICES

Section 1. NAME

The name of this non-profit health care district organization shall be the Northern Inyo Healthcare District, hereinafter "the District".

Section 2. AUTHORITY

a) This District, having been established January 11, 1946, by vote of the residents of the District under the provisions of Division 23, Section 32000 et seq, of the Health and Safety Code of the State of California, otherwise known and referred to herein as "The Local Health Care District Law," and ever since said time having been operated thereunder, these bylaws are adopted in conformance therewith, and subject to the provisions thereof.

b) In the event of any conflict between these bylaws and "The Local Health Care District Law," the latter shall prevail. To the extent they are not in conflict with these bylaws, the proceedings of the District Board shall be guided by the most recent edition of Robert's Rules of Order.

Section 3. OFFICES

The principal office for the transaction of business of the District is hereby fixed within the boundaries of the District as determined by the Board of Directors.

Section 4. TITLE OF PROPERTY

The title to all property of the District shall be vested in the District, and the signature of the Chair and/or Secretary, or any officer designated by the Directors, as authorized at any meeting of the Directors, shall constitute the proper authority for the purchase or sale of property, or for the investment or other disposal of funds which are subject to the control of the District.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE II

PURPOSES AND SCOPE

Section 1. PURPOSES

The purposes of the Northern Inyo Healthcare District shall include, but not be limited to the following:

a) Within available resources, to provide facilities and health services for quality acute and continued care of the injured and ill, inducing health maintenance and education, regardless of sex, race, creed, cultural or national origin.

b) To coordinate, wherever possible and feasible, the activities of the District with health agencies and other health facilities providing specialized as well as comprehensive care.

c) To conduct educational and research activities essential to the attainment of its purposes.

d) To do any and all other acts necessary to carry out the provisions of the Health Care District Act.

Section 2. SCOPE OF BYLAWS

a) These bylaws shall govern the Northern Inyo Healthcare District, its Board of Directors and its relationship to affiliated or subordinate organizations. The primary purpose of these bylaws is to provide rules for the self-governance of the District and the Board of Directors, to provide a structure for the Board of Directors to fulfill its functions and responsibilities with respect to an organized self-governing Medical Staff, and to provide a structure for Administration of the licensed healthcare inpatient and outpatient facilities operated by the District (specifically Northern Inyo Hospital, 1206 D and 1206 B clinics).

b) The Board of Directors may delegate certain powers to the Authority of the Board's committees, the Medical Staff, and to other affiliated and subordinate organizations and groups governed by the District, such powers to be exercised in accordance with the respective bylaws or guidelines of such groups. All powers and functions not expressly delegated to such affiliated or subordinate organizations or groups are to be considered residual powers vested in the Board of Directors of this District.

c) The Bylaws, Rules and Regulations of the Medical Staff and other affiliated and subordinate organizations and groups governed by the District, and any amendments to such bylaws, shall not be effective until the same are approved by the Board of Directors of the Northern Inyo Healthcare District. The provisions of these District bylaws shall be construed to be consistent with the Medical Staff's bylaws. Except that these Bylaws shall not conflict with the bylaws of the Medical Staff as approved by the Board of Directors, the Board of Directors may review these Bylaws and revise them as it deems appropriate.

Section 3. NOT FOR PROFIT STATUS

There shall be no contemplation of profit or pecuniary gain, and no distribution of profits to any individual, under any guise whatsoever; nor shall there by any distribution of assets or surpluses to any individual on the dissolution of this District.

Section 4. DISPOSITION OF SURPLUS

Should the operation of the District result in a surplus of revenue over expenses during any particular period, such surplus may be used and dealt with by the Directors for charitable District purposes or for improvements hospital's facilities for the care of the sick, injured, or disabled, or for other purposes not inconsistent with the Local Health Care District Act, or these bylaws. The Board of Directors may authorize the disposition of any surplus property of the District by any method determined appropriate by the Board.

Section 5. INDEMNIFICATION

a) Any person made or threatened to be made a party to any action or proceeding, whether civil or criminal, administrative or investigative, by reason of the fact that he/she, his/her estate, or his/her personal representative is or was a Director, officer or employee of the District, or an individual (including a medical staff appointee) acting as an agent of the District, or serves or served any other corporation or other entity or organization in any capacity at the request of the District while acting as a Director, officer, employee or agent of the District shall be and hereby is indemnified by the District, as provided in Sections 825 *et.seq.* of the California Government Code.

b) Indemnification shall be against all judgments, fines, amounts paid in settlement and reasonable expenses, including attorney's fees actually and necessarily incurred, as a result of any such action or proceeding, or any appeal therein, to the fullest extent permitted and in the manner prescribed by the laws of the State of California, as they may be amended from time to time, or such other law or laws as may be applicable to the extent such other law or laws is not inconsistent with the law of California, including Sections 825 *et.seq.* of the California Government Code.

c) Nothing contained herein shall be construed as providing indemnification to any person in any malpractice action or proceeding arising out of or in any way connected with such person's practice of his or her profession.

Section 6. FISCAL YEAR

The fiscal year of the District shall commence on the first day of July and each year shall end on the last day of June of each year.

Section 6 Annual Audit removed see section see VI Section, 2, b.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE III

BOARD OF DIRECTORS

Section 1. ELECTION

The Board of Directors shall be elected as provided in "The Local Healthcare District Law," which shall also govern eligibility for election to the Board of Directors.

Section 2. POWERS

The Board of Directors shall have and exercise all the powers of a Healthcare District as set forth in the Healthcare District Act. Specifically, the Board of Directors shall be empowered as follows:

a) To control and be responsible for the overall governance of the District, including the provision of management and planning.

b) To make and enforce all rules and regulations necessary for the administration, government, protection and maintenance of hospitals and other facilities under District jurisdiction and to ensure compliance with all applicable laws.

c) To appoint a Chief Executive Officer and to define the powers and duties of such appointee, and to delegate to such person overall responsibility for operations of the District, the Hospital, and affiliated entities as specified herein and consistent with Board of Directors' Policies. The Board shall also retain legal counsel and independent auditors as needed for District and Hospital operations.

d) To authorize the formation of other affiliated or subordinate organizations which they may deem necessary to carry out the purposes of the District.

e) To periodically review and develop a strategic plan for the District and the Hospital.

f) To determine policies and approve procedures for the overall operation and affairs of this District and its facilities according to the best interests of the public health and to assure the maintenance of quality patient care.

g) To enter into Joint Powers Agreements with other public entities, and to carry out the District's responsibilities in regard to such Joint Powers Authority as prescribed by law.

h) To evaluate the performance of the Hospital in relation to its vision, mission and goals.

i) To provide for coordination and integration among the Hospital's leaders to establish policy, maintain quality care and patient safety, and provide for necessary resources.

j) To be ultimately accountable for the safety and quality of care, treatment and services.

k) All powers of the Board of Directors, which are not restricted by statute, may be delegated by an employment agreement, policies, and by direction of the Board to the Chief Executive Officer or to others employed by or with responsibilities to the District, to be exercised in accordance with that delegation.

l) In the event of a vacancy in any Board office established by Article V of these Bylaws (Chair, Vice Chair, etc.), the Board of Directors shall select someone to fill such vacancy and to serve until the next regular election of officers, unless such person earlier resigns or is removed in accordance with said Article.

m) To do any and all other act and things necessary to carry out the provisions of these bylaws or of the provisions of the Local Healthcare District Law.

Section 3. COMPENSATION

The Board of Directors shall serve without compensation except that the Board of Directors, by a majority vote of the members of the Board, may authorize payment not to exceed one hundred dollars ($100) per meeting, or for each committee meeting or other meeting authorized by Board or Chair of the Board, and not to exceed five (5) meetings a month as compensation to each member of the Board of Directors, in accordance with Section 32103 of the California Health and Safety Code, as amended.

Each member of the Board of Directors shall be allowed his/her necessary traveling and incidental expenses incurred in the performance of official business of the District pursuant to the Board's policy.

A budget for the Board of Directors educational expenses is developed each year. At least annually, the entire Board will review their travel and incidental expenses.

Section 4. VACANCIES

Any vacancy upon the Board of Directors shall be filled by the methods prescribed in Section 1780 of the Government Code.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE IV

MEETINGS OF DIRECTORS

Section 1. REGULAR MEETINGS

The regular meetings of the Board of Directors of the Northern Inyo Healthcare District shall be held monthly, or as periodically determined by the Board, on such day and at such time as the Board of Directors shall from time-to-time establish by resolution and/or motion.

Section 2. SPECIAL MEETINGS

Special meetings of the Board of Directors may be called by the Chair or three (3) Directors, and notice of the holding thereof shall be received by each member of the Board of Directors at least twenty-four hours (24) before said meeting.

Section 3. QUORUM

A majority of the members of the Board of Directors shall constitute a quorum for the transaction of business, and motions and resolutions shall be passed if affirmatively voted upon by a majority of those voting at the time the vote is taken. If a member has a conflict of interest and may not vote they may not be counted towards a quorum.

Section 4. ADJOURNMENT

A quorum of the Board of Directors may adjourn any Directors' meeting to meet again at a stated day and hour; provided, however, that in the absence of a quorum, a majority of the Directors present at any Directors' meeting, either regular or special, may adjourn until the time fixed for the next regular meeting of the Board of Directors. An adjourned meeting can consider only the business of the meeting which was adjourned. An adjourned meeting must be completed prior to the convening of a new meeting.

Section 5. PUBLIC MEETINGS

All meetings of the Board of Directors whether regular, special or adjourned, shall be open to the public in accordance with Government Code Sections 54950 through 54961, commonly known as the Ralph M. Brown Act provided, however, that the foregoing shall not be construed to prevent the Board of Directors from holding executive sessions to consider the appointment,

employment, promotion, demotion or dismissal of an employee or public officer, as the term is defined by law, or to hear complaints or charges brought against such officer or employee, to discuss labor negotiations, or to consult with legal counsel concerning litigation to which the District is a party, and prospective and probably litigation, as provided in Sections 54956.7 through 54957 of the Government Code. In addition, closed sessions may be held to discuss trade secrets as defined in Government Code Section 54956.7, and provided in Section 32106 of the Health and Safety Code. To the extent not in violation with the Ralph M. Brown Act or the California Public Records Act, and California Health and Safety Code Section 32155, any information and reports protected from discovery by California Evidence Code Section 1157 that are provided to the Board of Directors by the Medical Staff shall be presented and discussed in closed sessions, maintained as confidential and not released except as required by applicable laws.

Section 6. MINUTES

A book of minutes of all public meetings of the Board of Directors shall be kept at the principal office of the District and shall be open for public inspection upon request.

Section 7. SCOPE OF MOTIONS AND RESOLUTIONS

The decisions of the Board establishing general rules or procedures of the District and/or procedures affecting the Directors shall be by motion or resolution. All motions or resolutions become effective at the time voted upon affirmatively by a majority of the Directors voting at the time the vote is taken.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE V

OFFICERS AND THEIR DUTIES

Section 1. OFFICERS

The officers of the Board of Directors of the Northern Inyo Healthcare District shall be a Chair, Vice Chair and a Secretary, a Treasurer, and “Member at Large”.

Section 2. ELECTION OF OFFICERS

a) The officers of the Board of Directors shall be chosen every year by the Board of Directors at the December meeting of every calendar year; and each officer shall hold office for one year, or until a successor shall be elected and qualified, or until the officer is otherwise disqualified to serve.

b) If an officer of the Board, other than the Chair, is unable to act, the Board may appoint some other member of the Board of Directors to do so, and such person shall be vested temporarily with all the functions and duties of the office.

c) Any officer on the Board of Directors may resign at any time or be removed as a Board officer by the majority vote of the other Directors then in office at any regular or special meeting of the Board of Directors. In the event of a resignation or removal of an officer, the Board of Directors shall elect a successor to serve for the balance of that officer's unexpired term.

Section 3. DUTIES

a) Chair: The Board of Directors shall elect one of their members to act as Chair. If at any time the Chair shall be unable to act, the Vice Chair shall assume office and perform the duties of the office. If the Vice Chair shall also be unable to act, then the Secretary/Treasurer shall assume the office and shall immediately conduct a Board election to appoint a Chair, and such person shall be vested temporarily with all the functions and duties of the Chair.

The Chair, or member of the Board of Directors acting as such, as above provided:

(1) Shall preside over all meetings of the Board of Directors, and shall review all requested agenda items submitted to the Chair and the Chair & Chief Executive Officer pursuant to the Board's written policies;

(2) Shall sign as Chair on behalf of the District all instruments in writing that the Chair has been specifically authorized by the Board to sign;

(3) Shall act as the main liaison between the Board and management for communications and oversight purposes. It is expected that the Chair will discuss District business with the Chief Executive Officer and Vice Chair on a regular basis;

(4) Shall appoint or remove members of committees subject to approval by the Board of Directors.

(5) Shall have, subject to the advice and control of the Board of Directors, general responsibility for the affairs of the District and generally shall discharge all other duties which shall be required of the Chair by the Bylaws of the District.

b) Vice Chair: The Vice Chair shall, in the event of death, absence, or other inability of the Chair, exercise all the powers and perform all the duties herein given to the Chair. It is expected that the Vice Chair will participate in regular discussions with the Chair and Chief Executive Officer regarding District business.

c) Secretary:

(1) The member of the Board who is elected to the position of Secretary shall act in this capacity for both the District and the Board of Directors;

(2) Shall be responsible for seeing that records of all actions, proceedings and minutes of meetings of the Board of Directors are properly kept and are maintained at the District offices;

(3) Shall serve, or cause to be served, all notices required either by law or these bylaws, and in the event of absence, inability, refusal or neglect to do so, such notices may be served by any person thereunto directed by the Chair of the Board of Directors of this District;

(4) Shall be responsible for seeing that the seal of this District is in safekeeping at the District and shall use it under the direction of the Board of Directors;

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(5) Shall perform such other duties as pertains to the office and as are prescribed by the Board of Directors. The Secretary may delegate his or her duties to appropriate

management personnel.

d) Member at Large: The Member at Large shall have all the powers and duties of the Secretary in the absence of the Secretary, and shall perform such other duties as may from time to time be prescribed by the Board of Directors.

e) Treasurer:

(1) Shall have the responsibility for the safekeeping and disbursal of funds in the treasury of the District in accordance with the provisions of the "Local Healthcare District Law" and in accordance with resolutions, procedures and directions as the Board of Directors may adopt;

(2) Shall receive monthly reports from management with respect to the financial condition of the District and shall present such reports to the Board of Directors as directed by the Board of Directors;

(3) Shall perform such other duties as they pertain to this office and as prescribed by the Board of Directors. The Treasurer may delegate his or her duties to appropriate management personnel.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE VI

COMMITTEES

Section 1. COMMITTEES

a) 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.

b) The duties of these committees shall be to develop and make policy recommendations to the Board and to perform such other functions as shall be stated in these bylaws or in the resolution or motion creating the committee. Each Standing Committee will include two Board members, one of whom shall act as Chair of the Standing Committee. The Chair and Board members of each Standing Committee shall be appointed by the Chair of the Board and approved by the Board at the earliest possible time at the beginning of each calendar year and shall serve for one year, or until a successor has been appointed and approved. Other members of each standing committee are automatically members with one year terms, or until a successor has been appointed and approved. The two Board members shall be the only voting members of each Standing Committee, unless otherwise provided for in these Bylaws.

c) Special or ad hoc committees may be appointed by the Chair with the approval of the Board of Directors for such specific tasks as circumstances warrant. Special committees may consist only of Board members, or they may include individuals not on the Board. Voting rights on special committees shall be specified by the Board of Directors at the time the committee is created. No committee so appointed shall have any power or authority to commit the Board of Directors or the District in any manner; however, the Board may direct the particular committee to act for and on its behalf, by special vote.

d) All committees shall keep minutes of each meeting and shall maintain their minutes at the District offices and shall submit reports to the Board as requested.

e) Aside from committees upon which the Chair is appointed as a voting member, the Chair of the Board shall be an ex officio member of each committee, without being a voting member. The Chair shall be notified of all committee meetings.

Section 2. STANDING COMMITTTEES

Governance Committee: Members of this standing 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. The function of this Committee is to recommend amendments or changes to the District bylaws and Board policies. This Committee shall commence an on-going review of the Bylaws to ensure that the Bylaws are maintained current and consistent with the Board's and the District's functions and operations. This Committee shall also review the Board Policy Manual, at least every four years, and make recommendations to the Board on any additions or deletions of policies. The Committee shall also be responsible for development of a format for the evaluation of the Chief Executive Officer, and for the conduct of a periodic evaluation. This Committee shall also be responsible for developing a format and administering the Board of Directors' periodic self-evaluations. Such Board evaluation shall include an annual assessment of resolution of safety and quality issues and initiatives.

Section 3. AD HOC COMMITTEES

As needed, and from time to time, the Board shall create the following ad hoc committees as follows:

a) Quality and Safety Committee: Two members of the Board shall comprise the Quality and Safety Committee, being advised by the , Chief Executive Officer, the Medical Executive Committee, the Chief of Staff, and Medical Staff members from time to time. The Quality and Safety Committee shall:

(1) Analyze data regarding safety and quality of care, treatment and services and establish priorities for performance improvement.

(2) Oversee the Medical staff's fulfillment of its responsibilities in accordance with the Medical Staff Bylaws, applicable law and regulation, and accreditation standards.

(3) Ensure that recommendations from the Medical Executive Committee and Medical Staff are made in accordance with the standards and requirements of the Medical Staff Bylaws, Rules and Regulations with regard to:

- completed applications for initial staff appointment, initial staff category assignment, initial department/divisional affiliation, membership prerogatives and initial clinical privileges;
- completed applications for reappointment of medical staff, staff category, clinical privileges;
- establishment of categories of Allied Health Professionals permitted to practice at the hospital, the appointment and reappointment of Allied Health Professionals and privileges granted to Allied Health Professionals.

(4) Provide a system for resolving conflicts that could adversely affect safety or quality of care among individuals working within the hospital environment.

(5) Ensure that adequate resources are allocated for maintaining safety and quality care, treatment and services.

(6) Analyze findings and recommendations from the Hospital's administrative review and evaluation activities, including system or process failures and actions taken to improve safety, both proactively and in response to actual occurrences.

(7) Assess the effectiveness and results of the quality review, utilization review, performance improvement, and risk management programs.

(8) Perform such other duties concerning safety and quality of care matters as may be necessary.

b) <u>Finance Committee</u>: Two members of the Board shall comprise the Finance Committee. The Finance Committee in consultation with the Chief Executive Officer shall be responsible for reviewing and monitoring the annual budget and, as appropriate, its long term capital expenditure plan. The Finance Committee shall oversee retention of auditors and approve audits, and business plans pursuant to subsidiary organizations.

c) <u>Community Benefit Committee</u>: The members of this Committee shall be two members of the Board of Directors. The Committee shall be assisted, as needed, by the Chief Executive Officer and the Director of Community and Government Affairs, along with any other staff or representatives designated by the Committee. The two members of the Board of Directors shall be the only members of the Committee with voting privileges. This Committee shall have general responsibility for development and implementation of an achievable Community Benefit Initiative, including identification of a process by which the initiative can be pursued, achieved, and sustained. The Committee will assess and marshal resources available to the District to advance the Initiative in a manner responsive to community health needs, prioritized based on a balance of need and outcome attainability, and, where helpful, in partnership with District and community stakeholders.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE VII

CHIEF EXECUTIVE OFFICER

Section 1 GENERAL PROVISIONS

The Board of Directors shall have the authority to employ and discharge the Chief Executive Officer and shall specify the terms and conditions of the person's employment. The performance of the Chief Executive Officer will be evaluated on an annual basis by the Board of Directors based on performance criteria established from time to time by the Board of Directors.

The Chief Executive Officer shall be responsible for the overall management of the Hospital and District, and has the necessary and full authority to effect this responsibility subject to the Board's oversight, any policies and directives issued by the Board, and as called upon pursuant to the JPA Agreement. Chief Executive Officer is directly responsible to the Board of Directors and the Authority, for the management of the Hospital and all of its departments and activities.

Section 2. QUALIFICATIONS, DUTIES AND RESPONSIBILITIES

Qualifications, specific duties and responsibilities of the Chief Executive Officer shall be set forth in the appropriate section of the Policy Manual and any employment agreement with the Chief Executive Officer.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE VIII

MEDICAL ADMINISTRATION IN THE HOSPITAL

Section 1. ESTABLISHMENT OF A MEDICAL STAFF

There shall be a Medical Staff for the Hospital established in accordance with the requirements of the Local Healthcare District Law (H. & Safety Code 32000, *et.seq*.), whose membership shall be comprised of all physicians, dentists and podiatrists who are duly licensed and privileged to admit and care for patients in the Hospital. The Board of Directors shall appoint the Medical Staff, which shall be an integral part of the Hospital. The Medical Staff derives its authority from the Board of Directors and shall function in accordance with the Medical Staff Bylaws, Rules and Regulations and Policies that have been approved by the Medical Staff and by the Board.

The Medical Staff shall be represented before the Board of Directors by the Chief of Staff or his/her designee and shall be afforded full access to the Board through the Board's regular meetings and committees as described herein. The Medical Staff, through its officers, department chiefs, and committees, shall be responsible and accountable to the Board of Directors for the discharge of those duties and responsibilities set forth in the Medical Staff's Bylaws, Rules and Regulations, and Policies, and as delegated by the Board of Directors from time to time.

Section 2. BYLAWS, RULES AND REGULATIONS

The Medical Staff is responsible for the development, adoption, and periodic review of the Medical Staff Bylaws and Rules and Regulations, consistent with these District Bylaws, applicable laws, government regulation, and accreditation standards. The Medical Staff Bylaws, Rules and Regulations and all amendments thereto, shall become effective upon approval by the Medical Staff and the Board of Directors.

Section 3. BOARD ACTION ON MEMBERSHIP AND CLINICAL PRIVILEGES

(a) Medical Staff Responsibilities: The Medical Staff is responsible to the Board of Directors for the quality of care, treatment and services rendered to patients in the Hospital. The Board of Directors shall delegate to the Medical Staff the responsibility and authority to investigate and evaluate all matters relating to Medical Staff membership status, clinical privileges, and corrective action, except as

provided in Section 3(d). The Medical Staff adopt and forward to the Board or committee of the Board specific written recommendations, with appropriate supporting documentation, that will allow the Board of Directors to take informed action. When the Board of Directors does not concur with a Medical Staff recommendation, the matter shall be processed in accordance with the Medical Staff Bylaws and applicable law before the Board renders a final decision. The Board of Directors shall act on recommendations of the Medical Staff within the period of time specified in the Medical Staff Bylaws or Rules and Regulations, or if no time is specified, then within a reasonable period of time. However, at all times the final authority for appointment to membership on the Medical Staff of the Hospital remains the sole responsibility and authority of the Board of Directors.

(b) Criteria for Board Action: The process and criteria for acting on matters affecting Medical Staff membership status and clinical privileges shall be as specified in the Medical Staff Bylaws.

(c) Terms and Conditions of Staff Membership and Clinical Privileges: The terms and conditions of membership status in the Medical Staff, and the scope and exercise of clinical privileges, shall be as specified in the Medical Staff bylaws unless otherwise specified in the notice of individual appointment following a determination in accordance with the Medical Staff Bylaws.

(d) Initiation of Corrective Action and Suspension: Where in the best interests of patient safety, quality of care, or the Hospital staff, and after consultation with the Chief of Staff, the Board of Directors shall have the authority to take any action that it deems appropriate with respect to any individual applying for or appointed to the Medical Staff or who is seeking or exercising clinical privileges or the right to practice in the Hospital. Action taken by the Board of Directors in such matters shall follow the procedures for corrective action outlined in the Medical Staff Bylaws, Rules and Regulations. The Board shall notify the Executive Committee immediately of any such action.

Chief Executive Officer may summarily suspend or restrict clinical privileges of any Medical Staff member where failure to take action may result in imminent danger to the health of any individual and when no person authorized to take such action by the Medical Staff is available, provided that the Chief Executive Officer has made reasonable documented attempts to contact the person or persons so authorized. A suspension by the Chief Executive Officer that has not been ratified by the Medical Executive Committee within two working days, excluding weekends and holidays, shall terminate automatically.

(e) Fair Hearing and Appellate Procedures: The Medical Staff Bylaws shall establish fair hearing and appellate review mechanisms in connection with Staff recommendations for the denial of Staff appointments, as well as denial of reappointments, or the curtailment suspension or revocation of privileges. The

hearing and appellate procedures employed by the Board of Directors upon referral of such matters shall be consistent with the Local Healthcare District Law at Section 32150 *et. seq*. of the Health & Safety Code, and those specified in the Medical Staff Bylaws, Rules and Regulations to the extent not inconsistent therewith. Any doctor or other practitioner who feels aggrieved by any adverse recommendation or deprivation of Medical Staff status or clinical privileges shall be required, as a condition to exercising his or her right of appeal to the Board, to pursue his or her appeal through orderly channels of appeal and at the proper time and in the manner prescribed by the Bylaws and procedures of the Medical Staff of this hospital. When the Medical Staff has made its final ruling and decision concerning the appeal of any aggrieved doctor or practitioner in accordance with the Bylaws of the Medical Staff, and such doctor or practitioner then desires to appeal to the Board, he or she shall give notice in writing to the Hospital Administrator within ten (10) days next following the date of the entry of the final order of the Medical Staff. Said notices must state in substance the grievance made and complained of, and must be given in the time and manner herein specified, or the Board shall not take cognizance thereof except at its discretion. If said notice is so given within said time, then it shall be the duty of the Board to then consider such grievance in its entirety and render the decision of the Board in writing, and deliver a copy of its decision and findings to the aggrieved doctor or practitioner. Such decision shall be final.

The Medical Staff shall have the right to be heard, through its Chief of Staff or designee at meetings of the Board.

Section 4. ACCOUNTABILITY TO THE BOARD

The Medical Staff shall conduct and be accountable to the Board for conducting activities that contribute to the preservation and improvement of quality patient care and safety in the Hospital.

Section 5. DOCUMENTATION

The Board shall receive and act upon the findings and recommendations emanating from the activities required by Section 4. All such findings and recommendations shall be in writing and supported and accompanied by appropriate documentation upon which the Board can take appropriate action.

Section 6. COMPENSATED MEDICAL DIRECTOR POSITIONS

Compensated Medical Director positions shall be responsible to the Chief Executive Officer and the Medical Staff for documentation of activities related to their assignment. Compensated Medical Directors shall be approved by the Chief Executive Officer and for fit and compensation amount. Medical Staff may appoint Service Directors, the slate of Service Directors must be approved by the Board of Directors.

NORTHERN INYO HEALTHCARE DISTRICT

BYLAWS

ARTICLE IX

AMENDMENT

These Bylaws may be amended by affirmative vote of a majority of the total number of members of the Board of Directors at any regular or special meeting of the Board of Directors, provided a full statement of such proposed amendment shall have been sent to each Board member not less than forty-eight (48) hours prior to the meeting.

Affirmative action may be taken to amend these Bylaws by unanimous vote of the entire Board membership at any regular or special meeting of the Board of Directors, in which event the provision for forty-eight (48) hours notice shall not apply.

____

Chair, Board of Directors
June 15, 2022

DRAFT

Charter

Governance Committee
Northern Inyo Healthcare District

Purpose:
The purpose of this document is to:

1. Focus intentionally, and in a meaningful manner, on the importance of this Northern Inyo Healthcare District (NIHD) Board holding itself accountable to the public and to the District through informed and thoughtful decision making.
2. And in doing so, will align the charter in the Governance Committee (the "Committee") of the NIHD Board of Directors, and further, to delineate the Committee's duties and responsibilities.

Responsibilities:
The Governance Committee of the Board shall function as a standing committee of the Board responsible for addressing governance-related issues. The Committee shall develop, maintain, and recommend the necessary governance-related policies and procedures to the Board which determines the District's governance practices.

Duties:

1. Conduct an annual review of the Bylaws and Board and submit recommendations to the Board of Directors as necessary.
2. Ensure Board policies are reviewed by their respective committees as required.
3. Submit recommendations to the Board of Directors for changes to Bylaws and Board policies as necessary.
4. Develop new Board policies and procedures as necessary or as directed by the Board of Directors.
5. Advance best practices in Board governance including formal Board election and Board orientation plans
6. Ensure an annual Board self-assessment is conducted.
7. Ensure an annual Board goal-setting, education and retreat discussion and planning process is conducted.
8. Ensure an annual discussion, review and/or evaluation of Board legal services is conducted.

Composition:

The Committee shall be comprised of two (2) Board members. The Board Chair shall serve as Chairperson of the Committee, and the second Committee member shall be appointed by the Board Chair.

Meeting Frequency:

The Committee shall meet as needed.