May 18 2022 Regular Board Meeting

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Consent Agenda

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

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

May 18, 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 Years of Service, Hospital Week & Nurse Week Celebration *(Board will receive this presentation)*

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

C. Northern Inyo Healthcare District Governance Committee Update *(Board will receive this update)*

D. Approval of the District Board Resolution 22-07, Amending the Northern Inyo Healthcare District Bylaws to create current Standing Committee Ad Hoc Committees with only the Governance Committee as a Standing Committee or, alternatively, Approval of the District Board Resolution 22-08, Amending the Northern Inyo Healthcare District Bylaws to create all current Standing Committees Ad Hoc Committees.(*Board will consider the adoption of these District Board Resolutions*)

E. Northern Inyo Healthcare District CEO Absence from the July 20, 2022 Board of Directors Meeting *(Board will consider change of date for the July Regular Board Meeting or substitution of lead Executive role during this meeting)*

F. District Board Resolution 22-09, Consolidation of Election *(Board will consider the adoption of this District Board Resolution*)

4. Chief of Staff Report, Sierra Bourne MD:

A. Medical Staff Appointments (*Board will consider the approval of these Medial Staff Appointments)*

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

B. Changes in Medical Staff Category (*Board will consider the approval of these changes in Medical Staff Category)*

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

C. Medical Staff Privilege Form (*Board will consider the approval of these Medical Staff and Privilege form)*

1. Cardiovascular Disease

D. Medical Staff Resignations *(Board will consider the approval of these 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

E. Policies *(Board will consider the approval of these 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*

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

Consent Agenda

5. Approval of District Board Resolution 22-10, 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 20, 2022 Regular Board Meeting *(Board will consider the approval of these minutes)*
7. Approval of minutes of the April 26, 2022 Special Board Meeting (*Board will consider the approval of these minutes)*
8. Chief Executive Officer Report (*Board will consider accepting this report)*
9. Chief Medical Officer Report (*Board will consider accepting this report)*
10. Chief Nursing Officer Report (*Board will consider accepting this report)*
11. Financial and Statistical reports as of March 31, 2022 (*Board will consider accepting this report)*
12. Approval of Policies and Procedures *(Board will consider the approval of these Policies and Procedures)*
    A. Password Policy
    B. ITS Service Desk Work Order
    C. Licensure of Nursing Personnel

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

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.

16. Return to open session and report on any actions taken in closed session.
17. Adjournment

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

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

Date: 5/5/2022

Title: **2022 Years of Service Recipients**

Synopsis: During the week of May 6th through the 14th, NIHD celebrated Nurses Week and Hospital Week. On May 9th and May 13th, NIHD honored employees for their years of service with the District. Those being recognized had hit a 5 year milestone over the past 3 three years. This was catch up for those who hit that mark in 2019, 2020, and 2021, due to the COVID-19 pandemic. These honorees received a gold plated pin with some semi-precious stones in them based on their service term. They also received 8 hours of PTO if they were full time, 6.4 hours if part time, and $100 if per diem. Congratulations to the recipients below!!

Prepared by: Greg Bissonette, Foundation ED

Approved by: Kelli Davis, CEO

2022 HOSPITAL WEEK CELBRATIONS

5 Year Award

Yesenia	Arellano	Medical Records
Tammy	Arzola	Rural Health Clinic
Jason	Babb	Information Technology
Jenny	Bates	Emergency Department
Luis	Becerra	Kitchen
Greg	Bissonette	Foundation Executive Director
Silvia	Borow	Medsurg
Jessica	Buccowich	Emergency Department
Brooklyn	Burley	Medsurg
Cesar	Cardelas Acosta	Kitchen
Jennifer	Colbert	Accounting
Shira	Crook	Rural Health Clinic
Lorelei	Dennis	Physical Therapy
Jasmine	Duff	Pharmacy
Elizabeth	Esparza	Rural Health Clinic
Kelly	Faldowski	Ortho Clinic
Melanie	Fox	Utilization Review
Rosemarie	Graves	Op Procedure
Donna	Hardy	Rhc Ob Gyn Specialty Service
Bryan	Harper	Information Technology
Kathryn	Hayes	Op Registration
Natalie	Henderson	Labchemistry
Tyler	Honeyman	Physical Therapy
Lindsey	Hughes	Emergency Department
Monica	Jones	Occupational Therapy
Rita	Klabacha	Rural Health Clinic
Nancy	Landaverde	Labchemistry
Barbara	Laughon	Marketing
Margo	Lella	Pacu
Dean	Lewis	Information Technology
Anthony	Lewis	Plant Maintenance
Oscar	Lopez Esparza	Rural Health Clinic
Colleen	McEvoy	Pediatric Office
Sierra	Merchant	Environmental Serv
Steven	Messmore	Physical Therapy
Tara	Misiewicz	Medsurg

Rocio	Morales Garcia	Environmental Serv
Alison	Murray	Hr And Education
James	Nichols	Purchasing
Jessica	Nott	Pediatric Office
Justin	Nott	Medsurg
Brandy	Park	Pediatric Office
Kimberly	Parkinson	Nursing Supervisors
Dianne	Picken	Med Staff Admin
Cathy	Poquette	Mammography
Jotendra	Ranabhat	Occupational Therapy
Kaylyn	Rickford	Rural Health Clinic
Marjorie	Routt	Staff Development
Crystal	Salveson	Accounting
Gardiel	Santana	Central Supply
Martha	Santana	Environmental Serv
Mary	Snyder	Labchemistry
Sandra	Sommer	Labchemistry
Scott	Stoner	Information Technology
Jacinda	Thomsen	Emergency Department
Julie	Tillemans	Alternative Birthing Center
Davidson	Tracy	Central Supply
Terrence	Tye	Echo
Laura	Valadez Cortes	Labchemistry
Conor	Vaughan	Compliance
Paige	Wagoner	Compliance
Adam	Wills	Respiratory Care
Lisa	Wray	Rural Health Clinic
Brooke	Yarnell	Alternative Birthing Center

10 Year Award

Austin	Archer	Respiratory Care
Ellen	Bartlett	Rural Health Clinic
Thomas	Cunha Jr	Environmental Serv
Shawn	Delehanty	Op Registration
Tanya	Deleo	Ip Admitting
Rafael	Haro	Nursing Supervisors
Evan	Higginbotham	Cat Scan
Mykala	Howard	Ekg
Cameron	Hubbard-Shinto	Environmental Serv
Isabel	Landaverde	Nih Specialty Clinic

Jannalyn	Lawrence	Rural Health Clinic
Evamarie	Mathieu	Op Registration
Elizabeth	McCown	Ortho Clinic
Ryan	McVeitty	Purchasing
Morgan	Nutting	Respiratory Care
Brent	Obinger	Medsurg
Alison	Patterson	Icu
Leslie	Perez	Radiology
Maria	Santana	Pediatric Office
Hallie	Vickers	Rural Health Clinic
Heleen	Welvaart	Rural Health Clinic
Shawn	Williams	Labchemistry

15 Year Award

Kristine	Alcala	Radiology
Anneke	Bishop	Alternative Birthing Center
Samantha	Bumgarner	Emergency Department
Cheryl	Carter	Surgery
Diana	Church	Rural Health Clinic
Marnie	Davis	Op Registration
Ronald	Daywalt	Pacu
Wendy	Derr	Emergency Department
Patricia	Dickson	Compliance
Fabiola	Esparza	Business Office
Lori	Forehand	Medsurg
Katie	Galvin	Radiology
Jessica	Hepburn	Labchemistry
David	Kim	Ultrasound
Neil	Lynch	Purchasing
Sarah	Malloy	Rural Health Clinic
Veronica	Mewborn	Respiratory Care
Shauna	Murray	Op Procedure
Robert	Ralston	Plant Maintenance
Amanda	Rhodes	Central Supply
Michelle	Scott	Medsurg
Joan	Walker	Pharmacy

20 Year Award

Francine	Berube	Medsurg
Andrea	Daniels	Environmental Serv
Cynthia	Dayhuff	Medsurg
Marion	Heslinger	Medsurg
Scott	Hooker	Proj-Prop Mngmt
Julie	Laliberte	Pathology
Reuben	Morgenstein	Hr And Education
Jennifer	Norris	Rhc Ob Gyn Specialty Service
Amy	Stange	Respiratory Care
Mara	Yolken	Rural Health Clinic

25 Year Award

Melanie	Hagopian	Labchemistry
Jeanette	Smith	Information Technology

30 Year Award

Jalaine	Beems	Medical Records
Robin	Christensen	Infection Control
Nita	Eddy	Surgery
Cindy	Henderson	Plant Maintenance
Toni	Rhodes	Surgery

35 Year Award

Christina	Cauldwell	Surgery

40 Year Award

Kimberly	Robison	Pathology

Community Health Needs Assessment

Marketing Team ▪ May 3, 2022

NORTHERN INYO HEALTHCARE DISTRICT
150 PIONEER LANE, BISHOP CA 93514 | (760) 873-5811 | NIH.ORG

NEWS RELEASE | May 3, 2022
Contact: Barbara Laughon, NIH Strategic Communications
(760) 873-5811 ext. 3415 | Barbara.Laughon@NIH.org

NIHD launches Community Health Needs Assessment

Tell us what you think are the most important health issues in our community

What are the most pressing health needs in our community? Let Northern Inyo Healthcare District know by taking its Community Health Needs Assessment (CHNA) survey. The survey will run from May 2 to June 3.

The 10-minute anonymous survey asks questions about what you think are the most important health issues in our community and what matters to you most. Please follow the link or the QR code shown below to complete the survey.

- Directly to the survey website: https://www.surveymonkey.com/r/NIHD2022CHNACommunitySurvey
- Or use this QR Code:

The survey is available in English and Spanish. Paper versions of the survey are available at all admission desks within NIHD.

The CHNA survey results will assist with the development of NIHD's community benefits plan, involving many community partners, to improve the health of our community. The survey is also important because its results can affect funding, spending, and other wide-reaching decisions about health care.

Improving our communities, one life at a time. One goal. One team. Your health.

- The Inyo Register
- KIBS/KBOV Radio
- Sierra Wave Media (KSRW-FM)
- Eastern Sierra NOW
- The Sierra Reader
- El Sol de la Sierra
- The Sheet

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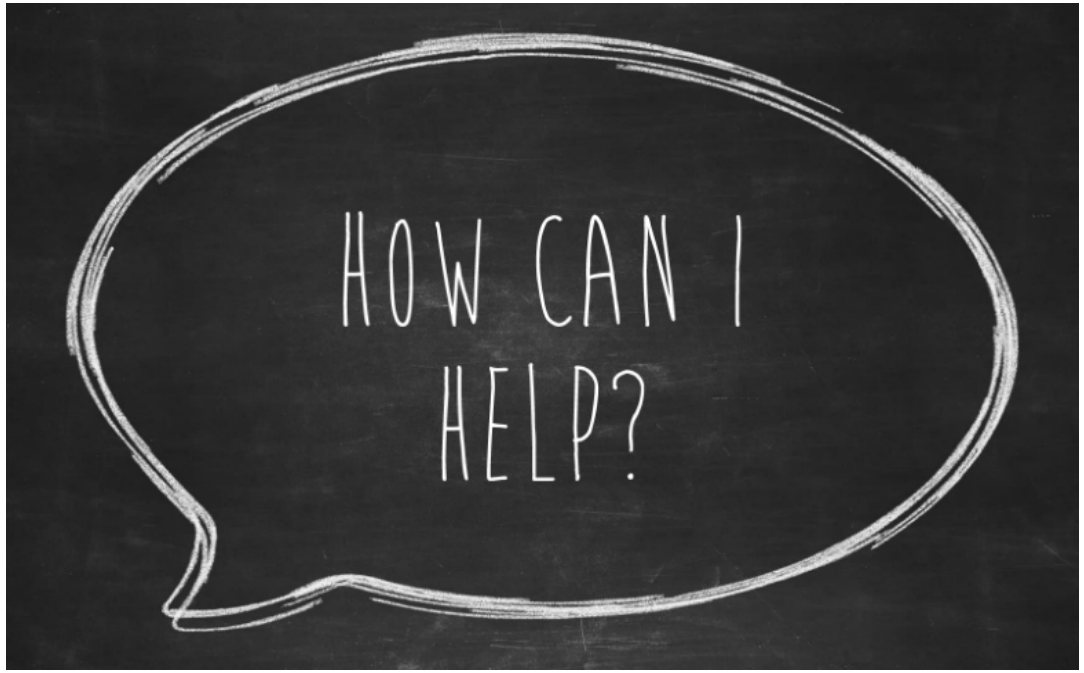
- KIBS/KBOV Radio
- Sierra Wave Media (KSRW-FM)
- Eastern Sierra NOW

In-house posters & flyers

Social Media pushes

What can I do to help?

- Discuss this effort with your team, emphasizing the importance of this information for the District's future and that of the community
- Encourage team members, loved ones, friends, associates to take this survey
- SHARE the NIHD Social Media information on your social accounts
- Encourage people to use the QR code or make the paper copies accessible.



Thank you!

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

Date: 05/09/2022

Title: **NIHD Governance Committee Meeting Update**

Synopsis: The Governance Committee has continued to meet regularly, attached is a copy of the following meeting minutes:

- March 24, 2022
- April 12, 2022
- May 3, 2022

The Governance Committee would like the Board to consider a Special Board Meeting to ensure that the Board is able to review and consider the approval of a few draft documents created by this committee and allow for a discussion to take place about upcoming projects and focus areas they like the Governance Committee to accomplish in the near future. The Board has been polled for a Special Board Meeting in May.

Special Board Meeting Tentative Date: Wednesday, May 25th at 6:00 p.m.

Prepared by: _____
Erika Hernandez, Board Clerk

Approved by: Kelli Davis
Kelli Davis, CEO

NORTHERN INYO HEALTHCARE DISTRICT

NORTHERN INYO HEALTHCARE DISTRICT
BOARD MEMBER GOVERNANCE COMMITTEE MEETING MINUTES
Date: May 3, 2022, 7:00 a.m. Zoom

1. **Call to Order**
   7:02 a.m.
2. **Roll call**
   Board: Jody Veenker, Chair & Jean Turner, Treasurer
   Staff: Kelli Davis, CEO & Erika Hernandez, Administrative Assistant/Board Clerk

3. **APPROVAL OF MINUTES OF:**
   Ms. Turner and Ms. Veenker approved the Governance Meeting Minutes for March 24, 2022 and April 12, 2022.

4. **ITEMS FOR COMMITTEE DICUSSION AND/OR RECOMMENDATION**

4.1 NIHD Board Governance

A discussion took place, Ms. Turner suggestion that this item be include on the agenda for this month's Regular Board Meeting to update the Board as a whole and allow for an opportunity to discuss and receive feedback from each Board member.

4.1.1 NIHD Board Bylaws

Ms. Davis reported that Keith Collins provided two versions of the NIHD Board Bylaws with proposed revisions as discussed and recommended during the April 20, 2022, NIHD Board of Director's Meeting regarding standing committee, ad hoc committee and special committee language.
Action: Provide copies of the two version of the NIHD Bylaws to Ms. Turner and Ms. Veenker for review.

4.2 NIHD Board Policies Review

4.2.1 Governance Committee will review and consider sample Policies

- Guideline for Business by the Northern Inyo Healthcare District Board of Directors

Ms. Davis asked if there were any question on the proposed policy titled: "Guideline for Business by the Northern Inyo Healthcare District Board of Directors". Ms. Veenker suggested that she would like to see additional language under section B5- "Closed Session Meetings" that speaks specific to what agenda items may fall under this portion of the Board meeting to provide District transparency.

Action: Ms. Davis will reach out to Mr. Collins about adding additional language to this policy that would help explain which items may be fall under closed session portion of the Board of Directors meeting.

- Order and Decorum of Board Business for 2022

Ms. Davis asked if there were any question on the proposed policy titled: "Order and Decorum of Board of Business for 2022". Ms. Turner mentioned she was pleased with this policy. Ms. Turner and Ms. Veenker did not have any questions.

Action: This policy is ready for Board review and consideration.

4.3 Governance Committee Charter Discussion

Ms. Turner and Ms. Veenker reviewed the proposed Governance Committee Charter draft. Ms. Turner and Ms. Veenker made a recommendation to add language under "Duties" about continued Board education and retreat planning. They also recommended adding a duty that would ensure the Board review and discuss personnel contracts and legal services during closed session on an annual basis.

Action: Ms. Davis will make the appropriate changes as requested by Ms. Turner and Ms. Veenker. This policy will then be ready for the Board review and consideration.

5. Other Business

5.1 Governance Committee will discuss and consider top priority areas of focus for the Committee based on NIHD Board of Directors direction and recommendations.

Action: A discussion took place about possibly scheduling a Special Board Meeting that would allow the Board as whole to review and discuss the proposed two policies and the Governance Committee Charter draft and any additional area of focus the Board would like the Governance Committee to focus on.

6. <u>Next Meeting Date</u>

Tuesday, May 24th at 7:00 a.m.

7. <u>ADJOURNMENT OF MEETING</u>

7: 56 a.m.

NORTHERN INYO HEALTHCARE DISTRICT
BOARD MEMBER GOVERNANCE COMMITTEE MEETING MINUTES
Date: April 12, 2022, 7:00 a.m. Zoom

1. **Call to Order:**
   7:05 a.m.
2. **Roll call:**
   Board: Jean Turner, Treasurer

   Staff: Kelli Davis, CEO and Erika Hernandez, Administrative Assistant/Board Clerk

   Other: Keith Collins, Legal Counsel

   Absent: Jody Veenker, Chair
3. **APPROVAL OF MINUTES OF:** March 24, 2022 NIHD Governance Committee Minutes were approved by Jean Turner; minutes will be sent to Jody Veenker for electronic review and feedback.

4. **ITEMS FOR COMMITTEE DICUSSION AND/OR RECOMMENDATION**

4.1 NIHD Board Governance

4.1.1 NIHD Board Bylaws

Keith Collins, General Legal counsel explained that Board Standing Committees are subject to the Brown Act. A discussion took place about possibly revising the District Bylaws re: Standing Committees, Board would set expectations for the CEO to allow for the formation of these committees and request for Board participation on a quarterly basis. Ms. Davis explained that NIHD does have operational committees in place including Finance, Quality and Safety, Compliance and Ethics, and a recent Ad Hoc Committee was formed for the 2022 Community Health Needs Assessment project.

Action Items: Erika Hernandez will review and provide feedback on any previously adopted District Board Resolutions for Board Committee formation.

4.1.2 Brown Act Requirements

Action: Keith will have a discussion with legal counsel, Noel Caughman, regarding any legal insight and/or risk of removing the standing committees from the NIHD Bylaws.

4.1.3 Robert's Rules of Order

Mr. Collins explained that Robert's Rule of Order is designed to be a guideline for struggling Board Members to conduct a successful Board Meeting. It is not a Brown Act requirement to adopt Robert's Rules of Order.

4.2 NIHD Board Policies Review

4.2.1 Governance Committee Consideration of sample Policies

- Guideline for Business by the Northern Inyo Healthcare District Board of Directors
- Orders and Decorum of Board Business for 2022

Policy consideration and discussion was held over to a future meeting.

4.3 Governance Committee Charter Discussion

4.3.1 No discussion took place. This item was held over to a future meeting.

5. Next Meeting Date

Tuesday, April 26, 2022 at 7:00 a.m.

6. ADJOURNMENT OF MEETING

7:53 a.m.

NORTHERN INYO HEALTHCARE DISTRICT

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS
GOVERNANCE COMMITTEE
MEETING MINUTES
Date: March 24, 2022, 7:00a.m. Teleconference

1. **CALL TO ORDER**
   7:03am

2. **ROLL CALL**
   Board: Jody Veenker, Chair; Jean Turner, Treasurer
   Staff: Kelli Davis, CEO; Cori Stearns, Executive Administrative Assistant

3. **APPROVAL OF MINUTES OF:** March 3, 2022 – Approved via email for March 16, 2022, NIHD Board Meeting Packet. (*Included in Governance Committee agenda for informational review/use*)

4. **ITEMS FOR COMMITTEE DISCUSSION AND/OR RECOMMENDATION**

4.1 Board Governance

4.1.1 New Board Member Onboarding

Robert and Jean were selected as BOD representatives for the Ad Hoc Onboarding Committee. Focus will include onboard processes for new Board Members. Marjorie Routt and Alison Murray were the staff selected. Alison may transition off as the committee gets developed.

a) Onboarding Ad Hoc Committee Members

Jean Turner, NIHD Board Treasurer – Appointed by NIHD Board on March 16, 2022
Robert Sharp, NIHD Board Member-at-Large – Appointed by NIHD Board on March 16, 2022
Kelli Davis, NIHD CEO
Alison Murray, NIHD Director of HR
Marjorie Routt, NIHD Manager of HR

b) NIHD Board Member Onboarding Ad Hoc Committee Meeting #1 –
Will take place sometime after April 11, 2022.

c) Board Member Vaccination Requirements/Documentation

NIHD Director of Nursing/Quality & Infection Prevention, Robin Christensen, researched vaccination requirements and determined that Board members will follow visitor procedures. Documentation such as providing a declination will still be required.

4.2 NIHD Board Policies Review

4.2.1 Governance Committee Document Discussion

Three document samples were reviewed and discussed:

a. *Guidelines for Business by the Northern Inyo Healthcare District Board of Directors*
   - Keith Collins, General Counsel, reviewed and provided insight via email.

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS
GOVERNANCE COMMITTEE
MEETING MINUTES
Date: March 24, 2022, 7:00a.m. Teleconference

- Discussion was had around Brown Act requirements of Standing Committees, the role Robert's Rules of Order holds in comparison and requirements of Board related standing committees versus District committees with appointed Board member participants.

Action: Kelli will reach out to Keith Collin's for further insight to the Brown Act, Robert's Rules of Order, Bylaw Standing Committee requirements and ACHD input on Standing Committee requirements

b. Order and Decorum of Board Business for 2022

Discussion was had regarding submission of late documents. Emphasis was made to minimizing late submissions to an urgent need basis. Justification in writing on the cover page with the reasoning as to what it means from an operational perspective is imperative for Board understanding of the late submission. Input and clarification is needed with regard to "Requests for Input/Dialogue (#5) and Individual Board Member Agenda Requests (#6). A form may be considered for a formal process.

Action: Kelli will research document samples for "agenda requests".

4.3 Governance Committee Charter Discussion

4.3.1 Clarification from Keith on Standing issue. Otherwise, this is a good document.
Group reviewed the draft document and the role of a standing committee. This again, needs clarification. Under duties, it was suggested that Board Bylaws are reviewed by the Governance Committee and the Board as a whole, on an annual basis versus bi-annual basis for consistency and familiarity.

Action: Kelli will contact Keith and provide an email to Jody and Jean with documents.

5. **NEXT MEETING DATE**
Tuesday, April 12

6. **ADJOURNMENT OF MEETING**
8:02am

RESOLUTION NO. 22-07

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTHERN INYO HEALTHCARE DISTRICT MODIFYING DISTIRCT BYLAWS REGARDING BOARD COMMITTEES.

WHEREAS, the Northern Inyo Healthcare District has adopted bylaws that govern the operation of the District and its officers; and

WHEREAS, the Board of Directors finds that modifications to the bylaws regarding Board committees are necessary to improve committee efficiency and Board oversight.

NOW, THEREFORE, THE BOARD OF DIRECTRORS OF THE NORTHERN INYO HEALTHCARE DISTRICT DOES HEREBY RESOLVE AS FOLLOWS:

SECTION 1. Article VI ("Committees") of the Northern Inyo Healthcare District Bylaws is hereby amended to read as follows:

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 of the Standing Committee. The President and Board members

of each Standing Committee shall be appointed by the President 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 President 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 is appointed as a voting member, the President of the Board shall be an ex officio member of each committee, without being a voting member. The President 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) Finance Committee: 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) 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.

SECTION 2. The Clerk shall certify to the adoption of this Resolution.

PASSED, APPROVED AND ADOPTED this 18th day of May, 2022.

_____

Jody Veenker, Chair

Board of Director

ATTEST:

_____

Erika Hernandez, Board Clerk

RESOLUTION NO. 22-08

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTHERN INYO HEALTHCARE DISTRICT MODIFYING DISTIRCT BYLAWS REGARDING BOARD COMMITTEES.

WHEREAS, the Northern Inyo Healthcare District has adopted bylaws that govern the operation of the District and its officers; and

WHEREAS, the Board of Directors finds that modifications to the bylaws regarding Board committees are necessary to improve committee efficiency and Board oversight.

NOW, THEREFORE, THE BOARD OF DIRECTRORS OF THE NORTHERN INYO HEALTHCARE DISTRICT DOES HEREBY RESOLVE AS FOLLOWS:

SECTION 1. Article VI ("Committees") of the Northern Inyo Healthcare District Bylaws is hereby amended to read as follows:

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 of the Standing Committee. The President and Board members

of each Standing Committee shall be appointed by the President 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 President 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 is appointed as a voting member, the President of the Board shall be an ex officio member of each committee, without being a voting member. The President shall be notified of all committee meetings.

Section 2. 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) Finance Committee: 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) 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.

d) 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.

SECTION 2. The Clerk shall certify to the adoption of this Resolution.

PASSED, APPROVED AND ADOPTED this 18th day of May, 2022.

_____

Jody Veenker, Chair

Board of Director

ATTEST:

_____

Erika Hernandez, Board Clerk

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

Date: May 9, 2022

Title: **NIHD CHIEF EXECUTIVE OFFICE ABSENCE FROM JULY 20, 2022 BOARD OF DIRECTORS MEETING**

Synopsis: Kelli Davis, CEO, will be out of town on July 20, 2022. A request is being made to for the Board of Directors to approve:

- Substitution of another member of the NIHD Executive Team to sit in place of the CEO for the Board Meeting lead; OR
- Selection of another date for the July Board Meeting in July.

Prepared by: _____
Erika Hernandez
Administrative Assistant/Board Clerk

Approved by: Kelli Davis
Kelli Davis
CEO

RESOLUTION NO. 22-09

RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTHERN INYO HEALTHCARE DISTRICT REQUESTING CONSOLIDATION OF ELECTION

WHERAS, it is necessary that three (3) directors be elected to the Board of Directors of Northern Inyo Healthcare District, one each from Zones II, III, and V of said District; and

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of Northern Inyo Healthcare District that it request that the Board of Supervisors of the County of Inyo, State of California, consolidate said election of directors with the statewide election to be held on November 8, 2022; and,

BE IT FURTHER RESOLVED THAT THE Hospital Chief Executive Officer be, and is hereby directed to file copies of this Resolution with said Board of Supervisors of the County of Inyo, State of California, and the County Clerk-Recorder, Registrar of Voters of said County.

Adopted, signed and approved this 18th day of May, 2022.

_____

Jody Veenker, Chair

Attest: _____

Topah Spoonhunter, Secretary

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: May 4, 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. Paul Kim, MD (*anesthesiology*) – Active Staff
    2. Carolyn Saba, MD (*anesthesiology*) – Courtesy Staff
    3. Leena Sumitra, MD (*psychiatry*) – Telemedicine Staff

B. Change in Medical Staff Category (*action item*)
    1. Farres Ahmed, MD (*radiology*) – requested to be changed from Courtesy Staff to Active Staff.

C. Medical Staff Privilege Form (*action item*)
    1. Cardiovascular Disease

D. Medical Staff Resignations (*action item*)
    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

E. Policies (*action item*)
    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*

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

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

Cardiovascular Disease

Delineation of Privileges

Applicant's Name: ,

Instructions:

1. Click the Request checkbox at the top of a group to request all privileges in that group.
2. Uncheck any privileges you do not want to request in that group.
3. Sign form electronically and submit with any required documentation.

Facilities

☑ **NIHD**

Required Qualifications

Education/Training	Completion of an ACGME or AOA accredited Residency training program in Internal Medicine. **AND** Completion of an ACGME accredited fellowship training program in Cardiovascular Disease or an AOA accredited fellowship training program in Cardiology.
Certification	Current certification or active participation in the examination process leading to certification in Internal Medicine by the American Board of Internal Medicine or AOA equivalent. **AND** Current certification or active participation in the examination process leading to certification in Cardiovascular Disease by the American Board of Internal Medicine or AOA equivalent.
Clinical Experience (Initial)	Applicant must provide documentation of provision of cardiovascular disease services representative of the scope and complexity of the privileges requested during the previous 24 months. (waived for applicants who completed training during the previous year).
Clinical Experience (Reappointment)	Applicant must provide documentation of provision of clinical services representative of the scope and complexity of privileges requested during the previous 24 months.
Additional Qualifications for Device Related Privileges	Applicant must have completed manufacturer designated training including human subjects experience when device related privileges are requested OR provide documentation of training and current clinical competence if training occurred during fellowship.

Core Privileges in Cardiovascular Disease

Description: Evaluation, diagnosis, consultation and treatment of patients with acute and chronic cardiovascular conditions.

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Admit to inpatient or appropriate level of care
☐	Perform history and physical examination
☐	Evaluate, diagnose, provide consultation and medically manage and treat patients with cardiovascular complaints. Privileges include medical management of general medical conditions which are encountered in the course of caring for the cardiovascular patient.
	Procedures
☐	Arterial line insertion
☐	Elective cardioversion
☐	Electrocardiogram (EKG) interpretation including ambulatory monitoring
☐	Insertion of central venous catheter
☐	Transthoracic echocardiography
☐	Stress testing: exercise or pharmacologic
☐	Placement of temporary transvenous pacemaker

FPPE (Department Chief to select)	
☐	5 retrospective chart reviews reflective of the scope and complexity of privileges granted

Transesophageal Echocardiography (TEE)

Description: Placement of the transesophageal probe, image acquisition and interpretation.

Qualifications

Education/Training	Successful completion of an ACGME accredited residency or fellowship training program that included education and direct experience in transthoracic echocardiography (TEE) with performance and interpretation of supervised cases. Confirmation of completion of level 2 training and current clinical competence from the residency or fellowship program director if the training was completed during the previous 24 months **OR** National Board of Echocardiography certification in TEE.
Clinical Experience (Initial)	Documentation of ongoing clinical practice representative of the scope of privileges requested during the previous 24 months.
Clinical Experience (Reappointment)	Documentation of ongoing clinical practice representative of the scope of privileges requested during the previous 24 months.

Request	Check the Request checkbox to select all privileges listed below. Uncheck any privileges you do not wish to request in the group.
☐	Transesophageal Echocardiography (TEE) including probe placement, image acquisition and interpretation

FPPE (Department Chief to select)	
☐	Concurrent review of 1 case
☐	Retrospective review of 3 cases
☐	Feedback from Cardiopulmonary Director

Acknowledgment of Applicant

I have requested only those privileges for which by education, training, health status, current experience, and demonstrated competency I believe that I am competent to perform and that I wish to exercise at Northern Inyo Healthcare District and I understand that:

A. In exercising any clinical privileges granted, I am constrained by applicable Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.

B. Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

_____

Practitioner's Signature NIHD

Department Chief Recommendation - Privileges

I have reviewed the requested clinical privileges and supporting documentation and my recommendation is based upon the review of supporting documentation and/or my personal knowledge regarding the applicant's performance of the privileges requested:

Privilege	Condition/Modification/Deletion/Explanation

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Access to Medications in the Absence of the Pharmacist		
Owner: Acting Director of Pharmacy	Department: Pharmacy	
Scope: District Wide		
Date Last Modified: 01/19/2022	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/20/2010	

PURPOSE:
To delineate a system for safely providing medications to meet patient needs when the pharmacy is closed.

POLICY: Pharmacist-on-call

1. Pharmacy hours are 0630 to 1700. From 1701 through 0629, seven days per week, a pharmacist will be available by telephone and will be within 20 minutes of the hospital.
2. The pharmacist on call will verify the orders in the pharmacy electronic health record (aka information system) through a secure computer connection after reviewing the orders for appropriateness and safety. Overrides are not permitted except in extreme emergencies.
3. These medications removed without pharmacist review via override are reviewed for appropriateness prior to administration with special attention given to:
    a) Dose
    b) Frequency
    c) Route of administration.
    d) Therapeutic duplication
    e) Drug allergies or sensitivities
    f) Potential interactions with other medication, food or nutritional products.
    g) Laboratory values

4. Only medications determined by the Director of Pharmacy with approval of the Pharmacy and Therapeutics Committee will be available for override including the following items:
    a) Naloxone
    b) Dextrose 50%
    c) Diphenhydramine
    d) Flumazenil
    e) Parenteral Analgesics
    f) Ondansetron (Zofran) parenteral and ODT (disintegrating tablets).
    g) Promethazine
    h) Prochlorperazine
    i) Plasma expanders w/o potassium.
    j) Nitroglycerine (NTG) sublingual tablets.
    k) RSI Kits – Rapid Sequence Intubation Kits
    l) Hemorrhage Kits – limited to OB
    m) Parenteral Benzodiazepines

n) Pitocin Drips

5. An override report will be generated automatically each day by the automatic dispensing unit (Omnicell) and will be analyzed by the incoming morning pharmacist on duty for appropriateness.
6. Performance improvement will be taken by the Director of Pharmacy for any unnecessary overrides.
7. The pharmacy shall maintain medications in the automated dispensing cabinets (Omnicell) for use throughout the District.
8. The pharmacist-on-call will be available for relevant questions that cannot wait until the Pharmacy re-opens.
9. The pharmacist-on-call will return to the hospital (call-back) whenever the pharmacist-on-call and the nursing supervisor agree to the need.

Floor Stock

1. Other than medications available for administration that are stored in the Automatic Dispensing Units, no medications shall be available for use on any nursing unit.

Automated Dispensing Units

1. The Director of Pharmacy in consultation with the unit Supervisor shall determine the nature and quantity of medications in the automatic dispensing units (Omnicell) with approval by the Pharmacy and Therapeutics Committee.
2. The pharmacy staff will stock or restock the automatic dispensing (Omnicell) units in accordance with the Automatic Dispensing Unit policy.
3. Pharmacists and pharmacy personnel will ensure that all medication containers are labeled with the drug name, strength, manufacturer, lot number, and expiration date in the dispensing cabinets (Omnicell).
4. Each business day when the pharmacy department opens the staff shall:
    a) Review the medications used since the pharmacy last closed.
    b) Restock the after-hours medication supply up to the established par levels.
    c) Adjudicate the controlled substance utilization.
5. All pharmaceuticals stored or used by any department in the District shall be under the supervision of the Pharmacy Department.
6. Any repackaging performed in the pharmacy will be done under the supervision of the pharmacist. All repackaged items shall be labeled with the following information:
    a) Name of ingredient(s).
    b) Strength and dosage form (if indicated).
    c) Manufacturer
    d) Lot number and expiration date.
    e) Date of repackaging followed by the initials of the preparer and logged for archival.
7. Only pharmacy personnel may transfer, repackage or relabel medication.
8. A pharmacist will verify all technician performed work prior to stocking or delivering out of the department.
9. Only the necessary amount of medication may be removed by authorized personnel from the automatic dispensing cabinets.

Pharmacy Access after Pharmacy Hours

1. There shall be no access to the pharmacy by anyone other than a registered pharmacist.
2. In the event of a failure of the key card system to gain access to pharmacy two "disaster" keys to the pharmacy exist. One shall be in the possession of the Pharmacy Director and the other shall be kept in the Automatic Dispensing Unit in Diagnostic Imaging in a sealed and tamper-evident envelope that shall only be accessible by one of the registered pharmacist staff at NIHD.

Crash Cart Medication Trays

1. One back up set of 4 Crash Cart medication trays will be kept in the Nursing Supervisor Office in a locked cabinet.
2. If the nursing supervisor accesses the back-up trays, the supervisor will notify the pharmacy or the relieving supervisor who will notify the pharmacy of the use of the back-up trays.

REFERENCES:

1. California Board of Pharmacy 4023.5, 4029, 4106.5, 4116
2. The Joint Commission (CAMCAH manual) (Jan 2022) Standard MM.05.01.13

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Pharmacist Clinical Interventions
2. Medication Override Policy
3. Pharmacy and Medication Security
4. Access to Medications in the Absence of the Pharmacist

RECORD RETENTION AND DESTRUCTION:

On call records must be kept for 6 years.

Supersedes: v.4 Access to Medications in the Absence of the Pharmacist

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Barcode Medication Administration		
Owner: Acting Director of Pharmacy	Department: Pharmacy	
Scope: Hospital Wide		
Date Last Modified: 01/17/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/25/2015	

PURPOSE:

To define use of Bar Code Medication Administration (BCMA) at NIHD.

POLICY:

1. Upon admission to the hospital, a barcoded name band shall be applied to all patients by (admitting or the admitting nurse).
2. There shall be only one active barcoded name band per patient.
3. Nursing staff shall replace worn, missing, or inaccurate name bands as soon as discovered by hospital staff.
4. Northern Inyo Healthcare District staff permitted by State law and hospital policy to administer medications shall use the barcode system wherever it is implemented in facility. Current locations with bar code medication administration include:
    1. Medical-Surgical Unit
    2. Intensive Care Unit
    3. Perinatal Unit
    4. Emergency Department
    5. Perioperative Services

PROCEDURE:

1. Obtain the patient's medication from the automated dispensing machine per Automated Dispensing Unit policy and procedure, or from the medication storage device for medications mixed and labeled by pharmacy.
2. Select the patient to whom the medication is to be administered in the electronic medication administration record (MAR).
3. Verify the label on the medication with the patient’s MAR before scanning
4. Identify the patient using two (2) patient identifiers
5. Scan the barcode on the patient’s identification name band before medication administration. A green check mark will verify that the patient scanned is the patient whose MAR is open.
6. Scan the barcode on each medication immediately before administration to verify:
    1. The right patient
    2. Right medication
    3. Right time
    4. Right dose
    5. Right route

7. Verify the allergy information displayed in barcode system before medication administration with information from another source, i.e., allergy bracelet, asking patients to recite allergies before medication administration.
8. The barcode system will give the nurse a visual warning if a medication cannot be matched with the order.
9. If a warning is issued, the nurse shall not administer the medication until the discrepancy is resolved by calling the pharmacist.
10. When all the medications for the administration have been scanned, click "CONFIRM." The system will show a green check mark for confirmation.
11. Administer the medications.
12. Click "Chart"
13. Complete any reason requirements (for example, late admin reason, early admin reason, pain scale, etc.)

STAFF EDUCATION:

1. All clinical staff permitted to administer medications in this hospital shall receive education addressing the hospital's barcoding system at the time of orientation and as needed.
2. Staff shall receive training as needed when the barcode system is updated.

TROUBLE SHOOTING:

For troubleshooting please call the pharmacist.

INFECTION PREVENTION AND CONTROL:

Barcoding system equipment shall be cleaned per manufacturer's recommendation. (See link in reference list.)

PERFORMANCE IMPROVEMENT:

The NIHD Medication Administration Improvement Committee (MAIC) and the Pharmacy and Therapeutics Committee (P&T) in conjunction with the Pharmacy Department shall develop, implement and proactively conduct continuous improvement activities on the use of barcoding in this hospital as part of the Medication Error Reduction Plan.

DOWNTIME:

The IT Department, Nursing Department and Pharmacy Department shall ensure that policies and procedures are in place to address contingency plans during downtime and that the appropriate staff is notified of scheduled downtimes.

REFERENCES:

1. The Joint Commission (CAMCAH manual) (Jan 2022) Standard PI.01.01.01 EP 12
2. The Joint Commission (CAMCAH manual) (Jan 2022) Standard MM.08.01.01 EP 1
3. Honeywell Barcode Scanner manufacturer's recommendation link https://sps.honeywell.com/us/en/support/blog/productivity/honeywell-disinfectant-ready-housing-cleaning-and-disinfecting-guide

4. Disinfection, non-critical patient care equipment, ambulatory care https://procedures.lww.com/lnp/view.do?pId=3358992&hits=care,equipment,disinfect,patient,disinfected,noncritical,disinfecting,patients,disinfection&a=false&ad=false&q=disinfection%20noncritical%20patient%20care%20equipment

RECORD RETENTION AND DESTRUCTION:

Medication administration is documented in the medical record, which is maintained by NIHD records department.

Quality records and data are maintained for 10 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Administration of Drugs and Biologicals
2. Chemotherapy Administration and Precautions
3. Intravenous Medication Policies

Supersedes: v.1 Barcode Medication Administration*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Cardiac Arrest in the OR		
Owner: Perioperative Manager	Department: PACU	
Scope: Surgery		
Date Last Modified: 03/17/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/07/2007	

PURPOSE:
To provide life support for the patient experiencing cardiac or respiratory arrest in the operating room

POLICY:
Resuscitation measures will be instituted immediately upon cessation of cardiac or respiratory function in the patient undergoing surgical intervention unless otherwise specified on the operative consent.

Because Surgery is a restricted area and surgical procedures are done under sterile set-up, a "Code Blue" is not normally paged overhead. The circulating RN will call an internal page "Perioperative Code Blue, OR Room #" in the Perioperative Unit and all Perioperative staff will respond immediately to this internal page. The circulating RN will call the House Supervisor to Surgery and the House Supervisor will elicit additional help as needed for an emergency in Surgery.

A Code Blue Debriefing will be completed after every Code Blue.
All codes will be reviewed by the Resuscitation Committee.
All codes will be peer reviewed as a critical indicator at the Surgery, Tissue, Transfusion, Anesthesia Committee.

PROCEDURE:
The anesthesiologist or the surgeon performs the **CODE BLUE TEAM LEADER** role

The circulating RN performs or delegates the **RN CODE LEADER** role:

1. Coordinates team members and treatment. Ascertains physician in charge and receives orders directly from that physician.
2. Insures that all Basic Life Support (BLS) is delivered per latest American Heart Association (AHA) standards, including proper rate and depth of compressions, adequate changes in compressor role, and quick resumption of cardiopulmonary resuscitation (CPR) after interventions or pulse checks.
3. Follows ACLS and PALS algorithms and performs cardioversion, pacing, defibrillation, monitors patients and administers drugs as per Medical Staff orders. All procedures, treatments, and medications will be carried out per order of the physician, with the use of closed loop communication.
4. All procedures, treatments, and medications will be communicated to the recorder to insure complete and timely documentation.
5. Insures that traffic, noise and unnecessary conversations are kept to a minimum.

6. For C-sections - document on the Resuscitation Record for any infant code until the House Supervisor arrives and can take over or reassign this role
7. Delegates a team member to ensure a Social Worker, Case Manager or staff member is assigned to family if present during the resuscitation.

A Surgery RN or PACU RN assumes the **CODE ASSIST RN** role:

1. Positions bed and removes head board
2. Brings crash cart into OR Suite
3. Applies fast patches and/or monitor leads from the defibrillator.
4. Runs initial monitor strip.
5. Assist with any additional procedures as needed.
6. Insert NG tube or delegate to another staff member.
7. Insert Foley catheter or delegate to another staff member.
8. Set up procedure trays as needed or prepare Intra-osseous (IO) for physician.
9. Insures that vital signs are done every 5 minutes if blood pressure and pulse present

Two other staff members: RNs, Scrub techs, Unit Clerks, or CNAs perform the **CODE COMPRESSIONS**:

1. Places backboard under patient. This can be found on the back of the crash cart.
2. Takes over cardiac compressions. This requires frequent changes with no person performing compression for longer than 2 minutes at a time. This is to insure good quality compressions are maintained and to avoid fatiguing staff

The House Supervisor performs or delegates the **CODE RECORDER** role:

1. Recorder - records all information during code on code sheet
2. Accurately times start of Code and all treatments.
3. Charts VS Q 5 min. when BP and pulse present or insures that an electronic record of vital signs is maintained.
4. Prompts Code Leader for appropriate ACLS and PALS protocols.
5. Sees that an Unusual Occurrence Report (UOR) will be filled out

CIRCULATING NURSE RESPONSIBILITIES:

1. All nurses employed in the operating room must have Advanced Cardiac Life Support and Pediatric Advanced Life Support certificates.
2. It is the responsibility of every nurse in the operating room to know:
    - The location and use of emergency call buttons in each surgical suite.
    - The location of the crash cart /defibrillator and be familiar with its functions.
    - Location and contents of emergency medications and supplies in each surgical suite.

SCRUB TECH or RN RESPONSIBILITIES:

1. It is the responsibility of the scrub person to institute measures to maintain sterility of field including instrument table and mayo stand.
2. Assist as needed in sterile procedures.

DOCUMENTATION:

1. A Code Blue form (located on the Crash Cart) should be completed.
2. Documentation shall include, but not limited to:
    - Time of arrest
    - Medications administered, times of administration.
    - Time of defibrillation, number of joules.
    - Personnel
    - Procedures performed
    - Time code stopped and by whom

REFERENCES:

1. AORN: "Medication Safety" Recommendation III, "Positioning the Patient", "Information Management" Recommendation IV
2. TJC: PC 03.01.01, 03.01.05, and NPSG 03.04.01
3. California Code of Regulations: Title 22 Standards: 70217, 70223 b #3 & e, 70225, 70227, 70233, 70237
4. American Heart Association: Advanced Cardiac Life Support

RECORD RETENTION AND DESTRUCTION:

Documentation is maintained within the medical record by the NIHD Medical Records Department.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Code Blue Procedure – Code Blue Team
2. Code Blue (Cardiac Arrest) Documentation

Supersedes: v.3 Cardiac Arrest in the OR

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Cleaning and Care of Surgical Instruments		
Owner: DON Perioperative Services	Department: Sterile Processing	
Scope: Sterile Processing and Surgery		
Date Last Modified: 01/31/2022	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/04/2010	

PURPOSE:

Personnel in Sterile Processing have a vital role in the continuing battle against microorganisms. The proper handling of equipment that has been used or contaminated is not a mere function, but an obligation for patient and personnel safety. Continuous emphasis must be exerted in order to have personnel carry out the necessary steps.

POLICY:

Manufacturer's written, validated instructions for handling and reprocessing should be obtained and evaluated to determine the ability to adequately clean and reprocess the equipment. Manufacturer's written instructions should be used to determine how to properly clean and sterilize instruments.

It is our policy NOT TO REPROCESS SINGLE USE ITEMS for patient use. All personnel practice standardized precautions and wear protective gown, glasses, goggles and gloves when appropriate.

PROCEDURE:

New, Repaired, or Refurbished Instruments:

- All new, repaired or refurbished instruments should be examined, cleaned, and sterilized according to manufacturer's written instructions before use.
- All moving parts, tips, box locks, ratchets, screws and cutting edges should be examined for defects and to ensure proper working order.
- Instruments should be pre-treated according to manufacturer's written instructions, when indicated.
- All instruments should be decontaminated according to manufacturer's written instructions before use.
- All instruments should be sterilized according to manufacturer's written instructions before use.

Loaner Instruments

Upon scheduling a procedure that requires loaner instrumentation, the Surgery Manager, Materials Management Analyst or designee contacts the vendor or other hospital facility to arrange a timely delivery of instruments and implants.

- Loaner instruments should be requested when the surgery is scheduled, and delivered in time for the surgical procedure to allow inspection and inventory of instruments.
- Loaner instruments should be logged in and inventoried before use.
- Loaner instruments should be considered contaminated and are delivered to the decontamination area for processing.

- All moving parts, tips, box locks, ratchets, screws and cutting edges should be examined for defects and to ensure proper working order.
- Vendors will provide manufacturers' written instructions for disassembly, cleaning, packaging and sterilization of instruments and implants.
- All loaner instruments and implants will be cleaned, inspected, inventoried, wrapped, sterilized, cooled, documented and tracked to each patient according to published standards and Manufacturer instructions, and hospital policy and procedure.
- Quality control sterilization monitoring will be done per hospital policy and procedures.
- If an item must be released from quarantine because of a documented necessity, all other monitors: sterilization cards, chemical integrator, and biological indicator should be reviewed and documentation reflects that the item was released without the results of the Biological Indicator being known. The physician will be notified of the situation.
- After the surgical procedure is completed, the borrowed instruments should be disassembled, cleaned, and decontaminated.
- The instruments are to be returned to the source from which they were borrowed per their instruction.

Preliminary Steps in Surgery

- Instruments should be wiped with sterile water moistened sponges as needed during the surgical procedure to remove gross soiling to prevent corrosion, rusting and pitting.
- Instruments with lumens should be irrigated with sterile water as needed throughout the surgical procedure.
- Cautery tips should be cleaned frequently to prevent eschar build-up.
- Instruments needing repair should be tagged or labeled and removed from service until repaired.

Cleaning and decontamination of Surgical Instruments.

- Decontaminate the instruments at the point of use – see above.
- All instruments opened in the operating or procedure rooms need to be decontaminated whether or not they have been used.

Sorting

- Sharp instruments should be segregated from other instruments.
- Disposable sharps should be removed and discarded into proper receptacles.
- Reusable sharp instruments, including scissors, should be placed in a separate puncture proof receptacle for transportation, such as emesis basin.
- Reusable scalpel handles should be considered sharp instruments

Transportation to Decontamination Area

- Soiled instruments must be transported covered and contained in a manner to prevent exposure to patients or personnel to blood borne pathogens, and other potentially infectious organisms.
- Soiled instruments from the ancillary departments and clinics will be transported to the decontamination area in covered containers by the perioperative courier.
- Hand-carried must be contained in a container with a lid.
- Large quantities of items must be contained in a cart or transport container with doors or plastic cover.
- Items placed on top of cart must be contained safely to prevent falling off.

Cleaning

Instruments should be decontaminated in an area separated from locations where clean activities are performed.

- Instruments should not be decontaminated in scrub or hand sinks.
- The decontamination area should be physically separate from clean areas and include a door.
  The area should contain:
  Sinks
  Hand washing facilities
  Eye wash station
  Automated equipment consistent with the types of instruments to be decontaminated
  Compressed air supply
  Adaptors and accessories to connect instruments with cleaning equipment and utilities.

Water Quality

- Potable water should be used for manual or mechanical decontamination cleaning methods unless contra-indicated by manufacturer's instructions.

- Softened or de-ionized water should be used for the final rinse.
- Water quality assessment should be performed periodically or after maintenance to water sources. Impurities in the water can reflect insufficient filtration, necessitating repairs bases on testing.

Manufacturer's Instructions

Following manufacturer's instructions decreases the possibility of cleaning agents harming instruments.

Cleaning Methods

Manufacturer's instructions should be followed regarding types of cleaning methods (e.g. manual, automated) to be used for decontamination.

Manual cleaning

- Before beginning the cleaning process, instruments should be rinsed in cold running water to remove gross debris.
- Instruments should be thoroughly washed.
- Some delicate instruments, power equipment and other instruments that cannot be submerged should be cleaned manually.
- Instruments should be completely submerged in warm water and appropriate detergent for 5 minutes prior to cleaning.
- Instruments should be completely submerged in rinse solution after cleaning.
- Mechanical cleaning of surgical instruments is accomplished by ultra-sonic cleaners, washer-decontaminators/disinfectors, or washer-sterilizers.

Ultrasonic cleaners

- Ultra-sonic cleaners should be used according to manufacturer's instructions.
- Ultra-sonic cleaners should be used only after gross soiling has been removed.
- Manufacturer's instructions regarding detergent selection and "degassing" should be followed.
- Only instruments made of similar materials should be combined, unless specified otherwise.
- Some instruments should not be placed in an ultra-sonic cleaner

    - Chrome-plated instruments
    - Power instruments
    - Rubber, silicone, or plastic instruments
    - Endoscopic lenses
- Instruments with lumens should be submerged and filled with cleaning solution to remove air from within the channel.
- Instruments should be thoroughly rinsed after ultra-sonic cleaning.
- A lid should be in place to prevent aerosolization of contaminants.
- Cleaning solutions should be checked between cycles and changed if visibly soiled.
- Ultra-sonic cleaners should be emptied each day, cleaned, rinsed with sterile water, and chamber wiped with alcohol or other disinfectant, as per manufacturer recommendation.

Automated washer decontaminators or disinfectors, washer/sterilizers

The amount of time necessary to efficiently clean and rinse instruments is determined according by manufacturer's instructions

Inspection of surgical instruments

- Instruments should be inspected for
    - Cleanliness
    - Alignment
    - Corrosion, pitting, burrs, nicks, and cracks
    - Sharpness of cutting edges
    - Loose set pins
    - Wear and chipping of inserts and plated surfaces
    - Missing parts
    - Any defects
    - Removal of moisture
    - Proper functioning
    - Instruments should be thoroughly dried.

Lubricants

- Use manufacturer's written instructions for selection and use of lubricants
- Instruments should be clean before lubrication.
- Lubricants should be compatible with the method of sterilization to be used.

Disinfection of Instruments

Instruments will be disinfected prior to handling in the washer disinfector following policy and procedure.

Packaging

Instruments to be processed should be packaged and sterilized according to AORN recommendations.

Sterilization

Cleaned surgical instruments should be organized for packaging to allow the sterilant to contact all exposed surfaces.

- Instruments should be placed in a container that is large enough to evenly distribute the metal mass in a single layer.

- Broad-surfaced or concave surfaced instruments should be placed on edge to facilitate drying.
- Instruments with hinges should be opened, and those with removable parts should be disassembled when placed in trays designed for sterilization, unless indicated to the contrary.
- Instruments should be kept opened and unlocked using instrument stringers, racks, or instruments pegs designed to contain instruments.
- Delicate and sharp instruments should be protected using a device such as tip protectors.
- Heavy instruments should be positioned in the bottom of the tray to prevent damage to delicate items.
- Only validated containment devices should be used to organize or segregate instruments within sets.
- Rubber bands should not be used to keep instruments together.
- Paper-plastic peel pouches should not be used inside the tray unless validated by the manufacturer.

Powered Surgical Instruments

Powered surgical instruments and all attachments should be decontaminated, lubricated, assembled, sterilized, and tested before use according to manufacturer's written instructions.

- Powered instruments and attachments should be cleaned and maintained according to manufacturer's instructions.
- Attachments should be properly affixed to instruments and tested before use.
- Trigger handles should be placed in safety position when changing attachments.
- Medical-grade compressed air or nitrogen should be used to operate air-powered equipment according to manufacturer's instructions.
- To determine the correct pressure setting, use the manufacturer's instructions.
- Only grounded outlets shall be used for electrical powered equipment.

Ophthalmic Surgical Instruments

Special precautions shall be taken before reprocessing ophthalmic surgical instruments.

- Instruments should be wiped clean with sterile water and lint-free sponge during the surgical procedure to remove viscoelastic solution, which can harden quickly.
- Instruments should be immersed in sterile water immediately at the end of the procedure.
- Single-use cannula should be used whenever possible.
- Manufacturer's instructions for cleaning each instrument should be reviewed and followed.
- Irrigation and aspiration ports, phacoemulsification hand piece, tips and tubing should be flushed before disconnecting the hand piece from the unit. (see manufacturer instructions for the Quick Rinse system)
- Intraocular lens injectors, lens inserters, should be carefully cleaned.

Insulated electrosurgical instruments

- Insulated electrosurgical instruments should be inspected for small breaks in insulation before initial use and after decontamination.
- Insulated instruments should be kept away from sharp instruments, and segregated from sharp objects after the case.

Personal Protective Equipment

Personnel handling contaminated instruments and equipment must wear appropriate personal protective equipment (PPE) and should be vaccinated against Hepatitis B virus.

- PPE consistent with the anticipated exposure should be worn.
- The appropriate PPE for this exposure should include, but not be limited to,
    - A fluid-resistant gown
    - Heavy-duty gloves
    - Mask
    - Face protection
- Hands must be washed after removing PPE**.**
- Reusable PPE must be decontaminated and the integrity of the attire checked between each use.
- Two pairs of gloves should be worn when cleaning instruments and equipment, if there is a risk for perforation.
- Personnel working with contaminated equipment should be vaccinated against the Hepatitis B virus.

Competency

Ongoing education, competency and validation of personnel facilitate the development of knowledge, skills, and attitudes that affect patient and worker safety.

Documentation

Documentation should be completed to enable the identification of trends and demonstrate compliance with regulatory and accreditation agency requirements.

- Records should be maintained for the time period specified (life of equipment plus 6 years)

PRECAUTIONS:

Care must be taken at all times to assure that no sharps, i.e., knife blades or needles are mixed in with instruments to be cleaned. Care must be taken to assure that careful handling of instruments is followed to prevent injury from sharp instruments such as towel clips, skin hooks etc.

REFERENCES:

1. Central Supply Technician Training Manual
2. AORN RP Cleaning and Care of Surgical Instruments
3. AAMI ST79
4. TJC: IC.02.01.01, IC.02.05.01
5. Title 22 Standards: 70831 (Central Sterile Supply), 70833 (Autoclaves and Sterilizers)

RECORD RETENTION AND DESTRUCTION:

Sterilization records **must** be maintained for 1 year. The recommendation is the sterilization records should be maintained for life of equipment plus 6 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

- Packaging, Wrapping, and Dating Trays and Instruments
- Precleaning and Returning of Instruments to Sterile Packaging

Supersedes: v.4 Cleaning and Care of Surgical Instruments

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Diet Texture Ordering Protocol		
Owner: DIRECTOR OF REHABILITATION	Department: Rehabilitation Services	
Scope: Inpatient Units		
Date Last Modified: 01/18/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/17/2019	

PURPOSE:

To give the discipline of Speech-Language Pathologist (SLP) privileges to adjust a patient's diet orders and swallow strategies to ensure safe swallowing.

POLICY:

1. The SLP will follow the adopted hospital diet texture manual for dietary options.

2. Upon completion of the evaluation by the SLP, the diet may be adjusted or changed with downgrades and advancements of textures including solids and liquids.

3. Diet modifications will be placed into the Electronic Medical Record (EMR) by the SLP and then sent over for the physician's signature as confirmation of the diet texture.
    a. SLP diet texture order changes need to take effect immediately with notification to physician, nursing staff, and dietary staff.
    b. All SLP dietary order changes will need physician e-signature as co-signing/confirmation within 24 hours. (SLP student interns may document in EMR, but they will not have diet management privileges or enter an SLP plan of care order).
    c. Each patient within the facility will need to have a diet order whether it is NPO, clear liquids, or full PO intake as outlined in the diet texture manual.

PROCEDURE:

1. Physician enters initial diet order on admission. All diet orders and changes are entered via the Computer Physician Order Entry system (CPOE).
2. Subsequent diet order changes may be made at the discretion of the physician.
3. Upon evaluation or re-evaluation of a patient, the SLP may adjust diet orders via a Speech/Swallow Plan of Care and in CPOE in the following scenarios:
    a. Downgrade a diet consistency (liquids and/or solids). E-signature by physician is required (i.e., changing diet from Regular consistency to Dysphagia Ground).
    b. Upgrades a diet consistency (liquids and/or solids). E-signature by physician is required (i.e., changing from Dysphagia Puree and Honey thick liquids to a Dysphagia Ground and Nectar thick liquids).
    c. Modifications in the delivery of the solids, liquids, or medications to ensure safe swallowing strategies. E-signature by physician is required (i.e., Changing diet from Dysphagia Advanced

with thin liquids to Dysphagia Advanced with thin liquids, but utilizing a small sip by cup with chin tuck and crushing the medications in applesauce).

4. Diet advancement off of NPO requires an order directly from the physician.
5. Diet upgrades or downgrades will not progress off of "Clear liquids only" (to a full liquid or Solid consistencies) or onto "Clear liquids only", as the "Clear liquids only" diet needs to be ordered or discontinued directly by a physician. However, the SLP may modify the "Clear liquid" diet with the liquid consistencies of "Thin, Nectar, or Honey thick" to reduce aspiration risk.
6. Changing a patient from a PO diet to an NPO diet also requires an order directly from the physician.
7. The SLP cannot directly order NPO or take a patient off NPO. However, the SLP may make the recommendations to do so in the Speech/Swallow Plan of Care.

REFERENCES:

1. Lippincott Procedures; "Impaired swallowing and aspiration precautions."
2. American Speech-Language-Hearing Association. (1986). *Autonomy of speech-language pathology and audiology* [Relevant Paper]. Available from www.asha.org/policy.
3. The Joint Commission; 2022 CAMCAH; PC.01.03.01

RECORD RETENTION AND DESTRUCTION:

Assessment by the Speech-Language Pathologist and dietary orders are included in the patient's medical records, which is maintained by the NIHD Medical Records Department.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Physician's Diet Orders
2. Scope of Care Rehabilitation Services

Supersedes: v.1 Diet Texture Ordering Protocol

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Focused and Ongoing Professional Practice Evaluation		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Medical Staff and Advanced Practice Providers		
Date Last Modified: 04/12/2022	Last Review Date: 08/21/2019	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/15/2016	

PURPOSE:
To clearly outline the purpose, function and procedures for Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE). This policy provides a structure for monitoring, evaluating, documenting, and reporting performance of medical staff practitioners granted clinical privileges.

POLICY:
The Northern Inyo Healthcare District (NIHD) Medical Staff, as part of the organization's ongoing commitment to quality, shall evaluate the competence of a practitioner in order to ensure safe, high quality care through focused and ongoing professional practice evaluations, by defining the circumstances requiring monitoring and evaluation of the practitioner's professional performance.

DEFINITIONS:
1. Focused Professional Practice Evaluation (FPPE) is the time limited evaluation of practitioner competence in performing a specific privilege. This process is implemented for all initially requesteds privileges and whenever a question arises regarding a practitioner's ability to provide safe, high-quality patient care.
2. Ongoing Professional Practice Evaluation (OPPE) is a document summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. Through this process, practitioners receive feedback for potential personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice in all practitioner competencies.
3. A peer is defined as an individual that is credentialed within the same specialty discipline and with the same scope of clinical privileges; an individual practicing in the same profession who has expertise in the appropriate subject matter under review.
4. Peer Case Review is an evaluation of a practitioner's professional performance for all defined competency areas using multiple data sources. Case Review is a part of OPPE. It is separate from other processes such as: root cause analysis, hospital PI, M&M conferences, or clinical management conferences.
5. Practitioner An individual permitted by law and by the organization to provide care, treatment and services without direct supervision. A practitioner operates within the scope of his or her license, consistent with individually granted clinical privileges. This may include; physicians, oral and maxillofacial surgeons, dentists, podiatrists, physicians' assistants and some Advanced Practice Registered Nurses (APRNs).
6. Practitioner Competencies: The medical staff has determined that for purposes of defining its expectations of performance, measurement of performance, and providing performance feedback for the

Joint Commission General Competencies, it will use the American College of Graduate Medical Education Framework outlined below:

a. Patient Care
   Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.
b. Medical/Clinical Knowledge
   Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.
c. Practice-Based Learning and Improvement
   Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
d. Interpersonal and Communication Skills
   Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
e. Professionalism
   Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.
f. Systems-Based Practice
   Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

7. Conflict of Interest: A member of the medical staff requested to perform OPPE evaluation may have a conflict of interest if he or she may not be able to render a fair and constructive opinion. An *absolute conflict* of interest would result if the practitioner is the provider under review or a first-degree relative or spouse. *Potential conflicts* of interest may result if the practitioner is directly involved in the patient's care but not related to the issues under review or a direct competitor, partner or key referral source. Potential conflicts may also result if the practitioner is involved in a perceived personal conflict with the practitioner under review.

   It is the obligation of the Evaluator to disclose to the Medical Executive Committee (MEC), in advance, the potential conflict. It is the responsibility of the MEC to determine on a case-by-case basis if a potential conflict is substantial enough to prevent the individual from participating.

PROCEDURE:

1. Focused Professional Practice Evaluation (FPPE)
   a. A requesting committee or person may initiate the FPPE process in the following ways:
      i. Selecting and recommending the appropriate FPPE plan on the privilege delineation form in the case of initial appointments or new privileges.
      ~~i.~~ii. Completing and submitting the Focused Professional Practice Evaluation (FPPE) Performance Monitoring Plan (PMP) to ~~either the Credentials Committee in the case of initial appointments or new privileges, or~~ the MEC~~,~~ in the case of questionable performance/outcomes.

Commented [DP1]: FPPE plans are now available on the new electronic privilege forms. The department chief selects the FPPE plan at the time of initial granting of privileges

~~ii.~~iii. A FPPE is indicated ~~on the~~as the result of an Ongoing Professional Practice Evaluation ~~and Recommendation Form, Section 1E (Recommendations)~~

~~iii.~~iv. A FPPE is indicated as the result of a ~~on th~~e Focused Professional Practice Evaluation ~~and Recommendation Form, Section 1D (Recommendations)~~

b. The FPPE for initial appointments and additional privilege grants will include proctoring and will be based on a representative number of cases as determined by the ~~Service~~ Department Chief, or designee. For ~~Allied Health Professional~~ Advanced Practice Provider members, the FPPE will include at least five proctored or reviewed cases by the sponsoring physician.
c. A FPPE may also be initiated when the performance or outcomes of a practitioner are questionable, which may become evident with the occurrence of a single or sentinel event and/or patterns or trends indicating potentially unsafe patient care. Focused review of a practitioner's performance may be requested by any Officer of the Medical Staff; ~~Service~~ Department Chief; Quality Improvement Committee; Medical Executive Committee; the Chief Executive Officer; or by the NIHD Board of Directors. If the MEC, in consultation with other appropriate committees and individuals, determines that a FPPE is warranted, then the MEC shall be responsible for defining the exact nature and scope of the FPPE. Any action, decision, finding or recommendation by the MEC shall be based upon the evaluation of the Practitioner's current clinical competence, practice behavior and ability to perform the clinical privileges under review.
d. If after the designated review period, the practitioner did not meet all FPPE requirements, then the evaluation period may be extended, a different type of evaluation process assigned, or evidence of successful proctoring from another facility may be accepted.
e. Information to be considered in a FPPE may include, but is not limited to: chart reviews monitoring clinical practice patterns, simulation, proctoring, external peer review and/or discussion with other care givers of specific patients (i.e., consulting physicians, assistants, nursing or administrative personnel).
f. External sources may be utilized in the Focused Evaluation process if there are concerns about conflict of interests or the possession of the appropriate level of experience or skill by the internal reviewers.
g. Evaluation results and recommendations are documented by the Evaluator on the Focused Professional Practice Evaluation and Recommendation Form, which shall be reviewed by the MEC and/or Credentials Committees, along with supporting documentation.
h. In the case of FPPEs generated by questionable practitioner performance, evaluation results and recommendations of the MEC shall be reported to the NIHD Board of Directors, unless the practitioner has demonstrated to the reasonable satisfaction of the MEC, implementation of recommended actions or other changes resulting in improved performance with respect to the applicable measurement and assessment activities.

2. Ongoing Professional Practice Evaluation (OPPE)
   a. The OPPE process shall begin immediately after satisfactory completion of the initial appointment FPPE process and provide continuous monitoring of practitioner's performance. Such evaluations shall be factored into credentialing, privileging and appointment decisions.
   b. An Ongoing Professional Practice Evaluation and Recommendation Form will be completed for each clinical staff member every ~~6~~ 8 months by an Evaluator. This form includes ~~ratings~~ performance measures for the following criteria (ACGME Core Competencies):
      i. Patient Care
      ii. Medical/Clinical Knowledge

Commented [DP2]: The form has changed; recommend removing reference to specific forms/sections to avoid continuous policy updates

Commented [DP3]: Recommend extending the OPPE cycle to 8-month intervals. 8 month intervals are still in compliance with the Joint Commission standards and will reduce burden on the Medical Staff Office, who will only prepare 3 OPPEs every 2 years for each practitioner, rather than 4

iii. Practice-Based Learning & Improvement
iv. Interpersonal and Communication Skills
v. Professionalism
vi. Systems Based Practice

c. An Evaluator may be the Chief of Staff, ~~Service~~ Department Chief or other designee and will be selected by the MEC. The evaluation results and recommendations of the Evaluator shall be reported to the MEC.
d. Elements for review may include, but are not limited to: operative and other clinical procedure(s) performed and their outcomes; pattern of blood and pharmaceutical usage; medical record completion; infection control results; morbidity and mortality data; patient satisfaction/complaints; additional elements of performance as defined by the department and organized medical staff. The information listed may be acquired through concurrent proctoring (direct observation), prospective proctoring/simulation, retrospective proctoring (medical record review), reciprocal proctoring (offsite/another facility), outcomes/performance measurement data review, monitoring of diagnostic and treatment techniques and/or discussion with other individuals involved in the care of each patient including consulting physicians, assistants, nursing, and administrative personnel.
e. If there are no elements available for review, the MEC may recommend continuing existing privilege(s), as long as there are no known issues/concerns regarding the practitioner. Recommendation without available elements, however, shall not occur for any two concurrent evaluations.
f. If there is uncertainty regarding the practitioner's clinical competence, practice behavior, & ability to perform the requested privileges, the organized medical staff may take actions, including, but not limited to the following: referral to ~~Medical Staff Assistance~~Physician Wellness Committee, referral/request for FPPE, reduction, revision, revocation or summary suspension of privileges, corrective and/or disciplinary actions, and should refer to the Medical Staff Bylaws for more information on specific procedures.

3. Reappointment to the Medical Staff/Renewal of Privileges
   ~~a. The Medical Staff Office shall complete OPPE Reappointment Summary form after each monitor period is reviewed by the MEC.~~
   ~~b.~~a. The Medical Staff Office will submit a completed OPPE Reappointment Summary ~~form and OPPE/FPPE Evaluations~~ and supporting documentation to the Credentials Committee during the Reappointment process. These documents shall be considered when making decisions to approve/reject reappointment to the NIHD Medical Staff or renewal of privileges of the evaluated practitioner.

REFERENCES:

1. The Joint Commission. "Medical Staff." Comprehensive Accreditation Manual for Critical Access Hospitals. Oakbook: Joint Commission Resources, 2015. MS-29-S-33. Print.
2. CNA. "Medical Staff Credentialing: Eight Strategies for Safer Physician and Provider Privileging." Vantage Point 9.3 (2009): n. pag. Web. 9 Mar. 2016. <https://www.cna.com/vcm_content/CNA/internet/Static%20File%20for%20Download/Risk%20Control/Medical%20Services/MedStaffCredentialing.pdf>.

RECORD RETENTION AND DESTRUCTION:

1. FPPE, OPPE, and Peer Review documents are confidential documents protected by California Evidence Code 1157. Documents are to be kept for the length of the practitioner's career, plus 6 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Northern Inyo Healthcare District Medical Staff Bylaws

Supersedes: v.1 Focused and Ongoing Professional Practice Evaluation*

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: High Alert Medications: Preparation, Dispensing, Storage		
Owner: Acting Director of Pharmacy	Department: Pharmacy	
Scope: District Wide		
Date Last Modified: 12/16/2021	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/2004	

PURPOSE:

To ensure that the preparation, dispensing, and storage of high alert medications occurs safely.

POLICY:

1. High Alert medications are cancer chemotherapy drugs, monoclonal antibodies for oncology, concentrated electrolytes solutions, insulin, heparin, PCA narcotics, neuromuscular blocking agents and any medications designated as High Alert by the Pharmacy and Therapeutics Committee.
2. High Alert medications will not be dispensed or prepared for dispensing without a Provider order.
3. Prior to preparation or dispensing, the pharmacist will check the diagnosis, indications, contraindications, precautions, adverse effects, dose, route of administration in an FDA sanctioned publication (e.g.: the package insert), or in an industry-recognized compendium, or in a peer-reviewed article in a recognized medical journal. This step may be skipped if the pharmacist is sufficiently familiar with the drug to judge the safety and appropriateness of the order.
4. The drug will only be prepared and dispensed if the pharmacist is satisfied of the safety and appropriateness of the drug and dose.
5. For cancer chemotherapy orders and for orders written on a Chemotherapy Orders sheet, the pharmacy Chemotherapy Compounding Policy and Procedure will be followed.
6. Prior to the final mixing of non-chemotherapy High Alert medication, the prepared dose of the medication will be double checked by another pharmacist, a pharmacy technician, or a registered nurse.

Department specific actions for High Alert Medications:

Class of Medication	Pharmacy	Nursing
Chemotherapy	Segregated in pharmacy Double check	Double check
Monoclonal Antibody (for oncology)	Segregated in Pharmacy Double check	Double check
Concentrated Electrolyte Sol.	Alert Note in Pharmacy Double check	3% Sodium Chloride 500ml in ED only, witness required.
Insulin	Double check	Double check
Heparin	Pre-mix sol (excludes Heparin Flush for line integrity)	Double check
PCA Narcotics	Double check	Double check Alert packaging
Neuro-Muscular Blocking Agent	Alert Note in Pharmacy	Alert packaging
Oxytocin	Double check	Double check Alert packaging
OB Premixed Epidural	Mixed by Pharmacist Only	Lock Box in Refrigerator Alert packaging Double check
Thrombolytic (Alteplase, TNKase)	Double check	Double check

Double check means that medication and dose are independently checked by 2 licensed practitioners.

REFERENCES:

1. The Joint Commission (CAMCAH Manual) (Jan 2022) Standard MM.01.01.01 EP 9.

RECORD RETENTION AND DESTRUCTION:

Documentation of double checks for chemotherapy are high risk medications administered by nursing workforce are contained within the medical record, which is maintained by the NIHD Medical Records Department.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Chemotherapy administration and precautions
2. Concentrated electrolytes, after hours
3. Heparin Dosing Protocol

Supersedes: v.3 High Alert Medications: Preparation, Dispensing, Storage*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Laser Safety		
Owner: DON Perioperative Services	Department: Sterile Processing	
Scope:		
Date Last Modified: 12/06/2021	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
To provide guidance to perioperative personnel for the use and care of laser equipment and to assist practitioners in providing a safe environment for patients and health care personnel during the use of laser technology. The expected outcome is that the patient will be free from signs and symptoms of injury related to the use of laser technology.

POLICY:
- A laser safety program will be established for all owned, leased, or borrowed laser equipment in any location where lasers are used in the health care organization. The program will include:
  - delegation of authority for supervising laser safety to a laser safety officer (LSO) responsible for:
    - verifying the manufacturer's hazard classification label of all lasers and laser systems;
    - performing a laser hazard evaluation before initial use;
    - overseeing the implementation of the health care laser system manufacturer's control measures;
    - developing policies and procedures for maintenance, service, and use of lasers;
    - verifying that protective equipment is available, used correctly, and free of defects;
    - ascertaining that warning signs and labels comply with the Federal Laser Product Performance Standard or international standards;
    - approving equipment and installation according to the manufacturer's instructions; and
    - coordinating laser safety and educational programs;
  - establishment of a multidisciplinary laser safety committee that includes the LSO and representatives from administration, medicine, anesthesia, nursing, and risk management;
  - establishment of use criteria and authorized procedures for all health care personnel working in laser nominal hazard zones;
  - identification of laser hazards and appropriate administrative, engineering, and procedural control measures;
  - education of personnel regarding the assessment and control of hazards; and
  - management and reporting of accidents or incidents related to laser procedures, including creating action plans to prevent recurrences.
- All personnel will know where lasers are being used, and access to these areas will be controlled.
- Patients and personnel in the laser treatment area will be protected from unintentional laser beam exposure.
- All people in the nominal hazard zone will wear appropriate eyewear selected and approved by the LSO.
- Potential hazards associated with surgical smoke generated in the laser practice setting will be identified and safe practices established.
- All people in the laser treatment area will be protected from electrical hazards associated with laser use.
- All people in the laser treatment area will be protected from flammable hazards associated with laser use.

PROCEDURE

- The laser treatment area will be identified with laser warning signs and access controlled to prevent unintentional exposure to the laser beam.
  - The LSO will determine the nominal hazard zone by referencing ANSI Z136.1 and ANSI Z136.3, as well as the safety information supplied by the laser manufacturer.
  - Clearly marked and recognizable warning signs specific to the type of laser being used and designed according to the information described in ANSI Z136.3 will be placed at all entrances to laser treatment areas when lasers are in use.
  - Doors in the nominal hazard zone will remain closed and windows, including door windows, will be covered as appropriate to the type of laser being used with a barrier that blocks transmission of a beam.
- Accidental activation or misdirection of the laser beam will be prevented by
  - restricting access to laser keys to authorized personnel who are skilled in laser operation;
  - placing lasers in standby mode when not in active use;
  - placing the laser foot switch in a position convenient to the operator with the activation mechanism identified;
  - allowing only the laser user to activate the foot pedal of the laser device;
  - using the emergency shutoff switch to disable the laser in case of a component breakdown or untoward event; and
  - protecting exposed tissues around the surgical site with saline-saturated materials (eg, towels, sponges) when lasers with a thermal effect are being used.
- The laser assistant (eg, RN, laser technician) must not have competing responsibilities that would require leaving the laser unattended during active use.
- Everyone in the nominal hazard zone will wear protective eyewear or use filters of specific wavelength and optical density for the laser in use.
  - Eyewear will be labeled with the appropriate optical density and wavelength for the laser in use.
  - Laser shutters or filters with the appropriate optical density will be used on microscopes, microscope accessory oculars, and endoscope viewing ports to protect the laser user from laser exposure.
  - Patients' eyes and eyelids will be protected from the laser beam.
    - Patients who remain awake during laser procedures will wear goggles or glasses designated for the type of laser being used.
    - Patients undergoing general anesthesia will be provided with appropriate protection, such as wet eye pads or laser-specific eye shields, as approved by the LSO.
    - Patients undergoing laser treatments on or around the eyelids will have their eyes protected by metal corneal eye shields that are approved by the US Food and Drug Administration (FDA).
- Surgical smoke will be removed by use of a smoke evacuation system in both open and minimally invasive procedures to prevent occupational exposure to laser-generated airborne contaminants.
  - When surgical smoke is generated, an individual smoke evacuation unit with a 0.1 micron filter (eg, ultra-low particulate air [ULPA] or high-efficiency particulate air [HEPA]) will be used to remove surgical smoke.
  - The capture device (eg, wand, nonflammable suction tip) of the smoke evacuation system will be positioned as close as possible, but no greater than two inches, from the source of the smoke.
  - Used smoke evacuator filters, tubing, and wands will be handled using standard precautions and disposed of as biohazardous waste.
  - Personnel will wear respiratory protection (eg, fit-tested surgical N95 filtering face piece respirator or high-filtration surgical mask) during procedures that generate surgical smoke.
- Laser systems and equipment will be evaluated for electrical hazards and approved by the LSO before they are placed in service.
- The manufacturer's directions for laser installation, operation, and maintenance and recommendations for electrical plugs and outlets will be followed.

- Laser service and preventive maintenance will be performed in accordance with the manufacturer's guidelines on a regular basis by qualified personnel who have knowledge of laser systems.
- Fire safety measures will be implemented when lasers are in use according to local, state, and federal regulations.
    - The laser will not be activated in the presence of flammable agents (eg, alcohol-based skin antiseptics, tinctures, de-fatting agents, collodian, petroleum-based lubricants, phenol, aerosol adhesives, uncured methyl methacrylate) until the agents are dry and vapors have dissipated.
    - Caution will be used in the presence of combustible anesthetic gases during surgery on the head, face, neck, and upper chest.
    - Sponges and drapes near the surgical site will be kept moist.
    - The lowest possible oxygen concentration that provides adequate patient oxygen saturation will be used.
    - Surgical drapes will be arranged to minimize the buildup of oxidizers (eg, oxygen, nitrous oxide) under the drapes.
    - Wet towels and saline will be available on the sterile field.
    - The LSO will determine the type of extinguishers needed for each specific laser based on manufacturers' instructions and recommendations.
    - Laser-resistant endotracheal tubes will be used during laser procedures involving the patient's airway or aerodigestive tract.
    - Endotracheal tube cuffs will be inflated with normal saline with dye (eg, methylene blue) during laser procedures involving the patient's airway or aerodigestive tract.
    - Moistened packs will be placed around the endotracheal tube and kept moist throughout the procedure.

DOCUMENTATION

Documentation will be completed to demonstrate compliance with local, state, and federal regulations.

- The following information will be documented in the perioperative record by the perioperative RN:
    - patient identification;
    - the type of laser used (eg, wavelength, serial or biomedical number);
    - laser settings and parameters;
    - safety measures implemented during laser use;
    - the operative or invasive procedure;
    - on/off laser activation and de-activation times for head, neck, and chest procedures; and
    - patient protection (eg, eyewear, eye shield).
- A laser safety checklist will be completed by the laser assistant and will include:
    - performing a laser self-test check before the patient is brought into the OR or procedure room,
    - calibrating the laser if needed,
    - conducting a test fire of the laser,
    - posting "laser in use" signs at all entrances of the OR or procedure room,
    - providing appropriate eyewear for the patient and personnel,
    - covering the windows of the OR or procedure room as needed,
    - checking the availability of saline at the surgical field, and
    - checking the appropriate type of fire extinguisher for the laser being used.
- The following information will be documented in the laser log by the laser assistant:
    - patient identification;
    - the type of laser, model number, serial number, and the health care organization-biomedical number;
    - the procedure(s) performed with laser;
    - names and titles of personnel in the room;
    - completed laser safety checklists;
    - the number of joules used;
    - the total energy used; and

- the wattage used.

COMPETENCY

- Perioperative personnel working in laser environments will receive education and complete validation activities on laser systems used and procedures performed in the facility, including:
  - the established laser safety program;
  - new laser equipment, accessories, or safety equipment purchased or brought into the facility; and
  - fire hazards associated with laser use, airway fire management, and fire drills.
- The LSO will complete a formal medical laser safety course and obtain certification.

GLOSSARY

American National Standards Institute (ANSI): Organization that provides guidance for the safe use of lasers for diagnostic and therapeutic uses in health care facilities. ANSI facilitates the development of consensus US standards and administers a system that assesses conformance to standards such as the ISO 9000 (quality) and ISO 14000 (environmental).

High-efficiency filter or *high-efficiency particulate air filter (HEPA):* Filters having a filtration rating of 0.3 microns at 99.7% efficiency.

Laser: Device that produces an intense, coherent, directional beam of light by stimulating electronic or molecular transitions to lower energy levels. Laser is an acronym for "light amplification by stimulated emission of radiation."

Laser assistant: Sets up the laser and runs the laser console to control the laser parameters under the supervision of the laser user.

Laser safety officer (LSO): Responsible for affecting the knowledgeable evaluation of laser hazards and authorized and for monitoring and overseeing the control of such laser hazards.

Laser treatment area: Area in which the laser is being operated.

Laser user: The laser user is employing the laser for its intended purpose within the user's scope of practice, education, and experience.

Nominal hazard zone: The space in which the level of direct, reflected, or scattered radiation used during normal laser operation exceeds the applicable maximum permissible exposure.

Optical density: The ability of laser protective eyewear to absorb a specific laser wavelength.

Ultra-low particulate air (ULPA) filter: Theoretically, a ULPA filter can remove from the air 99.9999% of bacteria, dust, pollen, mold, and particles with a size of 120 nanometers or larger.

REFERENCES:

- Petersen C, ed. *Perioperative Nursing Data Set*. 3rd ed. Denver, CO: AORN, Inc; 2010.
- Recommended practices for laser safety in perioperative practice settings. In: *Perioperative standards and Recommended Practices*. Denver, CO: AORN, Inc: 2013:143-156.
- ANZ136.3-2005: *Safe Use of Lasers in Health Care Facilities*. Washington, DC: American National Standards Institute; 2005.
- ANZ136.1-2007: *Safe Use of Lasers*. Washington, DC: American National Standards Institute; 2007.

CROSS REFERENCED POLICIES AND PROCEDURES:

- Argon Laser Safety

RECORD RETENTION AND DESTRUCTION:

Documentation in medical record is maintained per the Medical Record Department at NIHD.

Supersedes: v.1 Laser Safety

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Medical Staff Professional Conduct Policy		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Medical Staff and Advanced Practice Providers		
Date Last Modified: 03/14/2022	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/19/2013	

PURPOSE: The purpose of this policy is to ensure safe patient care by promoting a cooperative and professional healthcare environment, and to create a fair process for communicating and addressing complaints regarding behavioral concerns of privileged practitioners at Northern Inyo Healthcare District (NIHD).

POLICY: All ~~Medical Staff members~~practitioners shall conduct themselves at all times while on ~~Hospital~~ District premises in a courteous, professional, respectful, collegial, and cooperative manner. This applies to interactions and communications with or relating to Medical Staff colleagues, ~~AHPs~~Advanced Practice Providers (APPs), nursing and technical personnel, other caregivers, other ~~Hospital~~ District personnel, patients, patients' family members and friends, visitors, and others. Such conduct is necessary to promote high quality patient care and to maintain a safe work environment. Inappropriate~~Disruptive~~, discriminatory, or harassing behavior, as defined below, ~~are~~ is prohibited ~~and will not be tolerated~~.

DEFINITIONS:

1. **"Discrimination"** is conduct directed against any individual (e.g., against another Medical Staff member, ~~AHP~~APP, ~~Hospital~~ District employee, or patient) that deprives the individual of full and equal accommodations, advantages, facilities, privileges, or services, based on the individual's race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, or sexual orientation.
2. **"Sexual harassment"** is unwelcome verbal or physical conduct of a sexual nature, which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory or sexual-themed cartoons, drawings or posters) that is deemed severe or pervasive by the "reasonable person" standard (as per the U.S. Equal Employment Opportunity Commission). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct indicating that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

3. **"~~Disruptive~~ Inappropriate Behavior"** is marked by disrespectful behavior manifested through personal interaction with practitioners, ~~Hospital~~ District personnel, patients, family members, or others, which:
    a. interferes, or tends to interfere with high quality patient care or the orderly administration of District operations ~~the Hospital~~ or the Medical Staff; or
    b. creates a hostile work environment; or
    c. is directed at a specific person or persons, would reasonably be expected to cause substantial emotional distress, and serves no constructive purpose in advancing the goals of health care.

    Examples of prohibited~~, disruptive conduct~~ inappropriate conduct may include, but are not limited to, any of the conduct~~s~~ described below if it is found to interfere, or tends to interfere, with patient care or the orderly administration of the ~~Hospital~~ District or Medical Staff; or, if it creates a hostile work environment; or, if it is directed at a specific person or persons, causes substantial emotional distress, and has no legitimate purpose:
    a. Any striking, pushing, or inappropriate touching of ~~Hospital Staff~~District staff or others;
    b. Any conduct that would violate Medical Staff and/or ~~Hospital~~ District policies relating to discrimination and/or sexual harassment;
    c. Forcefully throwing, hitting, pushing, or slamming objects in an expression of anger or frustration;
    d. Yelling, screaming, or using an unduly loud voice directed at patients, ~~Hospital~~ District employees, other practitioners, or others;
    e. Refusing to respond to a request by any caregiver for orders, instructions, or assistance with the care of a patient, including, but not limited to, repeated failure to respond to calls or pages;
    f. Use of racial, ethnic, epithetic, or derogatory comments, or profanity, directed at ~~Hospital~~ District employees or others;
    g. Criticism which is unreasonable and unprofessional of ~~Hospital~~ District or Medical Staff personnel (including other practitioners), policies or equipment, or other negative comments that undermine patient trust in the ~~Hospital~~ District or Medical Staff in the presence or hearing of patients, patients' family members, and/or visitors;
    h. Use of medical record entries to criticize ~~Hospital~~ District or Medical Staff personnel, policies, or equipment, other practitioners, or others;
    i. Unauthorized use and/or disclosure of confidential or personal information related to any employee, patient, practitioner, or other person;
    j. Use of threatening or offensive gestures;
    k. Intentional filing of false complaints or accusations;
    l. Any form of retaliation against a person who has filed a complaint against a practitioner alleging violation of the above standard of conduct;
    m. Use of physical or verbal threats to ~~Hospital~~ District employees, other practitioners, or others, including, without limitation, threats to get an employee fired or disciplined;
    n. Persisting to criticize, or to discuss performance or quality concerns with particular District ~~Hospital~~ employees or others after being asked to direct such comments exclusively through other channels;
    o. Persisting in contacting a District ~~Hospital~~ employee or other person to discuss personal or performance matters after that person or a supervisory person, the Chief Executive Officer, ~~("CEO"),~~ or designee, or Medical Staff leader, has requested that such contacts be discontinued

[NOTE: ~~Medical Staff members~~Practitioners are encouraged to provide comments, suggestions and recommendations relating to ~~hospital~~ District employees, services or facilities; where such information is provided through appropriate administrative or supervisory channels];

~~o.~~

p. Obstructing the peer review process by intentionally refusing, without justification, to attend meetings or respond to questions about the practitioner's conduct or professional practice when the practitioner is the subject of a focused review or investigation.

PROCEDURE:

1. ~~Hospital~~ District Staff Response ~~to disruptive or discriminatory behavior or sexual harassment~~ ("Walk Away Rule")
    a. Any ~~Hospital~~ District employee ~~("Caregiver")~~ who believes that he or she is being subjected to ~~disruptive~~ inappropriate or discriminatory behavior or sexual harassment within the meaning of this Policy by a Medical Staff ~~member~~ privileged practitioner is authorized and directed to take the following actions:
        i. Promptly contact ~~the Caregiver's~~his/her immediate supervisor or Human Resources to report the situation and to arrange for the transition of patient care as appropriate ~~necessary~~ in order to permit the ~~Caregiver~~ employee to avoid conversing or interacting with the practitioner;
        ii. Discontinue ~~all conversation or~~ interaction with the practitioner except to the extent necessary to transition patient care responsibility safely and promptly from the ~~Caregiver~~ employee to another qualified person as directed by the ~~Caregiver's~~ employee's supervisor;
        ~~Continue work or patient care activity elsewhere as directed; and~~
        iii. Consult with supervisory personnel or with the Director of Human Resources about filing a written report of the alleged incident.

~~2. All complaints alleging disruptive discriminatory or unsafe behavior by members of the Medical Staff or Allied Practitioner staff shall be documented and handled as provided in the Medical Staff's Practitioner Complaint Policy.~~

2. Handling of Complaints
    a. All complaints and related documentation in which the subject of the complaint is a privileged practitioner will be directed to the Medical Staff Office. The Medical Staff Office will review the complaint and forward it for review as follows:

        i. For complaints involving concerns about quality of care, the patient encounter and related information will be submitted for peer review through the relevant Department Chief(s) or designee, following the normal peer review process. If determined to need additional review, the case may be referred to committee (standing or ad hoc), external peer review, recommendation for Focused Professional Practice Evaluation (FPPE) or other appropriate action. Any adverse privilege actions as a result of peer review will comply with the procedures detailed in the Medical Staff Bylaws.

        ii. For complaints involving behavioral concerns suspected to be related to impairment (physical, emotional, or psychiatric), the review will be delegated to the Physician Wellness Committee after consultation with the Chief of Staff.

iii. For complaints involving behavioral concerns not suspected to be related to impairment, including reports of discriminatory behavior or sexual harassment, the report will be submitted to the Chief of Staff, Department Chief, or designee for review. The reviewer (or designated ad hoc committee) will make a reasonable effort, through personal interviews and/or other fact-finding activities, to determine whether the allegations are credible. If it is determined that a formal corrective action investigation may be needed, the case should be referred to the Chief of Staff and/or Medical Executive Committee for determination and proper notice procedures as per the Medical Staff Bylaws.

iv. For any complaint involving any conduct such that failure to take immediate action may result in an imminent danger to the health of any individual, the Chief of Staff, Medical Executive Committee, or Chief of the Department may summarily restrict or suspend the individual's clinical privileges under the procedures further outlined in the Medical Staff Bylaws. The Chief Medical Officer and/or Administrator On-Call shall be notified of such summary restriction or suspension.

b. Practitioners who are the subject of a complaint shall be provided a summary of the complaint, either verbally or in writing, in a timely fashion (in no case more than 30 days from receipt of the complaint by the Chief of Staff, Department Chief, or designee). The practitioner shall be offered an opportunity to provide a written response to the complaint and any such response will be kept along with the original complaint.

c. Practitioners will be notified that attempts to confront, intimidate, or otherwise retaliate against the complainant is a violation of Medical Staff Professional Conduct Policy and may result in corrective action against the practitioner as further detailed in the Medical Staff Bylaws.

d. If the practitioner signs an agreement to keep the complaint and related information in strict confidence and to use the information exclusively within the formal Medical Staff peer review process, he or she may review a copy of the complaint and any supporting documentation submitted with the complaint by the complainant, with names redacted, in the Medical Staff Office.. The practitioner may not photograph or keep a copy of the complaint (see attached **Confidentiality Agreement**).

3. Progressive Discipline for Verified Inappropriate Behavior

a. If this is the first incident of verified inappropriate behavior the Chief of Staff or designee shall discuss the matter with the subject of the complaint, emphasizing that the behavior must cease. The subject of the complaint may be asked to apologize to the complainant. The approach during this initial intervention should be collegial and helpful.

b. Further isolated incidents that do not constitute persistent, repeated inappropriate behavior will be handled by providing the subject of the complaint with notification of each incident, and a reminder of the expectation he or she comply with Medical Staff Professional Conduct Policy.

c. If it is determined that there is repeated inappropriate behavior, a letter of admonition will be sent to the practitioner, and, as appropriate, a rehabilitation action plan developed by the Chief of Staff or Department Chief, with the advice and counsel of the Medical Executive Committee as indicated.

d. If in spite of admonition and intervention, inappropriate behavior recurs, the Chief of Staff or designee shall meet with and advise the practitioner such behavior must immediately cease or corrective action (as per the Medical Staff Bylaws) will be initiated. This "final warning" shall be sent to the practitioner in writing.

e. If after the "final warning" the behavior recurs, corrective action shall be initiated pursuant to the Medical Staff Bylaws.

4. Documentation and Records
   a. It is the responsibility of the Medical Staff Office to track the progress of all complaints and keep accurate records of any resolutions in the practitioner's quality file. All complaints (excepting any complaints that were found to have no substance or validity during the review process) will be reviewed at the time of re-credentialing and as part of the practitioner's periodic Ongoing Professional Practice Evaluation (OPPE).

   b. Complaints and all related investigation documents and reports shall be identified and maintained as confidential peer review documents protected under Evidence Code 1157.

REFERENCES:

1. Stanford Healthcare (2019). Medical Staff Code of Professional Behavior. Stanford, CA. Director of Medical Staff Services.

RECORD RETENTION AND DESTRUCTION:

1. Documentation of complaints and related records are to be kept for the length of the practitioner's career, plus 6 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Northern Inyo Healthcare District Medical Staff Bylaws

Supersedes: v.2 Professional Conduct. Prohibition or Discriminatory Behavior; v.1 Practitioner Complaint Resolution Process

Northern Inyo Healthcare District QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT (QAPI)

PLAN

CY 2022

SECTION 1: INTRODUCTION

PURPOSE

The Quality Assurance and Performance Improvement (QAPI) Plan establishes a District-wide program for an interdisciplinary and ongoing approach to monitor, assess, and improve patient care and services at Northern Inyo Healthcare District (NIHD). The QAPI Plan is designed to support the Mission, Vision, and Values of the District and collectively drive the safety and quality of patient care services provided.

MISSION, VISION AND VALUES

Northern Inyo Healthcare District (NIHD) mission statement is as follows:

Improving Our Communities one life at a time. One Team. One Goal. Your Health.

Northern Inyo Healthcare District Vision Statement as follows:

Northern Inyo Healthcare District will be known throughout the Eastern Sierra Region for providing high quality, comprehensive care in the most patient friendly way, both locally and in coordination with our trusted partners.

CORE VALUES: COMPASSION AND INTEGRITY

This set of values are the foundation that defines who will choose to dedicate themselves to the well-being of others.

ASPIRATIONAL VALUES: QUALITY/EXCELLENCE AND INNOVATION

This set of values drives the District to work towards making tomorrow's healthcare better than yesterday's healthcare.

PERMISSIVE VALUES: TEAM-BASED AND SAFETY

These are the values without which a patient would not allow the District to engage in her/his care.

SCOPE OF SERVICE AND AUTHORITY

The scope of this plan will include all patient care and support services throughout the District. The plan will measure, analyze, and track performance improvement indicators and other aspects of the quality of care. The plan reviews the District's operating systems and processes of care to identify and implement opportunities to provide high quality and safe care, focusing on improving health outcomes as well as preventing and reducing medical errors.

NIHD's Board of Directors is responsible for this plan, which supports the mission, vision, and values of the District and is ultimately responsible for ensuring that the QAPI Plan activities are met. The Board of Directors delegates the development, implementation, and sustainability of the plan to the Quality Council, Quality Department, and Executive Team.

NIHD's Executive Team delegates the implementation of the QAPI Plan to the Quality Council and Quality Department. The Executive Team ensures resources are available for the implementation of quality and performance improvement activities.

NIHD's medical staff is responsible for participating in the QAPI Plan to achieve quality and safe patient care. Medical staff members contribute to the QAPI Plan through involvement in performance improvement activities, serving on committees, working on project teams, and through taking on leadership roles.

DEFINITIONS AND PRINCIPLES

QUALITY SERVICES

Quality services are services that are provided in a safe, effective, patient-centered, timely, efficient and equitable fashion.

- SAFE: Avoiding injuries to patients from the care that is intended to help them.
- EFFECTIVE: Providing services based on scientific knowledge to those who would benefit, and refraining from providing services from those not likely to benefit.
- PATIENT-CENTERED: Providing care that is respectful of, and responsive to, individual patient preferences, needs, and values.
- TIMELY: Reducing delays in providing and receiving healthcare.
- EFFICIENT: Avoiding waste, including waste of equipment, supplies, ideas and energy.
- EQUITABLE: Providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status.

ADVERSE EVENT

Adverse event is an untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof.

ERROR

Error means the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems.

MEDICAL ERROR

Medical error means an error that occurs in the delivery of healthcare services.

PERFORMANCE IMPROVEMENT PRINCIPLES

Performance improvement is a systematic approach to assessing services and improving them on a priority basis. The District's approach to performance improvement is based on the following principles:

- *Patient Focused*. Every level of service shall be viewed from the perspective of the patient. With this frame of mind District will focus on the patient experience and how best to adopt changes that enhance the experience.
- *Workforce Engagement*. All NIHD workforce shall participate in ongoing quality improvement Workforce members shall understand that along with ownership of how they engage those who contact or present to the District they also are empowered to identify issues, bring those issues to the attention of others, and participate in processes intended to prevent the issue or improve the experience.
- *Leadership Involvement*. District Leadership along with Medical Staff will serve as 'Champions' of initiatives. As Champions, they will support and encourage the goals and provide necessary intervention when needed to reach these goals. Additionally, District leadership will ensure that the employees engaged in any given quality initiative have the tools, support and resources needed to achieve the defined goals.
- *Data Informed Practice*. The District utilizes data to identify opportunities, determine priorities, and evaluate the effectiveness of quality projects with the appropriate resources.
- *Statistical Tools*. The District will apply standard statistical tools to the data collected in order to generate information that is both informative and actionable.
- *Prevention over Correction.* Although this QAPI plan will provide for the identification of existing issues/concerns and correcting them, the goal of this QAPI plan is to emphasize the identification of potential areas of concern to prevent quality of care issues from arising.
- *Continuous Improvement.* The District will commonly use Plan-Do-Study-Act method of continuous improvement. This however will not be the exclusive method used. Each endeavor undertaken will warrant an assessment of the best method available to achieve the desired goal.

SECTION 2: PROGRAM STRUCTURE

LEADERSHIP

The key to the success of the performance improvement process is leadership. Leaders foster teamwork and provides support to the quality improvement goals, objectives, and activities.

Leadership utilizes performance improvement methodology to identify opportunities for improvement and to monitor the effectiveness, safety, and quality of services provided. They accomplish this by:

- Implementing quality and performance activities that align and support the QAPI Plan.
- Reporting and monitoring indicators on departmental pillars/scorecards.
- Communicating and sharing results of measurement activities and overall performance.

The Quality Department and Quality Council provide ongoing operational oversight of the quality and performance improvement activities at the District.

The Quality Department drives the development of quality and performance improvement activities at the District and participates in committees and project teams related to improving quality of care. The

department assists the District in fulfilling its responsibilities to assure patients receive quality care which also complies with regulatory and accreditation organizations. It does this by:

- Developing the annual QAPI Work Plan and collaborating with the Quality Council on the annual review of the QAPI Plan.
- Establishing measurable objectives based upon priorities identified through use of established criteria for improving quality and safety of services.
- Continuously monitoring regulatory standards and District performance.
- Identifying opportunities for improvement and presenting recommendations to the Quality Council for project approval.
- Supporting quality improvement activities.
- Monitoring progress until goals have been met and maintained.
- Standardizing processes to achieve quality improvement in patient care services.

The Quality Council guides and monitors the quality management efforts throughout the District and coordinates quality improvement efforts with the medical staff.
The Quality Council fulfills such responsibility by:

- Evaluating and making recommendations for improvement to the QAPI Plan.
- Reviewing and assessing feasibility of requests for quality related projects.
- Appointing subcommittees or teams to work on specific quality projects as necessary.
- High level trending of data to identify opportunities for improvement.
- Prioritizing QAPI projects and making recommendations to the Executive Team.
- Overseeing the progress of quality projects to assure timely implementation.
- Utilizing regulatory requirements to identify opportunities for improvement.

WORKFORCE MEMBERS

The Northern Inyo Healthcare District Workforce, including the medical staff, play a vital role in the QAPI Plan. The workforce participates and contributes to the Plan through their delivery of quality of care. Workforce members may be asked to participate in committees, project teams and other initiatives.

Workforce members, including individual members of the medical staff, are invited to bring forth ideas and suggestions for performance improvement activities to their department leaders, chairs or directly to the Quality Council.

GOALS & OBJECTIVES

The goals of the QAPI Plan are to assess the services provided by the District, including contracted services, identify quality and performance opportunities, implement improvement activities and ensure monitoring and sustainability of activities. The QAPI Plan takes a pro-active approach at identifying priorities and aligns with the District Strategic Plan on quality improvement and safety.

The following objectives have been established as long-term goals of the QAPI Plan.

- To evaluate and improve performance measurement systems to assess key processes or outcomes.
- To bring leaders, clinicians, and staff together to review data and clinical adverse occurrences to identify problems.
- To carefully prioritize identified problems or desired projects and set goals for their resolution.

- To achieve measurable improvement in highest priority areas for the selected goals.
- To meet internal and external reporting requirements.

Annually, a Work Plan is established to address the goals and objectives that have been identified as high priority, high volume, or high risk areas. NIHD also prioritizes activities related to improved health outcomes and the prevention and reduction of medical errors, adverse events, acquired conditions and infections, and transition of care.

SECTION 3: PERFORMANCE IMPROVEMENT METHODOLOGY

PERFORMANCE MEASUREMENT

Performance measurement is the process of regularly assessing the results produced by the District. It involves identifying and selecting indicators of processes, system, and outcomes that are integral to the performance of the service delivery system, and analyzing information related to these indicators on a regular basis. Performance improvement involves taking action as needed based on the results of the data analysis and the opportunities for performance improvement they identify.

The purpose of the measurement and assessment is to:

- Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level.
- Identify problems of a process or outcome.
- Assess the outcome of the care provided.
- Assess whether a new or improved process meets performance expectations.

Measurement and assessment involves:

- Selection of a process or outcome to be measured.
- Identification and/or development of performance indicators for the selected process or outcome to be measured.
- Aggregating data so that it is summarized and quantified to measure a process or outcome.
- Assessment of performance with regard to these indicators at planned and regular intervals.
- Taking action to address performance discrepancies when indicators show that a process is not stable, is not performing at an expected level or represents an opportunity for improvement.
- Reporting within the organization on findings, conclusions and actions taken as a result of performance assessment.

PERFORMANCE INDICATORS

A performance indicator, otherwise known as a metric or measure, is a quantitative tool that provides information about the performance of a department's process, services, functions, or outcomes.

Selection of a Performance Indicator is based on the following considerations:

- Alignment with and support of NIHD's mission, vision, and/or values
- Regulatory/accreditation requirement
- Clinical Importance that involves areas or processes that are problem prone, high risk, and/or high volume

- Scientific foundation: Relationship between the indicator and the process, system or clinical outcome.
- Validity: Whether the indicator assesses what it purports to assess
- Meaningfulness: Whether the results of the indicator can be understood, the indicator measures a variable over which NIHD has control, and the variable is possible to change by reasonable performance improvement efforts.
- Availability of industry benchmarks

For the purpose of this plan, performance indicators are tracked and monitored by the Quality department. Measurement of the metrics may be District-wide in scope, targeted to specific areas, departments, services, or selected populations.

The measurements may be ongoing, time limited, intensive, or recurring. The duration and frequency of monitoring are based on the need of the organization, external requirements, and based on the results of the data analysis.

DATA ANALYSIS & ASSESSMENT

Data analysis is completed through the collection and compilation of information. Internal and external collection is used for monitoring performance and ultimately guide the QAPI Plan in data informed decision making.

Assessment is accomplished by comparing actual performance on an indicator with:

- Trends over time.
- Pre-established standards, goals, benchmarks, or expected levels of performance.
- Evidence-based practices.
- Other hospitals, clinics, or similar service providers.

Data will be assessed for patterns, trends, and/or variations that may identify opportunities for improvement. Data analysis may also be necessary when performance levels or variation indicate a serious event, such as the following:

1. A sentinel event has occurred, triggering a root cause analysis.
2. Performance varies significantly from that of other organizations or recognized standards.

SECTION 4: PERFORMANCE IMPROVEMENT INITIATIVES

The purpose of an initiative is to improve the performance of existing services, quality of care, or to design a new service.

Opportunities for improvement (OFI) may be identified and prioritized by the Quality Council through several means, including:

- Results, actions, or recommendation from internal reporting of events (i.e. Unusual Occurrence Reports).
- Results, responses, and status of regulatory and accreditation surveys or District tracer activities.
- Results of operational or process audits.
- Actions and improvements of Root Cause Analyses and/or Failure Modes Effects (and Criticality) Analyses (FMEAs/FMECAs).

SECTION 5: QAPI PLAN EVALUATION

An evaluation of the QAPI plan will be completed on an annual basis. This evaluation and subsequent report will be completed by the Quality Department and Quality Council and presented to the Executive Team and Board of Directors for review and approval.

The evaluation will summarize the goals and objectives of NIHD's QAPI plan and the performance improvement activities conducted during the past year. QAPI annual reports will include:

- Summary of progress towards meeting annual goals and objectives.
- Brief summary of the findings for each of the indicators used during the year, including both the outcomes of the measurement process and the conclusions and actions taken in response to these outcomes.
- Summary of progress for performance improvement initiatives and projects including project activities, outcomes, and status.
- Recommendations for actions needed to improve the QAPI plan effectiveness.

REFERENCES:

1. Center for Medicare & Medicaid Services. Conditions of Participation: Quality Assessment and Performance Improvement Program, §485.641.
2. Dixon, L. (2021, March 23) *CMS Hospital Conditions of Participation (CoP) QAPI Standards and Worksheet* [Webinar]. Healthcare Risk Education and Consulting, LLC.
3. The Joint Commission. *Comprehensive Accreditation Manual for Critical Access Hospitals* (2022). LD.01.03.01, PI.01.01.01, PI.02.01.01, PI.03.01.01, PI.04.01.01.

CROSS REFERENCE POLICY & PROCEDURE:

1. InQuiseek - #500 Program Evaluation Policy
2. InQuiseek - #510 Quality Assurance and Utilization Review
3. InQuiseek – 530 Risk Management Policy

Committee Approval	**Date**
Quality Council	**6/5/2020**
Medical Executive Committee	**05/11/2021**
Board of Directors	**08/19/2021**
Last Board of Director Review	**08/19/2021**

- Developed: 10/19ta
- Reviewed:
- Revised: 5/2020ta, 2021AF, 2022 AF,MG,

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Safe Patient Handling – Minimal Lift Program		
Owner: EMPLOYEE HEALTH INFECT PREV SPEC	Department: Employee Health	
Scope: Clinical Staff District Wide		
Date Last Modified: 04/13/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/01/2014	

PURPOSE:

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

POLICY:

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

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

8. Any injury resulting from patient lifting or positioning, including strains, sprains, or any other muscular skeletal injury must be handled according to the Work related Accidents Policy.
9. If a patient is unable to assist the HCW with repositioning or transfers, then the lifting and moving of the patient will be done with minimum of two person assist with or without the use of an assistive device.
10. Transferring patients out of any inpatient unit, and/or ED, on a gurney or bed, to and from the Imaging Department will be done with a minimum of two-person assistance. One person will act as the lead directing the second person for any assistance needed throughout the transport.

~~10.~~ If a patient is being transferred on a gurney, on a flat surface to any inpatient unit or PACU/OR, it is permissible for one person to perform the transport. ~~Transferring patients out of the unit on a gurney or bed to the Radiology Department will be done with a minimum of two-person assistance. If transferring a patient on a gurney, on a flat surface to any inpatient unit or PACU/OR is permissible for 1 person to transport a patient on a gurney.~~

DEFINITIONS:

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

PROCEDURE:

A. Direct Patient Care Employee Responsibility
   1. Take responsibility for their own health and safety, as well as that of their co-workers and their patients during patient handling activities.
   2. Complete initial training and annual training as required.
      a. Complete additional training to correct improper use/understanding of safe patient handling and movement.
      b. Notify manager of need for re-training in the use of patient handling equipment and aids.
   3. Assess patient for condition and ability to cooperate with transfer and appropriate level of patient assist.
      a. Identify and avoid hazardous manual patient handling and movement tasks whenever possible.
   4. Use proper techniques, mechanical lifting devices, and other approved equipment and/or aids during performance of high risk patient handling tasks.
   5. Promptly report to manager or shift supervisor any injury without fear of negative consequence.
   6. Follow procedures for reporting patient handling equipment in need of repair.

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

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

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

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

F. Reporting of Injuries:
   1. Employees are required to follow the Work related Accidents Policy for any patient handling injury event
   2. Employees who are non-compliant with the Safe Patient Handling Policy must be re-trained and demonstrate competency in equipment use before returning to work. Continued failure to use proper patient handling practices may result in corrective action up to and including termination.

REFERENCES:

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

RECORD RETENTION AND DESTRUCTION:

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

CROSS REFERENCED POLICIES AND PROCEDURES:

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

Supersedes: v.3 Safe Patient Handling – Minimal Lift Program

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Sentinel Event/Serious Harm Reporting and Prevention		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 02/04/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/05/2012	

PURPOSE:

1. To have a positive impact in improving patient care, treatment and services and in preventing unintended harm.
2. When a sentinel event/serious adverse event occurs, to focus attention on efforts to understand the factors that contributed to the event and to change the hospital's culture, systems and processes in order to reduce the probability of such an event in the future.
3. To increase the general knowledge about patient safety events, their contributing factors and strategies for prevention of errors.
4. To maintain the confidence of the public (community) and Northern Inyo Healthcare District (NIHD) workforce that patient safety is a priority.
5. To outline the reporting requirements and process as required by California Department of Public Health (CDPH) and The Joint Commission (TJC).

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. An appropriate action plan should demonstrate the following:

a. Identification of changes that can be implemented to reduce risks, or formulates a rationale for not undertaking such changes.
b. The plan should address responsibility for implementation, oversight, pilot testing as appropriate, time-lines, and strategies for measuring the effectiveness of the actions.

Adverse event:

An unplanned or unusual deviation in the patient care process.

Close call: (or "Good Catch", "Near Miss")

A patient safety event that did not reach the patient. Used to describe any process variation which did not affect the outcome, but for which a recurrence carries a significant chance of a serious adverse outcome.

Hazardous condition:

A circumstance, other than the patient's own disease process, or condition, that increased the probability of an adverse event.

No-harm event:

A patient safety event that reaches the patient but does not cause harm.

Patient safety event:

An incident or condition that could have resulted or did result in harm to a patient. It can be the result of a defective system or process design, a system breakdown, equipment failure, or human error. Patient safety events also include adverse events, no-harm events, close calls and hazardous conditions.

Sentinel Event:

An unexpected occurrence involving death or serious physical or psychological injury or the risk thereof. Serious injury specifically includes loss of limb or function. This may include "risk thereof" situations.

TJC defines this as a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in any of the following:

a. Death;
b. Permanent harm;
c. Severe temporary harm (potentially life-threatening harm lasting for a limited time without permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period;
d. Suicide of any patient receiving care, treatment, or services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the Emergency Department;
e. Unanticipated death of a full-term infant;
f. Discharge of an infant to the wrong family;
g. Abduction of any patient receiving care, treatment or service;
h. Elopement of any patient from a staffed around-the-clock care setting that leads to death, permanent harm or severe temporary harm to a patient;
i. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities;
j. Rape, assault or homicide of patient, workforce, visitor or vendor while on site at the District;
k. Invasive procedure on the wrong patient, site or that is the wrong procedure;
l. Unintended retention of foreign object in a patient after an invasive procedure or surgery;
m. Severe neonatal hyperbilirubinemia (bilirubin>30 milligrams/deciliter).

Unusual Occurrences:

An incident is any unanticipated occurrence that deviates from regular District operations; injury may or may not result from the incident. At NIHD an Unusual Occurrence Report (UOR) is completed by staff aware of the unusual occurrence to allow for investigation, tracking/trending and performance improvement needs identification.

CDPH requires notification of events which could seriously compromise quality or patient safety. Title 22 requires NIHD to report any occurrence, as soon as reasonably practicable, to the local health officer and to CDPH Licensing and Certification office (San Bernardino), which includes, but is not limited to, the following:

a. An epidemic outbreak;
a. Poisoning;
b. Fire, major accident, disaster, other catastrophe or unusual occurrence which threatens the welfare, safety, or health of patients, personnel, or visitors.

Serious Injury:

A serious injury is further defined as one that results in a transfer to a higher level of care, extended hospital stays or additional medical treatment.

Risk Thereof:

For the purposes of this policy, the phrase "or risk thereof" is defined as an event that did not result in death or serious injury, but carries a significant chance of recurring; the recurrence of which may indeed have a more untoward outcome. In determining the risk of an event recurring, the following guidelines are used:

a. Processes involved in the event that are not well codified or standardized across the organization are more likely to result in the recurrence of the event.
b. Processes that cross multiple disciplines and department lines and involve multiple steps in the process are more likely to result in the recurrence of the event.
c. Processes that demonstrate significant variation (i.e. lack of stability) are more likely to result in the recurrence of the event.

Reportable Sentinel Events:

The Joint Commission suggests notification of Sentinel Events on a voluntary basis, which include those resulting in unanticipated death or major permanent loss of function, or one of the following types of events:

a. Infant abduction
b. Infant discharged to the wrong family
c. Inpatient suicide
d. Rape (by another patient or staff)
e. Hemolytic transfusion reaction
f. Surgery on the wrong patient or wrong body part
g. Patient death or permanent injury/loss of function as a result of a nosocomial infection

Root Cause Analysis (RCA):

An RCA 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.

POLICY:

1. All Adverse Events of a serious nature that result in harm, or risk thereof, to a patient, workforce member, visitor or vendor (per the CDPH and TJC definitions) will require immediate notification via District's chain of command to the Administrator-On-Call. Timely investigation and reporting, when necessary, will be completed via the Administrator-On-Call or the Compliance Officer.
2. Reportable Sentinel Events/Severe Adverse Events will necessitate a Root Cause Analysis within 45 days of knowledge of the event.
3. Action Plans will be implemented and monitored for completion by the Quality/Informatics/Survey Readiness team, under the direction of the Director of Quality & Infection Prevention and the Chief Medical Officer. These findings will be reported to the Compliance Officer and the Executive Committee.

PROCEDURE:

I. Identification of a Sentinel Event/ Unusual Occurrence

A. Any potential sentinel event/significant adverse event is to be reported immediately to the Compliance Officer or the Administrator-On-Call via the NIHD chain of command. Upon notification, this individual will undertake or direct an initial investigation to determine if the occurrence is indeed a sentinel event/significant adverse event as defined by this policy.
B. If the event is determined not to be sentinel/significant in nature, it will be addressed in accordance with established unusual occurrence management policy and procedure. If the event is determined to be sentinel/significant adverse event in nature, then NIHD shall respond as noted in this document.

II. Mandated Reporting of Sentinel Event/Adverse Event

A. Reporting the Event to Beta Healthcare (NIHD Insurance)

1. Adverse Events of significance require prompt notification of NIHD's Risk Management Company.
2. Prior to notification to other agencies, appropriate risk/benefit discussion with Beta Health should occur and should involve the District CEO or designee.

B. Reporting of Sentinel Events to the Joint Commission (TJC)

1. TJC experts will help to clarify whether an event meets the sentinel event definition.
2. TJC can provide support and expertise during the review of a sentinel event by providing collaboration with their patient safety specialist resource.
3. Reporting, although not required, raises the level of transparency and helps to promote transparency.
4. Reporting proactively provides messaging that the District is working to prevent similar patient safety events in the future.

C. Reporting of Sentinel Event to CDPH

1. Report adverse events upon detection, within 24 hours of an ongoing urgent or emergent threat, or five (5) days for all other significant adverse events.
   a. Detection is defined as occurring on the first business day on which such adverse event is known to the hospital, or by exercising reasonable diligence that would have been known to the hospital. (e.g. error is discovered at 8pm on Tuesday; first business day begins on Wednesday at 8am.)
   b. Report the detection or allegation of sexual assault within 24 hours.
   c. Reportable events associated with restraints DO NOT include chemical restraints.
   d. Reportable medication errors DO NOT include when the medication is in control of the patient or consumer.
2. Healthcare Event Reporting tool – CalHEART portal will be utilized to report.
   a. Email or telephone reporting may be utilized if CalHEART site is down/secure internet website is nonoperational.
   b. Administrator-On-Call to complete report via CalHEART or Compliance Officer if needed.

III. Investigation of Event/Conducting a Root Cause Analysis (RCA)

A. Remediation of any immediate threat or likelihood of recurrent sentinel event/adverse event will be put into place to prevent further occurrences.

B. RCA should take place timely – within 45-day window of discovery.

C. RCA team is to be formed to respond to a sentinel event/unusual occurrence.

1. Various District departments will participate in the investigation as necessary to obtain complete information related to the circumstances involved.
2. An experience District Leader will lead the RCA team.
3. Individuals directly involved in the event should participate.

D. Root Cause Analysis (six steps)

1. Define the problem
   a. Develop an accurate, impartial description of the event.
   b. Define the scope of the issue(s).
2. Find causes
   a. List potential causes of the event in question
   b. Develop a deeper understanding of the issue(s)

3. Finding the root cause (most common tools utilized)
    a. Five Whys
    b. Histogram
    c. Fault Tree
    d. Scatter Chart
    e. Cause & Event Tree
    f. Pareto Analysis
4. Find solutions (design corrective action plan using tools)
    a. Common tools
    b. Interviewing
    c. Brainstorming
    d. Benchmarking
    e. Flow Charts
    f. Why Not Process
5. Take action
    a. Take steps to implement the corrective action plan created by RCA team
    b. Include steps to ensure sustainability of the change(s)
    c. Update any necessary policy or procedural documents that are impacted to sustain the action plan.
    d. Educate workforce on policy or procedural changes.
6. Verify solution effectiveness
    a. Analyze results using data and/or observations

E. Protection from Discovery – All activities of investigation and RCA shall be done under the auspices of the medical staff quality/peer review process.

IV. Assess Culture of Safety Every Two Years using a nationally recognized survey tool

REFERENCES:

1. Title 22, California Code of Regulations, Sections 70737 (general acute care hospital).
2. Health and Safety Code, Division 2. Health Facilities; Article 3 – 1279.1, 1279.2, and 1279.6 (Jan 1, 2022).
3. CDPH All Facilities Letter (AFL 21-40, Nov. 12, 2021).
4. The Joint Commission (CAMCAH Manual) Sentinel Events Chapter (Jan. 1, 2022).
5. The Joint Commission (CAMCAH Manual) Standard LD.03.03.01 (Jan. 1, 2022).

RECORD RETENTION AND DESTRUCTION:

A record of the investigation into the sentinel event/unusual occurrence, the subsequent RCA, and any performance improvement activities undertaken is to be maintained by the Director of Nursing Quality & Infection Prevention and should be constructed in such a way as to be afforded statutory protection from discovery.

1. Records related to Adverse Event reports to California Department of Public Health (CDPH) will be maintained for 6 years after any appeal is concluded.
2. Records related to Adverse Events associated with Medical Devices will be maintained for the life of the device, plus 6 years.
3. Records related to adverse reaction to blood and blood component will be maintained for 15 years after the expiration date on the blood product.

4. RCA documents will be maintained for 6 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Unusual Occurrence Report Instructions
2. Communication with the patient/family after a harm event

Supersedes: v.1 Sentinel Events, Unusual Occurrences Policy/Procedure

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Single-dose vs Multi-dose Vial Policy		
Owner: Acting Director of Pharmacy	Department: Pharmacy	
Scope: District Wide		
Date Last Modified: 01/17/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/15/2015	

PURPOSE: To provide an accurate and safe method of administrating single-dose and multi-dose vials to our patients at Northern Inyo Hospital and Rural Health Clinic.

DEFINITION: Proper aseptic techniques of single-dose and multi-dose vial procedures will minimize the chance of contamination and prevention of infections.

a. Single-dose vials do not have preservative.
b. Multiple dose vials do have preservative

POLICY:

1. Nursing staff will use One Needle, One syringe, Only One time to ensure patient is protected from any time of contamination or infection.
2. Multiple dose vials will only be used for one patient only to reduce the risk of contamination.
3. Vials labeled by the manufacturer as "single-dose" or "single-use" will only be used for one patient. Single-dose vials lack antimicrobial preservatives and can become contaminated and serve as a source of infection when they are used inappropriately.
4. Single-dose vials/ampoules are for immediate use only, and once opened shall not be stored for any time period.
5. Single dose vial shall be used whenever possible and discarded immediately after use (within one hour).
6. Visually inspect all single-dose and multi-dose vials for integrity, precipitation, contamination, or damage before each use.
7. A pharmacy technician shall check opened vials during their daily rounds.

PROCEDURE:

Single-dose/single-use vials

1. Use a single-dose /single-use vial for a single patient during the course of a single procedure.

a) Do not re-puncture the vial.
b) Discard the vial after this single use
c) Used vials should never be returned to stock on clinical units, drug carts, and anesthesia carts.
d) Medications in single-dose/single-use vials lack antimicrobial preservatives and are therefore at greater risk to become contaminated and serve as a source of infection when used inappropriately.
e) Do not store used single-dose/single-use vials for later use, no matter what the size of the vial.

Multiple-dose vials

1. Only vials clearly labeled by the manufacturer for multiple dose use can be used more than once.
2. When multiple-dose vials are used more than once, use a new needle and new syringe for each entry. Do not leave needles or other objects in the vial between uses, as this may contaminate the vial's content.
3. Disinfect the vial's rubber septum before piercing by wiping with a sterile 70 percent isopropyl alcohol prep. Allow the septum to dry before inserting a needle or other devices into the vial.
4. Once a multiple-dose vial is punctured, it should be assigned a "beyond-use" date. The beyond-use date for an opened or entered (i.e. needle-punctured) multiple-dose container with antimicrobial preservatives is 28 days, unless otherwise specified by the manufacturer.
5. All vials should be **dated with 28 days' expiration and initialed when opened or taken from the refrigerator.** If reconstituted, the vial should be labeled with the concentration and the manufacturer's lists an expiration date of a shorter time frame than 28 days.
6. Multiple-dose vials (i.e., containing bacteriostatic agents) are considered single patient vials.
7. Unused or unopened multiple dose vials (MDV) shall be stored until the manufacturer's expiration date and according to manufacturer's recommendation.

REFERENCES:

1. CDC: The One and Only Campaign last revised December 3, 2019
2. The Joint Commission (CAMCAH manual) (Jan 2022) Standard NPSG. 03.04.01 EP 7

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Administration of Drugs and Biologicals
2. Safe Injection Practices

RECORD RETENTION AND DESTRUCTION:

Compounding log kept for 6 years.

Supersedes: v.1 Single-dose vs Multi-dose Vial Policy*

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Surgeries Requiring an Assistant		
Owner: DON Perioperative Services	Department: Surgery	
Scope: Surgery		
Date Last Modified: 04/27/2022	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/14/16	

PURPOSE:
To clarify which surgical procedures require the presence of an assistant.

POLICY:
The Surgery Committee adopted the use of the American College of Surgeons "Physician as Assistant at Surgery" as the method to determine which surgical cases need an assistant for the procedures that are performed at this institution.

The Surgeon will determine if he/she prefers a member of the medical staff or the use of a non-physician first assistant (Physician Assistant, Registered Nurse First Assistant, or Certified Nurse Midwife). The surgeon may choose to have an assistant for any surgical case but should have an assistant for the cases listed below.

Surgical Procedures Requiring an Assistant:

Abdominal Perineal Resection
Abdominal Hysterectomy
Aortic Procedures requiring cross clamping the Aorta
Hemi Gastrectomy
Nephrectomy
Thoracotomy
~~Total Knee~~
~~Total Shoulder~~

CROSS REFERENCED POLICIES / PROCEDURES:

- Non-Physician First Assistant in the Operating Room
- Standardized Protocol – Physician Assistant in the Operating Room
- Standardized Procedure for the Registered Nurse First Assistant
- Standardized Procedure – Certified Nurse Midwife

REFERENCES:

1. Title 22 70223, 70225
2. CMS 482.51 and 482.51(b) (1-18-2022)
3. California State Operations Manual Appendix W: 485.639 (2-21-20)
4. American College of Surgeons: Physicians as Assistants at Surgery; 9th Edition

Supersedes: v.4 Surgeries Requiring an Assistant

RESOLUTION NO. 22-10

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 18th day of May, 2022 by the following roll call vote:

AYES:
NOES:
ABSENT:

_____
Jody Veenker, Chair
Board of Directors

ATTEST:

_____
Name: Erika Hernandez
Title: Board Clerk

CALL TO ORDER	The meeting was called to order at 5:30 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 Vinay Behl, Interim Chief Financial Officer (via Zoom) Allison Partridge RN, MSN, Chief Nursing Officer Keith Collins, General Legal Counsel (Jones & Mayer)
ABSENT	Joy Engblade MD, Chief Medical Officer Sierra Bourne MD, Chief of Staff
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Veenker announced that the purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes being allowed for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered. No public comments were heard.
NEW BUSINESS	
PRESENTATION BY STERN SECURITY	Chief Executive Officer, Kelli Davis, introduced Peter Nelson, Security Engineer with Stern Security. Mr. Nelson provided a presentation on the finding from the cyber security test conducted at Northern Inyo Healthcare District (NIHD). NIHD Information Technology Director, Bryan Harper clarified question for the Board and explained that cyber-security testing will be conducted on an annual basis to help the District detect cyber vulnerabilities.
PRESENTATION BY EASTERN SIERRA CANCER ALLIANCE	Ms. Davis introduced Michelle Garcia, Secretary of the Eastern Sierra Cancer Alliance (ESCA). Ms. Garcia introduced Andrea Shallcross, Rosie Graves, Sherry Nostrant, Cheryl Underhill and other Board Members and volunteers of the ESCA. As a group, they provided a presentation of the history, services and resources provided by ESCA. They explained that

ESCA also collaborates with Northern Inyo Healthcare District to bring awareness and promote early detection and cancer prevention. Ms. Shallcross also provided current financial information for ESCA.

NORTHERN INYO HEALTHCARE DISTRICT BENEFIT HIGHLIGHTS PRESENTATION

Alison Murray, Director of Human Resources and Interim Chief Financial Officer, Vinay Behl, provided a presentation about the benefits provided to all NIHD employee and the value of these benefits from a financial perspective. Ms. Murray and Mr. Behl clarified questions for the Board. Public comment was heard from Marcia Male about the District employee pension plan.

APPROVAL OF THE DISTRICT BOARD RESOLUTION, 22-05 NONDESIGNATED PUBLIC HOSPITAL BRIDGE LOAN PROGRAM

Mr. Behl called attention to the proposed District Board Resolution 22-05, Nondesignated Public Hospital Bridge Loan Program.

It was moved by Jean Turner, seconded by Robert Sharp, and unanimously passed to approve the Board District Resolution 22-05, Nondesignated Public Hospital Bridge Loan Program as presented.

APPROVAL OF THE REPLACEMENT OF THE HEATING AND AIR CONDITIONING UNITS 1967 BUILDING $80,000.00

Scott Hooker, Director of Facilities called attention to the approval of proposed Replacement of the Heating and Air Conditioning Units 1967 Building for $80,000.00.

It was moved by Mr. Sharp, seconded by Mary Mae Kilpatrick, and unanimously passed to approve the Replacement of the Heating and Air Conditioning Units 1967 Building for $80,000.00 as requested.

NORTHERN INYO HEALTHCARE DISTRICT 2022 COMMUNITY HEALTH NEEDS ASSESSMENT CHNA UPDATE

Ms. Davis, provided an update on the District Community Health Needs Assessment (CHNA) and reported that the company selected to conduct the CHNA for 2022 is QHR. She explained that the first CHNA committee meeting with QHR took place on April 13, 2022. Director Spoonhunter, Director Kilpatrick and few employees from NIHD participated in this meeting.

NORTHERN INYO HEALTHCARE DISTRICT RADIOLOGY SERVICES UPDATE

Ms. Davis provided an update on the current contract for Radiology Services between Northern Inyo Healthcare District (NIHD) and Tahoe Carson Radiology and explained this contract expires in April 2023. NIHD will solicit bids and proposals from interested radiology groups for a new three (3) year contract. A final selection is anticipated in August.

NORTHERN INYO HEALTHCARE DISTRICT WORKFORCE HOUSING UPDATE

Ms. Davis additionally reported that the District is continuing to experience issues in securing local housing for traveling staff and new employees who are moving to the area. A discussion took place about possibly securing housing units for the District at two local places.

NORTHERN INYO HEALTHCARE DISTRICT GOVERNANCE COMMITTEE UPDATE AND DISCUSSION OF THE NIHD BOARD OF DIRECTORS STANDING COMMITTEE

Ms. Davis provided an update on the recent NIHD Governance Committee meetings that took place earlier in the month. A discussion took place to review and NIHD Board bylaws on current Standing Committees. Keith Collins, legal counsel clarified questions for the Board. The Board requested that Mr. Collins create two versions of the bylaws to propose to the Board for consideration at the next Regular Board Meeting, one that would make all standing committees ad hoc committees and one that would make the standing committee ad hoc committees with only the Governance Committee as a standing committee.

CHIEF OF STAFF REPORT

PROPOSED AMENDMENT TO MEDICAL STAFF BYLAWS

On behalf of Chief of Staff, Sierra Bourne, MD, Ms. Davis and Chief Nursing Officer, Allison Partridge called attention to the proposed amendment to the current Northern Inyo Healthcare District Medical Staff bylaws.

It was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve the amendment to the Northern Inyo Healthcare District Medical Staff Bylaws as requested.

POLICIES

Ms. Davis and Ms. Partridge, reported that the Medical Executive Committee recommends approval of the following District-Wide Policies:

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

It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve all five (5) Policies as presented.

MEDICAL EXECUTIVE COMMITTEE REPORT

Ms. Davis and Ms. Partridge provided a report on the Medical Executive Committee meeting and clarified questions.

_____.

CONSENT AGENDA

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

1. *Approval of District Board Resolution 22-06, to continue to allow Board meetings to be held virtually.*
2. *Approval of minutes of the March 16, 2022 Regular Board Meeting*
3. *Financials and Statistical reports as of February 28, 2022*
4. *Approval of Policies and Procedures*
    A. *Forms Development and Control Policy*

B. Nondiscriminatory Policy
C. Overtime
D. Smoking/Tobacco Policy
E. Standby/Callback
F. Unusual Occurrence Reporting
G. Paid Time Off

5. *Approval of the Northern Inyo Healthcare District Rural Health Clinic- Policies and Procedures & Addendums to the Policies*
   A. Policies and Procedures
      1. Regulatory Compliance Policy
      2. Formal Corporate or Organization Compliance Plan Policy
      3. Organizational Structure and Ownership
      4. Organizational Chart Policy
      5. Non-Discriminatory Policy
      6. RHC Service Area (Location)
      7. Advertising, Web-Presence and Social Media Representation
      8. Physical Plant Safety: General Policy
      9. Preventive and Required Maintenance
      10. Building Sanitation and Cleanliness
      11. Storage, Handling & Administration of Drugs, Biologicals, and Pharmaceuticals
      12. Blood Bourne Pathogens: Exposure Control (Including Needle Sticks)
      13. Infection Control Policy
      14. Disinfection and Sterilization Policy
      15. Accidental Needle Sticks
      16. Medical Waste Handling and Disposal
      17. Hazardous Materials
      18. Smoke-Free Workplace
      19. Fire Safety, Training and Evacuation
      20. Severe Weather and External Disaster Policy
      21. Communication During Internal or External Situations
      22. Visitor Policy
      23. Animals and Pet Policy
      24. RHC Provision of Services
      25. Medical Management Guidelines
      26. Patient-Provided or 3rd Party Pharmaceuticals
      27. Referral Policy
      28. Transitional Care and Continuity of Care Management
      29. Missed Appointments
      30. Emergency Care and Treatment
      31. Discharging/Dismissing a Patient
      32. After Hours Care
      33. Medical Records Policy
      34. Medical Records Integration Policy
      35. Health Information Technology/IT

36. *General Employment Policies*
37. *Credentialing and Employment Policy*
38. *COVID-19 Vaccination Policy*
39. *Periodic Performance Evaluation and Clinical Competency*
40. *Program Evaluation Policy*
41. *Quality Assurance and Utilization Review*
42. *Grievance Policy*
43. *Risk Management Policy*
44. *Financial Policies*

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

It was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve all five (5) 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 that Northern Inyo Healthcare District Board of Directors has scheduled a Special Board Meeting on April 26, 2022 at 6:00 p.m. to host the Pioneer Home Health Care Board of Directors.

ADJOURNMENT

The meeting adjourned at 8:03 pm.

_____
Jody Veenker, Chair

Attest: _____
Topah Spoonhunter, Secretary

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 a PHHC financial audit is expected to be conducted on an annual basis.

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

NORTHERN INYO HEALTHCARE DISTRICT

Improving our communities, one life at a time.
One Team, One Goal, Your Health!

150 Pioneer Lane
Bishop, California 93514

(760) 873-5811

DATE: May 5, 2022

TO: NIHD Board of Directors

FROM: Kelli Davis, Chief Executive Officer (CEO)

RE: Monthly CEO Report– Northern Inyo Healthcare District

REPORT DETAIL

2022 NIHD Community Health Needs Assessment

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.

NIHD has selected QHR as our vendor for the CHNA. The CHNA surveys will be available to our community the month of May. Surveys will be available in an electronic and paper format with an emphasis on increased participation and accessibility for English and Spanish speaking community members.

Chief Financial Officer (CFO) Recruitment

The CFO position has been posted and the application window closed on May 1st. The interview process is underway. We would like to see an offer extended by late May with a start date of early July.

Southern Mono Healthcare District Labor & Delivery Services

At the time of this report development, Mammoth Hospital has conveyed they plan to make every effort to re-open their L&D services. Per Mammoth Hospital CEO, Tom Parker, they are striving to re-open in 3-6 months if at all possible. NIHD L&D teams have continued to provide L&D services for patients from Mammoth for several months. NIHD continues to try to be as proactive in this service provision in the short-term and potential long-term state through executive, provider, nursing and Board conversations. Patient safety, risk management and provider/clinical support are our top priority. We remain dedicated to a collaborative partnership with Mammoth Hospital throughout this support and transition phase.

Information Item – National Rural Healthcare Association (NHRA)

Nearly half of rural hospitals lose money on childbirth services

About 40 percent of rural hospitals are losing money on OB programs, but many continue to provide

the service because of its importance for community health, according to a new study from the University of Minnesota, an NRHA member. Another study finds a growing number of non-white women are resorting to **alternatives to hospitals for labor and delivery**. Black women are also three times more likely to experience pregnancy-related deaths compared to white, non-Hispanic women, and for Native women the rate is twice as likely. To address these challenges, CMS recently announced policies to **improve maternal health** and **advance health equity**. Let's aim to achieve health equity at birth and beyond at **NRHA's 27th Health Equity Conference** hybrid event **May 10**. Join us virtually for half the cost.

Rural hospital administrators' beliefs on offering OB care – March 25, 2022

Administrators of rural hospitals providing obstetric care in the United States reported needing at least 200 annual births for safety and financial viability, according to a study from the University of Minnesota Rural Health Research Center, an NRHA member. The study also revealed that community maternity care needs strongly influenced hospital decisions to maintain obstetric services, even below that threshold. Access to high quality obstetric care is critical to ensuring optimal maternal and infant health outcomes. However, declining access to hospital-based obstetric care is a concern in rural communities in the U.S. A previous study from the Rural Health Research Center found that from 2014 to 2018, 53 rural counties lost hospital-based obstetric services. Please see the attached article for more information.

National Rural Health Care (NRHA) Annual Conference – May 10-13, 2022
The annual conference specific to rural health care, hospital innovation and health equity, will commence on May 10-13 this year. This is an opportunity for health care leaders to join NRHA and rural health leaders from across the country for a hybrid event hosted in the Land of Enchantment (Albuquerque, NM) to help raise the standard for rural health with over 80 innovative, practical, and cost-saving sessions and much more.
Members of the NIHD Executive Team are enrolled in the conference and will attend virtually. Please see the attached list of sessions being offered.

Noteworthy Data and Legislative Highlights

Virtual Public Meetings
"Will virtual public meetings continue even after the pandemic? Two new bills could ease California's teleconferencing restrictions for the long-term". Please see the attached legal alert from BBK Law Firm.

Rural Hospital Support Act
Unprecedented financial, clinical and workforce challenges during and beyond the COVID-19 pandemic have caused extreme hardships for rural hospitals across the United States. The Rural Hospital Support Act, supported by the American Hospital Association (AHA), is designed to help support rural health care providers through legislation that will make the Medicare Dependent Hospital (MDH) program of 1987 permanent as a contributory measure for stronger fiscal stability and stabilizer of access to care for rural community members. Please see the attached letter from AHA to Senators Casey and Grassley, dated April 11, 2022.

Who is the National Rural Health Association?
The National Rural Health Association (NHRA) is an advocate for the thousands of national rural health providers who strive to provide services in rural communities, improve rural health care and increase access to the health care needs of rural community members. NIHD works closely with the NHRA and finds this resource to be a top leader in information, legislative action and advocacy and resource and

support opportunities for District members. Please see the attached NRHA fact sheet outlining their many roles including the legislative focus priorities for 2022 and beyond.

Department Reports
Please find the reports from the department leaders I support in the next pages. You are sure to see much work underway, some challenges and of course, some celebration of the amazing work and service provision taking place at NIHD!

Closing
The support and partnership with the NIHD Board of Directors is greatly appreciated. As always, please do not hesitate to contact me with any questions or to share any concerns you may have.

Respectfully submitted,
Kelli Davis - CEO

Rural hospital administrators' beliefs on offering obstetric care

March 25, 2022

Credit: David Salafia

Administrators of rural hospitals providing obstetric care in the United States reported needing at least 200 annual births for safety and financial viability, according to a study from the University of Minnesota Rural Health Research Center published today in the journal JAMA Health Forum. The study also revealed that community maternity care needs strongly influenced hospital decisions to maintain obstetric services, even below that threshold.

Access to high quality obstetric care is critical to ensuring optimal maternal and infant health outcomes. However, declining access to hospital-based obstetric care is a concern in rural communities in the U.S. In a previous study from the Rural Health Research Center, from 2014 to 2018, 53 rural counties lost hospital-based obstetric services, continuing a decades-long decline in access. Rural obstetric unit closures are most common among low birth volume facilities located in remote areas. The consequences of losing obstetric services are concentrated in remote rural areas and include increases in preterm births, births occurring in emergency departments and out-of-hospital births.

To assess rural hospital administrators' experiences and beliefs about safety, financial viability and community need for offering obstetric care, the research team developed and conducted a national survey of obstetric unit managers or administrators at 292 rural hospitals that provided obstetric services in 2021.

Survey respondents reported the number of annual births they needed to safely provide obstetric care, and the median value was 200. From a financial perspective, the median number of annual births needed was also 200.

When making decisions about maintaining obstetric care:

- 64.6% of responding hospitals listed their highest priority as meeting local community needs, implying that rural hospital administrators feel that local conditions require obstetric services be available, even when the birth volume does not reach a threshold that the hospital feels is viable for safety or finances because residents need a place to give birth locally;

- 16.5% listed financial considerations as their top priority; and

- 12.7% listed staffing as their top priority.

One in four responding hospitals were not sure they would continue providing obstetrics or that they expected to stop offering this service, likely continuing the downward trend in access.

"Many hospital administrators in rural communities care deeply about the health of pregnant rural residents," said maternal health expert Professor Katy Backes Kozhimannil, director of the Rural Health Research Center and lead author of the study. "Indeed, rural hospital administrators prioritized local community needs over finances and staffing, keeping obstetric units open because local pregnant patients need care nearby. Policy investments are needed to help rural hospitals and communities support safe, healthy pregnancies and births."

"The responses from the rural hospital administrators strongly highlighted the fact that they provide obstetric services because they are so necessary and important for the health of the rural communities they serve," said Bridget L. Basile Ibrahim, a postdoctoral associate with the Rural Health Equity Postdoctoral Fellowship at the Rural Health Research Center and a coauthor of the study. "For many of the patients who give birth at these hospitals, it would be a huge burden for them to travel to the next nearest hospital to give birth."

The research team concluded that policies to improve rural obstetric care access should account for administrative concerns about community needs, clinical safety, and recruitment, retention, and training for the physician and nursing workforce, in rural communities with and without hospital-based obstetric care. Additionally, adjusting reimbursement policies for low-volume rural hospitals may help ensure financial viability and continued operations of rural hospitals' obstetric service lines.

Other members of the research team include Julia Interrante, a graduate research assistant at the Rural Health Research Center, and Lindsay Admon, an obstetrician-gynecologist and an assistant professor at the University of Michigan.

The study was supported by the Federal Office of Rural Health Policy, Health Resources and Services Administration, U.S. Department of Health and Human Services. It was also supported by the National Institutes of Health's National Center for Advancing Translational Sciences.

45th Annual Rural Health Conference
7th Rural Hospital Innovation Summit
May 11-13, 2022
Albuquerque, N.M.
In-person and virtual Draft Agenda

Sessions in blue are available to live participants only
Sessions in green are also available to virtual attendees

Tuesday, May 10, 2022
5 – 7 p.m.
Exhibit Hall Welcome Reception

Wednesday, May 11, 2022
7 – 8 a.m.
Breakfast
Exhibit Hall, Ballroom C

8 - 9:30 a.m.
Opening Session & Keynote ***(available to virtual attendees)***
Ballroom AB
Beth O'Connor, NRHA 2022 President
Alan Morgan, NRHA CEO
Brian Alexander, author

9:30 a.m. - 10:45 a.m.
Concurrent Sessions

1A
Adapting Prescription Opioid Messaging for Rural, Tribal Audiences
Isleta/Jemez
Brittany Curtis, MBA, CDC National Center for Injury Prevention and Control Division of Overdose Prevention, Health Communication Specialist

The Centers for Disease Control and Prevention will share insights discovered through formative research and in-depth interviews related to cultural sensitivities and communication strategies for addressing opioid use disorder, misuse, addiction, and recovery with the American Indian/Alaska Native community.

The Intersection of Rural Opioid Misuse and Trauma

Michael Meit, MA, MPH, East Tennessee State University Center for Rural Health Research Director of Research and Programs
Megan Quinn, DrPH, East Tennessee State University College of Public Health Associate Professor

Opioid misuse negatively impacts rural communities. Adverse childhood experiences increase risk for opioid-related harms, raising the potential for targeted strategies to mitigate both issues. This session will describe this relationship, including trends in opioid-related harms. Evidence-based strategies to promote resiliency and address trauma in rural communities will be discussed.

1B

Modernizing the Rural Health Clinic Program

Cochiti

John Gale, MS, University of Southern Maine Rural Health Research Center Senior Research Associate and Director of Policy Engagement

The Rural Health Clinic Program, established in 1977, pioneered new approaches to providing and paying for primary care. The program would benefit from updating to better serve rural communities. This session explores opportunities to modernize the RHC Program by building on its foundation of rural-relevant payment reform and team-based care.

1C

Combatting Obesity and Chronic Disease in Rural America

Apache

Jennifer Conner, DrPH, MPH, MAP, Delta Population Health Institute Director of Research and New York Institute of Technology College of Osteopathic Medicine at Arkansas State University Associate Professor
Jason Lofton, MD, Howard Memorial Hospital Family Practice Physician and Rural Community Obesity Advocate
Carrie Thielen, MPH, RD, Presbyterian Healthcare Services Manager of Regional Community Health
Anna Huff-Davis, Arkansas Community Health Worker Association Chair
Alva Ferdinand, PhD, MPH, Southwest Rural Health Research Center Director and Texas A&M School of Public Health Assistant Professor
Mary-Katherine McNatt, DrPH, MPH, MCHES, CPH, COI, A.T. Still University College of Graduate Health Studies Department of Public Health Chair and Associate Professor

Rural Americans face a unique combination of factors that create disparities in health care not found in urban areas. With rural residents at a greater risk of being obese, special attention must be directed towards mitigating the factors which contribute to obesity and associated comorbidities. This session intends to highlight the need to address obesity and chronic conditions in rural areas and address policy issues and solutions.

1D

NRHA Fellows Explore Mental Health in Rural Areas *(available to virtual attendees)*

Navajo/Nambe

Heather Whetsell, MBA MSHI, SIU Medicine Population Science & Policy Administrative Director
Janessa Graves, PhD, MPH, Washington State University Associate Professor of Nursing
Brenda Mack, DSW, MSW, LICSW, Bemidji State University Assistant Professor of Social Work/Director of Field Education/SOWK Club Advisor

Mental Health in rural areas is a crisis. The 2021 NRHA Rural Health Fellows mental health workgroup has explored challenges and barriers to mental health care in rural areas including access to care; workforce recruitment and retention; lack of broadband; and telepsychiatry. This session will explore their findings and recommendations.

1E

Got Rural Docs? How Osteopathic Schools Do It

Santo Domingo

Davis Patterson, PhD, University of Washington School of Medicine WWAMI Rural Health Research Center Research Associate Professor
Russell Maier, MD, FAAFP, Pacific Northwest University College of Osteopathic Medicine Associate Dean for Graduate Medical Education
Dana Shaffer, DO, FACOFP dist., FA, University of Pikeville Kentucky College of Osteopathic Medicine Dean (retired)

Osteopathic medical schools excel at producing rural physicians. Learn from leaders at Pacific Northwest University and University of Pikeville Kentucky Colleges of Osteopathic Medicine about successful strategies they use to recruit and educate medical students who will choose rural practice, based on data from the WWAMI Rural Health Research Center.

1F

Contemporary Uranium Exposure in Navajo Nation/Southwestern States

Taos

Johnnye Lewis, PhD, University of New Mexico College of Pharmacy Health Sciences Center Research Professor
Debra MacKenzie, PhD, University of New Mexico College of Pharmacy Health Sciences Center Assistant Professor

Denise Bartley, PhD, MSN, FNP-BC, Navajo Area Radiation Exposure Screening and Education Program (RESEP) Program Director

The Radiation Exposure Screening and Education Program (RESEP) and Radiation Exposure Compensation Act (RECA) have worked in tandem for two decades to serve individuals impacted by Cold War era nuclear weapons development. Now that RECA is planned to sunset in 2022, the persistent environmental health issue of contemporary uranium exposure in the southwestern US runs the risk of falling entirely into obscurity.

RHIS – APM Track
340B + ACOs = Improved Patient Outcomes *(available to virtual attendees)*
Picuris/Sandia
Lynn Barr, MPH, Caravan Health Founder and Executive Chairwoman

Safety net providers can thrive in accountable care, and now they can unlock more revenue potential and improve patient care. ACO participants have a view into their patients' care and prescription history. In this session, hear directly from rural health leaders about successes and best practices of succeeding with accountable care and 340B.

RHIS -- Operations
How to Attract, Recruit, and Retain Great Employees
Santa Ana
Steve Anderson, PhD, Integrated Leadership Systems President
Angelia Foster, Marshfield Medical Center Chief Administrative Officer

Attracting and keeping talented employees is a critical activity of any successful health care organization. This session will discuss the components of creating a culture that empowers employees and attracts the best talent, as well as how to deal with employees that harm your culture of excellence.

1G
Contributed Research Papers – COVID-19
Laguna

- **Addressing COVID-19 Concerns in Amish Country**
  Melissa K. Thomas, PhD, MSA, MSPH, Ohio University Heritage College of Osteopathic Medicine Assistant Professor
- **Rural COVID-19 Mortality Disparities, December 2020-January 2021**
  Whitney Zahnd, PhD, University of Iowa Assistant Professor
- **Community-engaged research promoting COVID-19 vaccination in Montana**
  Alexandria Albers, MS, University of Montana Graduate Research Assistant
- **Surveying rural healthcare workers for vaccine hesitancy concerns**
  Elizabeth Hall-Lipsy, JD, MPH, The University of Arizona College of Pharmacy Assistant Professor

10:45 – 11:00 a.m.

Poster Session/Break
La Sala Foyer

11:00 a.m. – 12:15 p.m.
Plenary Session – HRSA Rural Health Update *(available to virtual attendees)*
Ballroom AB
Tom Morris, Federal Office of Rural Health Policy Associate Administrator

This session will provide updates regarding key federal activities that help improve access to quality health care in rural communities.

12:15 p.m. – 2:30 p.m.
Lunch
Exhibit Hall, Ballroom C

1:00 — 2:00 p.m.
Welcome to the Revolution: Reimagining Rural Health Marketing
Ballroom AB
Mike Milligan, Legato Healthcare Marketing President
Amy Yaeger, Legato Healthcare Marketing Vice President Strategic Services

A new era of rural healthcare marketing is here, and your organization needs to make use of these tools now – or be left behind. This presentation will focus on the evolution of digital advertising, including streaming, PPC, SEM, email campaigns, social media, websites, blogs, reputation management, patient reviews and EHR communication – all of which allow rural healthcare leaders to build relationships with their current and future patients. Legato Healthcare Marketing's President Mike Milligan and Vice President of Strategic Services Amy Yaeger will discuss how to transform your organization's marketing plan to meet today's consumers on their terms – while also maximizing your return. After attending this session, instead of saying, "I didn't know we could do that!" your team will be able to say, "We've got this!"

1:30 – 5:00 p.m.
Student Track Session/Student Constituency Group Meeting
Zuni
Join other students for an interactive rural ethics session and the student constituency meeting.

2:30 – 3:45 p.m.
Concurrent Sessions

2A
The Intersection of Oral and Behavioral Health – Can We Meet in the Middle?
Isleta/Jemez

Laura McKeane, EFDA, AllCare Health Director of Oral Health Integration
Kelli Beaumont, EPDH, Capitol Dental Care Dental Hygienist

Can oral and behavioral health come together to meet people where they are? In rural Southern Oregon, access to both is challenging. So, this organization decided to tackle it head on and integrate oral health in a behavioral/physical health setting. This session will look at the successes as well as lessons learned.

2B
Geographic and Ethnic disparities among U.S. border residents
Cochiti

Janice C. Probst, PhD, University of South Carolina Arnold School of Public Health Distinguished Professor Emerita
Elizabeth Crouch, PhD, University of South Carolina Arnold School of Public Health Assistant Professor and Rural and Minority Health Research Center Deputy Director
Mary-Katherine McNatt, DrPH, MPH, MCHES, CPH, COI, A.T. Still University College of Graduate Health Studies Department of Public Health Chair and Associate Professor

This session will present findings from the 2021 Rural Border Health Chartbook, which presents a variety of health indicators and social determinants of health that have previously been identified as disparities warranting programmatic and policy interventions. Our findings will be useful for educating public health officials, policymakers, and other organizations.

2C
Capital Planning: Rural Foundations to Financing
Apache

Jonathan Chapman, MBA, Capital Link Chief Project Officer
Jennifer Williams, FQHC Resource Alternative CEO
Katie Parnell, CommuniHealth Services CEO

This presentation will examine the capital expansion planning process, highlighting rural projects and their firsthand experiences and challenges. The presentation will also review various capital project financing options available to health centers including conventional bank and USDA loans as well as sources such as new markets tax credits.

2D
Spreading Knowledge, Not COVID: Rural NC Latino/Hispanic Ambassadors
Taos

Hannah Robinson, MPH, Partners Aligned Toward Health Healthy Lifestyles Program Manager
Schell McCall, Partners Aligned Toward Health Executive Director
Sarah Thach, MPH, UNC Gillings School of Global Public Health Master of Public Health Program in Asheville Assistant Director
LaCosta Tipton, MPH, BSN, RN, Mountain Community Health Partnership Director of Operations
Amber Dillinger, MHA, Mountain Community Health Partnership Outreach Manager

Molly Martinez, BS, Community Ambassador Real Equality (CARE) Community Ambassador

In the fall of 2020, 12 bilingual rural North Carolina Latinx residents were recruited to create and share culturally responsive and relevant COVID-19 messaging, using the evidence-based Boot Camp Translation model adapted for the rapidly evolving pandemic. Participants disseminated messages and reported changed beliefs and are now addressing new community health concerns.

2E

Living Rurally with Long-Term Conditions Through COVID-19

Santo Domingo

Sarah-Anne Munoz, PhD, University of the Highlands and Islands Professor
Whitney Zahnd, PhD, University of Iowa Assistant Professor
Steve Bain, Doctor of Ministry Texas A&M University-Kingsville Professor and Dean

This session brings evidence from the USA and the UK on the experience of living rurally with a long-term condition (physical or mental) during COVID-19. Presenters will discuss the impact of the pandemic on rural residents with a long-term condition and their family and careers, as well as consider how support could be strengthened.

2F

FORHP Medicare Policy Update *(available to virtual attendees)*

Picuris/Sandia

Summary TBA

RHIS – APM Track

Community Engagement and Planning for Rural Health Systems

Santa Ana

John Gale, MS, University of Southern Maine Rural Health Research Center Senior Research Associate and Director of Policy Engagement

Rural hospital closures are driven, in part, by comparatively low utilization of local services. To remain viable, rural systems of care must have the active support of their communities. This session explores a framework to conduct community health planning and engagement to build robust, sustainable systems of rural health services.

RHIS -- Operations

Swing Bed Quality Certification, One Year Later *(available to virtual attendees)*

Navajo/Nambe

Kate Hill, RN, The Compliance Team, Inc, VP Clinic Division
Leslie Marsh, Lexington Regional Medical Center CEO
Jonathan Pantenburg, MHA, Stroudwater Associates Principal

Brittany Hueftle, BSN-RN, Lexington Regional Health Center Director of Transitional Services and Patient Care Coordinator

This lecture will highlight the benefits of achieving swing bed quality certification. Listen to an experienced CEO tell the swing bed quality story and the benefits to the hospital, along with the steps to take to achieve this distinction.

2G
Contributed Research Papers – Rural Maternal Health
Laguna

- **A Retrospective Exploration of Rural Maternal-Infant Disparities**
  Melissa White, DrPH(c), MPH, MS, East Tennessee State University Graduate Research Assistant
- **An Ecological Analysis of Rural Infant Mortality**
  Jacob Warren, PhD, MBA, Mercer University School of Medicine Director of the Center for Rural Health
- **Racial inequities in postpartum health insurance among rural and urban US residents**
  Julia Interrante, MPH, University of Minnesota Rural Health Research Center Doctoral Student
- **Structured Training for the Rural EnhancemenT of Community Health in Obstetrics: STRETCH-OB**
  Karen Liao, MD, University of Illinois College of Medicine Rockford Family Medicine Physician, Clinical Assistant Professor, and Associate Program Director

3:45 – 4:00 p.m
Poster Session/Break
La Sala Foyer

4:00 – 5:15 p.m.
Concurrent Sessions

3A
The Rural American Cancer Experience
Isleta/Jimez

Wade Swenson, MD, MPH, Lake Region Healthcare Medical Director
Emily Westergard, BA, DO, Gundersen Health System Hematology and Oncology Fellow, PGY-4

This session summarizes the collective experiences and unique needs of rural American cancer patients described in recent medical literature and incorporates the experience of a rural cancer center. The summary focuses on interventions and opportunities to improve rural cancer care delivery.

3B
Preparing RHCs and FQHCs for Value-Based Care *(available to virtual attendees)*
Picuris/Sandia

John Gale, MS, University of Southern Maine Rural Health Research Center Senior Research Associate and Director of Policy Engagement

Growth in value-based care requires rural health clinics to adapt to payment programs that emphasize primary care, preventive services, care coordination, disease management, population health, information sharing, and quality reporting. This session describes tools and care models to prepare RHCs for changes in the evolving rural health care marketplace.

3C
Understanding and Assessing Rural Recovery Ecosystems
Apache

Michael Meit, East Tennessee State University Center for Rural Health Research Director of Research and Programs
Robert Pack, PhD, East Tennessee State University College of Public Health Professor & Associate Dean
Ernie Fletcher, MD, Fletcher Group Co-Founder and Chief Medical Officer
Andrew Howard, Fletcher Group Director of Policy

Recovery ecosystems provide an environment where individuals can access substance use treatment and recovery support services such as housing and second chance employment. This session will highlight factors present in strong rural recovery ecosystems, recovery ecosystem supports implemented in eastern Kentucky, and initial development of a rural recovery ecosystem index.

3D
Community Engagement Developing Recovery Housing in Rural Communities
Cochiti

Janice Fulkerson, Fletcher Group Rural Center of Excellence COO
Nate Conklin, Fletcher Group Rural Center of Excellence Outreach & Engagement Specialist
Angie Gribble, BS, MHS, St. Luke's Health System Senior Director of Community Health

Recovery housing provides services to individuals with substance use disorder who also experience homelessness, criminal justice involvement, and high health care utilization. Rural community health, human services, corrections, and other stakeholders are crucial to establish recovery housing in rural communities. This case study presents a collaboration for a rural community.

Rural Housing Solutions

Kay Miller Temple, MD, Rural Health Information Hub Web Writer
Jana Reese, Rural Health Information Hub Funding Resources Specialist
Shonterria Charleston, Housing Assistance Council Training and Technical Assistance Director
Amanda Reddy, National Center for Healthy Housing Executive Director

Specifically connected to certain medical conditions, intuitively associated with population health and well-being, and indelibly linked to a rural community's economics and health care

delivery, housing is an important social determinant of health. This panel will describe housing needs and highlight a range of rural funding options to meet housing needs.

3E
Development of a Statewide, AHEC-Administered Pre-med Prep Project
Santo Domingo

David Gross, Northeast Kentucky Area Health Education Center Director
Catherine Malin, South Central Kentucky Area Health Education Center Director
Brenda Fitzpatrick, Northwest Kentucky Area Health Education Center Director

Rural Kentucky has a longstanding shortage of physicians. In response, the Northeast Kentucky Area Health Education Center developed a pre-medicine preparatory program that has been replicated in seven other regional centers. This session will explain the development of this project, from securing state funding to cross-center collaboration to data tracking.

3F
Rural Emergency Hospitals 101: What You Should Know
Taos

Emily Jane Cook, JD, MSPH, McDermott Will & Emery, LLP Partner
Margaret Greenwood-Ericksen, MD, MSc, University of New Mexico Professor of Emergency Medicine
George H Pink, PhD, North Carolina Rural Health Research Program Deputy Director
Pat Schou, MS, FACHE, Illinois Critical Access Hospital Network Executive Director
Sarah Young, MPH, Federal Office of Rural Health Policy Policy Research Division Deputy Director

The Consolidated Appropriations Act of 2021 (P.L. 116-260) established a new provider type, the Rural Emergency Hospital (REH), to allow certain small rural hospitals to transition to REH designation to provide necessary emergency and outpatient health care services as an alternative to a hospital closure. The first date for a hospital to transition to an REH is January 1, 2023. This is a major milestone since there has not been a new, permanent rural provider type established in statute since the creation of the Critical Access Hospital designation in 1997. This session will cover perspectives from rural legal and policy experts, rural health researchers, and rural health stakeholders on the National Advisory Committee for Rural Health and Human Services. Session attendees will learn about the law creating REHs, the rulemaking process and considerations for designing the REH program, how rural stakeholders can prepare for the change, and potential impacts of this new provider type on the rural health care landscape.

RHIS – APM Track
Paving a Path for the Future in 340B *(available to virtual attendees)*
Navajo/Nambe

Lisa Scholz, PharmD, MBA, FACHE, Sentry Data Systems Head of Industry Relations

In 2020, we will forever remember the pandemic. Another storm was brewing related to 340B. In July 2020, the first manufacturer announced they would stop selling 340B drugs to covered entities' contract pharmacies. The question on everyone's mind: "What will be the best strategy and path forward?"

RHIS -- Operations
Santa Ana

3G
Contributed Research Papers – Substance Abuse
Laguna

- **Community Perspectives on Opioid Misuse in Rural America**
  Carlin Rafie, PhD, MS, RD, Virginia Tech/Virginia Cooperative Extension Assistant Professor
- **SBIRT Diffusion in Rural vs. Urban Healthcare Settings**
  Angela Hagaman, DrPH, MA, NCC, ETSU NORC Rural Health Equity Research Center (RHERC) Research Operations Director
- **Rural WV Responds to Opioid Injection Epidemics**
  Drema Hill, PhD, MSP, WV School of Osteopathic Medicine Vice President for Community Engagement and Development
- **Sexual Health EBI Impact on Substance Use Among Native Youth**
  Lauren Tingey, PhD, MPH, MSW, Johns Hopkins Center for American Indian Health Associate Director; Laura Pinal, Johns Hopkins Center for American Indian Health Research Assistant

Thursday, May 12, 2022
8- 9 a.m.
Constituency Group Meetings and Continental Breakfast

Public Health Status/Clinical CG Meeting **Isleta/Jemez**

FQHC CG Meeting **Acoma/Zuni**

Research & Education/Journal of Rural Health **Santo Domingo**

Frontier/RHC **Laguna**

State Association Council **Apache**

Statewide Health Resources/NOSORH **Cochiti**

Hospital **Taos**

9:00 – 10:15 a.m.
Concurrent Sessions

4A
TBA

4B
How Telemedicine Answers the Call in Rural Health Care
Tesuque

Kelly Rhone, MD, FACEP, Avel eCare Medical Director of Outreach and Innovation

Mandy Bell, MHA, Avel eCare Vice President of Product Innovation

The COVID-19 pandemic caused a rapid adoption of telemedicine. Layering telemedicine into current processes allowed a weary workforce to provide care during the surge. How can telemedicine remain a critical part of health care delivery as we learn to live in a world where pandemics may be more common?

4C
Rural Libraries as Innovative Partners in Increasing Access to Health Care
Apache

Megan Weis, DrPH, MCHES, SC Center for Rural and Primary Healthcare Director of Community Engagement
Alanti McGill, MPH, SC Center for Rural and Primary Healthcare Program Manager

The South Carolina Center for Rural and Primary Healthcare's Rural Libraries and Health Innovations Program supports library systems as community health hubs. This presentation provides an overview of the program and learning collaborative and highlights different models, strategies, successes, and lessons learned.

4D
Together With Veterans for Rural Veterans Suicide Prevention
Santo Domingo

Leah Wendleton, MPH, MSW, Rocky Mountain MIRECC for Suicide Prevention Health Science Specialist
Nathaniel Mohatt, PhD, Rocky Mountain MIRECC for Suicide Prevention Community Psychologist

The Together With Veterans (TWV) is a community-based suicide prevention program for rural veterans. TWV involved partnering with rural veterans and community partners to implement public health strategies. This session will provide an overview of the program, lessons learned from implementing in more than thirty communities, and future program directions.

4E
Nurse Practitioner Residencies and Fellowships Promote Rural Practice *(available to virtual attendees)*
Navajo/Nambe

Louise Kaplan, PhD, ARNP, FAAN, Washington State University Associate Professor
Mykell Barnacle, DNP, FNP-BC, North Dakota State University NP Residency Program Director
Johanna Stiesmeyer, DNP, MS, RN, NPD-BC, Presbyterian Healthcare Services System Director of Clinical Education and Professional Development and HRSA Advanced Nursing Education Nurse Practitioner Residency Principle Investigator
Gregory Rys, DNP, Bassett Health Care Network Director of the Bassett Health Care Family Nurse Practitioner Rural Residency Program

Rural postgraduate nurse practitioner (NP) residencies and fellowships support recruitment and retention of NPs to rural primary care practice. This expert panel will review results of a study on rural NP program models and factors that influence their success, followed by discussion with attendees about how to expand programs further.

Grow Your Own APRNs and Keep Them Forever *(available to virtual attendees)*
Callie Anne Bittner, MS, RN, Colorado Center for Nursing Excellence Project Director
Ingrid Johnson, DNP, MPP, RN, Colorado Center for Nursing Excellence President and CEO

Building on several years of successful "grow your own" recruitment and retention strategies, this program was developed with grant funding to support nurse practitioners in Colorado to return to school and obtain a post-graduate psychiatric nurse practitioner certificate in rural provider shortage areas, increasing access by up to 25 percent.

4F
CDC Rural Health Update
Santa Ana
Summary TBA

RHIS – APM Track
Small Rural Hospital Blueprint for Performance Excellence and Value *(available to virtual attendees)*
Picuris/Sandia
Terry Hill, MPA, National Rural Health Resource Center Senior Advisor for Rural Health Leadership and Policy
Peggy Wheeler, MPH, California Hospital Association Vice President of the Rural Healthcare Center
Maggie Sauer, North Carolina Department of Health and Human Services Office of Rural Health Director

The Blueprint for Performance Excellence and Value identifies the most important critical success factors for small rural hospitals to achieve excellence. A summit with rural hospital leaders supported by the Federal Office of Rural Health Policy updated the Blueprint and confirmed the Blueprint offering examples, along with lessons learned and opportunities.

RHIS – Operations
Leveraging Partnerships to Score A WINN for Rural
Acoma/Zuni
Nicole Weathers, MSN, RN, Iowa Online Nurse Residency Program Program Manager
Tondeleyo Gonzalez, Colorado Center for Nursing Excellence Assistant Project Director

Increases in retirement and nurses transitioning away from the bedside left vacancies that academic institutions push to fill with new graduates. Eligible candidates prioritize ongoing

training and mentorship, challenging rural organizations where nurse residencies are scarce. Leveraging partnerships allowed for development of the Workforce Innovation Nursing Network serving rural facilities.

4G
Contributed Research Papers – Rural vs Urban Trends
Laguna

- **Addressing Geographic Disparities in the Provision of Ambulance Services**
  Yvonne Jonk, PhD, University of Southern Maine Associate Research Professor
- **Maternal Morbidity Risk across Rurality, Race, and Medicaid**
  Julia Interrante, MPH, University of Minnesota Rural Health Research Center Doctoral Student
- **Evaluation of Rural Inclusion in State Plans on Aging**
  Carrie Henning-Smith, PhD, MPH, MSW, University of Minnesota School of Public Health Associate Professor
- **Rural-Urban Disparities in Inpatient Psychiatric Care Quality**
  Peiyin Hung, PhD, MSPH, University of South Carolina Rural and Minority Health Research Center Assistant Professor

10:15 – 10:45 a.m.
Poster Session/Break
La Sala Foyer

10:45 a.m. – 12:00 p.m.
Concurrent Sessions

5A
HISP Programs Reduce Cardiovascular Disease Risk in Rural
Isleta/Jemez

Katherine Lloyd, MPH, Federal Office of Rural Health Policy Public Health Analyst
Manorama Khare, PhD, MS, University of Illinois College of Medicine Rockford Research Associate Professor
Donna Norkoli, BS, NCHES, District Health Department #10 Health Planner
Amanda Phillips Martinez, MPH, Georgia Health Policy Center Assistant Project Director

The Federal Office of Rural Health Policy's outreach program, funded by the Health Improvement Special Project, was created to address cardiovascular disease risk in rural communities. Presenters including two grantees will discuss results from the three-year implementation of programs to reduce cardiovascular disease risk in rural communities.

5B
CHWs Help Rural Providers with Outreach and Reducing Hospital Readmissions *(available to virtual attendees)*
Navajo/Nambe

Jane Bolin, Texas A&M School of Public Health and College of Nursing, Associate Dean for Research and Deputy Director, Southwest Rural Health Research Center
Heather Clark, DrPH, MPH, Texas A&M School of Public Health and Center for Community Health Development, Director of Public Health Practice and Research Assistant Professor
Catherine Catanach, Center for Community Health Development, Assistant Director

Community health workers (CHW) help patients navigate the health care system and engage in health education in people's homes, schools, churches, and neighborhoods. This session will give examples of how CHWs can be utilized in your organization to help manage patients, serve as navigators, and provide culturally acceptable patient teaching.

5C
The Telehealth Resource Centers: Response to COVID-19 and Beyond
Apache
Elizabeth Krupinski, PhD, Emory University Department of Radiology & Imaging Services Professor & Vice Chair for Research
Matt McCullough, PhD, Utah Education and Telehealth Network Director of Telehealth Services

The Telehealth resource centers are federally funded, nonpartisan, and unbiased technical assistance providers for health care practitioners, policymakers, and communities that have questions regarding telehealth. Attendees will learn more about these entities and the tools and assistance they offer in the evolving landscape of telehealth.

5D
Crisis Response Funding: Lessons from Rural Health Funders
Santo Domingo
Bronwyn Starr, MPH, New York State Health Foundation Senior Program Officer
Brian Byrd, New York State Health Foundation Senior Program Officer
Linda Beers, MPH, Essex County Public Health Public Health Director
Kevin Watkins, MD, MPH, Cattaraugus County Health Department Public Health Director

COVID-19 underscored the lack of government infrastructure for crisis response funding. This session will present a rapid response model that enabled the swift distribution of private dollars to rural health departments. While philanthropy cannot replace public funding, rural health organizations should be aware of how to tap into private dollars.

5E
Classroom to Community: Enhancing the Rural Physician Workforce
Tesuque
David Sandweiss, MD, Spencer Fox Eccles School of Medicine at the University of Utah Clinical Associate Professor of Pediatrics; Director of Rural and American Indian Outreach for the Department of Pediatrics Global, Rural, and Underserved Child Health Program; and Director of Tribal, Rural, and Underserved Medical Education Graduate Certificate

Stacy Eddings, PhD, University of Utah Spencer Fox Eccles School of Medicine Research Associate and Project Tracking and Evaluation Manager
Jerilyn Price, LCSW, Utah Navajo Health System, Inc. Substance Abuse/Social Worker
Ernest Begay, DHA, Utah Navajo Health System, Inc. Department of Behavioral Health Services Traditional Counselor
Cameron Arkin, MS2, BA, Spencer Fox Eccles School of Medicine at the University of Utah Medical Student

Students participating in a tribal, rural, and underserved medicine pathway and summer rural immersion trip reported increased comprehension of and commitment to rural primary care medicine. This session will present the curriculum, learning outcomes, and competencies. Additional content includes the process of developing reciprocal, mutually beneficial relationships with health care providers.

5F
Looking Back While Moving Forward: RCORP Past, Present, and Future
Santa Ana
Marcia Colburn, MSW, Federal Office of Rural Health Policy Rural Strategic Initiatives Division Public Health Analyst

The Rural Communities Opioid Response Program (RCORP) has now become a five-year initiative which has received $575 million in appropriations since its inception in FY 2018. To date, the more nearly 600 RCORP award recipients across nine unique grant programs and four cooperative agreements have served over 1,500 rural counties. Moreover, active grant recipients in FY 2020 provided medication assisted treatment (MAT) services for substance use to 70,869 rural individuals, and more than two million rural residents received an array of direct prevention, treatment, and recovery services. Throughout 2020 and 2021, many RCORP grantees developed unique approaches to continuing and even increasing service provision throughout the COVID-19 pandemic. This presentation will provide a brief history of RCORP and its growth, highlight some of the innovative, impactful practices that RCORP grantees have utilized to address substance use disorder (SUD) in their communities, and peak behind the curtain to get a glimpse of FORHP plans for the continued evolution of this initiative. Audience members will also have an opportunity to join in the discussion around SUD and behavioral health-related challenges in their rural communities, and strategies to address them.

RHIS – APM Track
How Federal Policy is Driving Rural Health Care towards New Models of Payment and Delivery *(available to virtual attendees)*
Picuris/Sandia
John Supplitt, MPA, MBA, American Hospital Association Senior Director

With one foot on the boat and another on the dock, rural hospitals are caught between volume versus value-based payment alternatives and models of delivery they incent. As public and

commercial payers steer providers away from volume-based payment, hospitals will learn to adapt to value-based incentives.

RHIS -- Operations
Assessing the Effect of COVID-19 on the Well-Being of North Dakota Hospital Employees
Acoma/Zuni

Daniel Kelly, DHA, McKenzie County Healthcare Systems, Inc. CEO
Shawnda Schroeder, PhD, Center for Rural Health Associate Director of Research and Evaluation

The Center for Rural Health has partnered with two other entities to complete an assessment on the impact of COVID-19 on the well-being of hospital staff in North Dakota. The findings will assist health care managers and administrative staff to better understand the psychological distress COVID-19 has had on health care employees.

5G
Contributed Research Papers – Telehealth
Laguna

- **Tele-Collaborative Pain Care for Rural Patients with Substance Use Disorder**
  Belle Zaccari, PsyD, VA Portland Health Care System Psychologist
- **Patterns of Telehealth Use in South Carolina**
  Samantha Renaud, MA, SC Center for Rural and Primary Healthcare Research Program Manager
- **Telehealth Services During COVID-19: A Rural/Urban Analysis**
  Kate Beatty, PhD, MPH, BS, East Tennessee State University Associate Professor
- **Telehealth and remote patient monitoring: Did early adoption of telecommunication technologies help rural and urban hospitals avoid revenue decline during COVID-19?**
  Claudia Rhoades, Ph.D. Candidate, Oklahoma State University Graduate Research Assistant

12 – 1:45 p.m.
Rural Health Awards Luncheon *(available to virtual attendees)*
Ballroom C

Join NRHA for a tribute to the 2022 Rural Health Award winners.

1:45 – 2:30 p.m.
Terry Reilly Lecture *(available to virtual attendees)*
Ballroom AB

Karriem Watson, DHSc, National Institutes of Health All of Us Research Program Chief Engagement Officer

2:30 – 3:15 p.m.
Terry Reilly Lecture *(available to virtual attendees)*
Ballroom AB

Xochitl Torres Small, United States Department of Agriculture Under Secretary for Rural Development

3:15 – 3:30 p.m.
Poster Session/Break
La Sala Foyer

3:30 – 4:45 p.m.
Concurrent Sessions

6A
Topic TBA
Isleta/Jemez

6B
Leveraging Trusted Messengers
Tesuque
Lindsey Nienstedt, MPH, MSW, Federal Office of Rural Health Policy Policy Research Division Public Health Analyst
Jason Steele, MPH, Federal Office of Rural Health Policy Hospital State Division Public Health Analyst
Sarah Scott, MSPH, Federal Office of Rural Health Policy Policy Research Division Health Insurance Specialist

Focus has increasingly shifted to the central, critical role rural health care providers and community organizations play in the effort to combat COVID-19. This session will provide an overview of the Federal Office of Rural Health Policy (FORHP) investment in Rural Health Clinic (RHC) and state level Small Rural Hospital Improvement Program (SHIP) programs created to respond to the COVID-19 pandemic, increase vaccine confidence, and ensure equity in COVID-19 response in rural communities. FORHP staff will share RHC and rural hospital success stories and lessons learned.

6C
Gun Violence Prevention: A Practical Skills-Based Training
Apache
Mina Tanaka, MD, MPH, Northern Navajo Medical Center Internal Medicine Physician

U.S. gun violence rates are rising with gun ownership being significantly higher in rural households. Although gun safety counseling in health care settings is tied to safer gun ownership practices, it is not commonly performed. This session will provide practical information to equip practitioners with skills related to gun violence prevention.

6D
Forensic Nursing: Closing the Gap on Violence in Rural and Under-Served Areas
Santo Domingo

Stacey Mitchell, DNP, MBA, Med, RN, SANE-A, DF-AFN, FAAN, Texas A&M College of Nursing Clinical Professor
Heather Clark, DrPH, Texas A&M School of Public Health Research Assistant Professor
Stacy Drake, PhD, MPH, RN, AFC-BC, D-ABMDI, FAAN, Texas A&M University College of Nursing Associate Professor
Nancy Downing, PhD, RN, SANE-A, SANE-P, FAAN, Texas A&M University College of Nursing Associate Professor

The Center of Excellence in Forensic Nursing at Texas A&M University College of Nursing was founded to increase access to evidence-based, trauma-informed health care for patients in rural areas who experience interpersonal violence through education, outreach, and research. In this session, we will discuss injury and violence and the need for access to expert forensic nursing care in rural areas, and describe projects funded by the state of Texas, HRSA, and the Office for Victims of Crime related to expanding rural access to forensic nursing care. We will describe innovative strategies to provide high-quality, evidence-based sexual assault nurse examiner (SANE) education such as simulated medical forensic examinations, virtual reality education, and use of technology for ongoing education, support, and mentorship to decrease burnout and promote retention. We will describe development of a statewide telehealth SANE program, Texas Teleforensic Remote Assistance Center (Tex-TRAC), to provide real-time expert SANE guidance to nurses in rural hospitals as they conduct medical forensic examinations. ECHO SAFE is modeled after Project ECHO to disseminate information to clinicians in rural and under-served areas. Evaluation data on all programs will be presented and discussed. Participants will be able to appraise strategies that might be transferable to their regions or states to address access to forensic health care in rural and underserved areas.

6E
Preparing Learners for Rural Interprofessional Collaboration and Practice *(available to virtual attendees)*
Picuris/Sandia
Stephanie Kiser, RPh, UNC Health Sciences at MAHEC Director of Interprofessional Education & Practice
Bryan Hodge, DO, UNC Health Sciences at MAHEC Chair of Department of Community and Public Health
Sarah Thach, MPH, UNC Gillings School of Global Public Health Master of Public Health Program in Asheville Assistant Director

UNC Health Sciences at MAHEC in Asheville trains medical, pharmacy, dental, and public health learners. Preparing them for rural, interprofessional practice, the program provides interprofessional case seminars, rotations in rural teaching hubs, shared community projects, and co-curricular experiences, and is developing collaborative research training. This session explains the approach and implementation framework.

6F
An Honest Conversation About Rural Health Policy

Santa Ana

John Gale, MS, University of Southern Maine Rural Health Research Center Senior Research Associate and Director of Policy Engagement

The American rural health system is under significant strain with growing rates of hospital and provider closures. This session reviews the history of state and federal efforts to support vulnerable rural providers; summarizes the lessons learned; and uses those lessons to inform current policy efforts to support rural health systems.

RHIS – APM Track

Widening Health Disparities Present New Challenges in Aftermath of Pandemic *(available to virtual attendees)*

Navajo/Nambe

Michael Topchik, The Chartis Group

The "new normal" for rural hospitals means treating COVID patients is part of everyday operations. An analysis by the Chartis Group suggests that socioeconomic and health disparity gaps between rural and urban may be widening, and in this new normal these indicators take on new importance for the delivery of care in rural communities.

RHIS -- Operations

How Presbyterian Medical Services Decreased their Exposure to Cyberattacks

Isleta/Jemez

John Gomez, Sensato Cybersecurity Solutions CEO
Gisela Bartolome, Presbyterian Medical Services Chief Information Officer
Kate Macaleer, Sensato Cybersecurity Solutions Senior Vice President of Operations

Health care organizations acknowledge the need to safeguard data and patients from cyberattacks. Presbyterian Medical Services took action to put software and procedures in place to reduce their risk and monitor for potential attacks. Hear how Presbyterian Medical Services developed a cybersecurity strategy to protect their network and patients with limited resources.

6G

Contributed Research Papers – Clinical

Laguna

- **Disparities in Diabetes Mortality in Rural United States**
  Sagar Dugani, MD, PhD, MPH, Mayo Clinic Rochester Physician-Researcher
- **Colorectal Screening Performance in Primary Care Practices**
  Tyrone Borders, PhD, University of Kentucky College of Nursing Professor
- **Cancer Prevention Activities in RHCs: Impacts of COVID-19**
  Whitney Zahnd, PhD, University of Iowa Assistant Professor
- **Rural-Urban Treatment Patterns for Opioid Use Disorder**
  Holly Andrilla, MS, WWAMI Rural Health Research Center Senior Research Scientist

Friday, May 13, 2022

8 – 9:30 a.m.

Washington Update *(available to virtual attendees)*

Ballroom AB

Carrie Cochran-McClain, NRHA Chief Policy Officer

Join rural health's top federal lobbyist for an insider's update about what's going on in Washington and what to expect in the next year.

9:30 – 9:45 a.m.

Break

9:45-11:00 a.m.

Concurrent Sessions

7A

Isleta/Jemez

Summary TBA

7B

Acoma/Zuni

Summary TBA

7C

Addressing Behavioral Health Needs Through Community Care Coordination

Apache

Kaarin Lund, National Rural Health Resource Center Community Program Specialist
Suzanne Snyder, Federal Office of Rural Health Policy Public Health Analyst/DRCHSD Program Program Coordinator
Gina Matlock, Henry County Medical Center Community Champion
Tory Daughrity, Henry County Medical Center Director of Marketing and Public Relations

With support from the Delta Region Community Health Systems Development Program, discover how Henry County Medical Center utilized community health needs assessment results and health outcome data to meet the behavioral health needs of their community, including step-wise approach to collaborate with community partners, measure knowledge, and create change.

7D

Dentist Retention through the Safety Net Certificate Program *(available to virtual attendees)*

Picuris/Sandia

Amy Martin, Medical University of South Carolina Professor and Chair
Amah Riley, Medical University of South Carolina Program Manager

Medical University of South Carolina convened the Safety Net Summer Institute for 10 rural dentists. Learners accessed online curriculum and participated in four in-person learning retreats at a rural hospital. They developed personalized improvement plans based on course content that included team leadership, advocacy, practice management, and empathetic communication.

7E

BS/MD Program, The Sequel - We Have Doctors!

Santa Ana

Jennifer Plymale, MA, Marshall University Director of the Center for Rural Health and Associate Dean of Admissions
Abbie Short, Marshall University Medical Student Class of 2023 BS/MD Program Member
Brandon Henderson, Marshall University Medical Student Class of 2023 BS/MD Program Member

Marshall University began its BS/MD program with high hopes and a unique model of "growing our own" physicians in a rural state by offering talented high school seniors acceleration and tuition waivers to medical school. After seven years, the program has an excellent retention rate and a crop of newly minted MDs.

7F

We Need to Talk About MAT

Santo Domingo

Sabrina Frost, MPH, Federal Office of Rural Health Policy Rural Strategic Initiatives Division Public Health Analyst
Lindsey Nienstedt, MPH, MSW, Federal Office of Rural Health Policy Policy Research Division Public Health Analyst

Since 2019, Rural Communities Opioid Response Program Medication Assisted Treatment (RCORP-MAT) Expansion grantees have exceeded yearly benchmarks, increased the number of MAT providers, and increased the number of MAT patients served. Rural Health Clinics (RHCs) have been an integral part of the RCORP-MAT program; and they have served as an example of the successful integration of MAT with traditional RHC services. This session will address specific RHC MAT policy concerns and provide examples of practical solutions to the unique challenges faced by MAT programs in rural service areas.

RHIS – APM Track

Improving Rural Health and Economic Vitality Through Innovation

Cochiti

Vijay Chauhan, BioSTL Global STL Lead

The Center for Rural Health Innovation strengthens the health and economic vitality of rural communities through rural-centric innovation. With four focus areas (access and affordability, workforce, affordable high-speed internet, and rural-specific SDoH) and "rural first" approach, the center sources innovative solutions to solve rural challenges and converts that innovation into value.

RHIS -- Operations
What is Keeping Hospital CEOs Up at Night? *(available to virtual attendees)*
Navajo/Nambe
Melissa Lackey, MSN, RN, CPPS, Texas A&M Rural and Community Health Institute Project Specialist
Nancy W Dickey, MD, FAAFP, Texas A&M Rural and Community Health Institute Executive Director
Adam Willmann, Goodall-Witcher Hospital CEO

Project ECHO is an innovative way to improve rural health care. The ECHO model has been used for a variety of topics, and this program focuses on what's keeping hospital CEOs up at night. Learn how to connect C-suite to specialists and their peers to educate and support each other.

7G
Contributed Research Papers – Population Health
Laguna

- **Rural Healthy People 2030: New Decade, New Challenges**
  Timothy Callaghan, PhD, Texas A&M University Assistant Professor
- **Pandemic Reversed 20 Years of Rural Mortality Improvement**
  Janice Probst, Rural & Minority Health Research Center at the University of South Carolina Director Emerita
- **Oral Health Needs of Rural Populations: Rapid Review**
  Anchee Nitschke Durben, BS, St. Catherine University Student; Juliette Kline, St. Catherine University Student; Stephanie de Sam Lazaro, OTD, OTR/L, St. Catherine University Associate Professor and Director of Graduate Occupational Therapy
- **Healthcare Conversion Foundation Investments in Communities by Rurality**
  Casey Balio, PhD, Center for Rural Health Research at East Tennessee University Research Assistant Professor

11:00 a.m.
End of Annual Conference

Will Virtual Public Meetings Continue Even After the Pandemic?

Two New Bills Could Ease California's Teleconferencing Restrictions for the Long-Term

April 26, 2022- As a result of the COVID-19 pandemic, the California Legislature previously passed AB 361 to allow for streamlined teleconferencing under the Brown Act during times of local emergency. Over time, public agencies and the general public have become more comfortable with fewer teleconferencing rules and restrictions. There are now two new bills that, if signed into law, would provide agencies with greater ease and streamlining in teleconferencing for the foreseeable future.

AB 1944 – Simple Approach Allowing For Broader and More Flexible Teleconferencing

AB 1944 would provide continued privacy to members of legislative bodies who are teleconferencing from private locations. The following requirements would apply:

- Legislative bodies must provide the public with virtual access when teleconferencing.
- Agendas must identify the members of the legislative body who will participate remotely.
- Legislative bodies must update agendas if members make last-minute decisions to teleconference.
- Legislative bodies must provide the public with a live video stream and an option to submit virtual public comments.
- A quorum must participate from within the agency's boundaries when teleconferencing, except under limited circumstances.

AB 1944 would authorize the legislative body to exempt itself by majority vote from the requirements that each teleconference location must be accessible to the public, and that their teleconference address be publicly identified in the notice and agenda. However, these exemptions would only apply when members of the legislative body teleconference from a non-public location (e.g. their home, a hotel, a hospital, etc.).

AB 1944 contains a Jan. 1, 2030 sunset for these provisions.

AB 2449 – More Complex Approach Allowing For Limited Teleconferencing

AB 2449 presents a more detailed approach to provide for similar goals as AB 1944. Generally, it only allows for relaxed teleconference rules "when a quorum of members participate in the meeting from a single public location," meaning

(continued from page 1)

relaxed teleconferencing is only available to some members of the legislative body. So far, this bill has been less active than AB 1944.

AB 2449 would authorize relaxed teleconferencing procedures (meaning there would be no need to identify each teleconference location, post agendas at all teleconference locations, or allow the public to access the teleconference locations) if at least a quorum of the legislative body participates in-person at a single location identified on the agenda that is open to the public, and the legislative body follows certain requirements, including:

- Giving regular notice of the meeting and posting agendas as otherwise required by the Brown Act
- Teleconferencing members must use both audio and visual technology
- Allowing the public to access the meeting and provide comments, including by teleconference, and including teleconference instructions in all notifications and agendas for the meeting on how the public can attend and provide comment
- Pausing the meeting when there is any teleconference disruption
- Allowing for real-time public comments and not requiring submission of comments in advance of the meeting
- Creating and implementing a procedure for receiving and swiftly resolving requests for reasonable accommodations for individuals with disabilities, and giving notice of this procedure in notifications and agendas for the meeting

AB 1944 and AB 2449 remain active as of publication of this Legal Alert, and have potential to become law. Best Best & Krieger will continue to track the progress of these bills and provide updates as appropriate.

Disclaimer: BB&K Legal Alerts are not intended as legal advice. Additional facts, facts specific to your situation or future developments may affect subjects contained herein. Seek the advice of an attorney before acting or relying upon any information herein.

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American Hospital Association™
Advancing Health in America

Washington, D.C. Office
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Washington, DC 20001-4956
(202) 638-1100

April 11, 2022

The Honorable Bob Casey
United States Senate
393 Russell Senate Office Building
Washington, DC 20510

The Honorable Chuck Grassley
United States Senate
135 Hart Senate Office Building
Washington, DC 20510

Dear Senator Casey and Senator Grassley:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, two million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) is pleased to support the Rural Hospital Support Act (S. 4009).

Rural hospitals are essential access points for care, economic anchors for communities and the backbone of our nation's rural public health infrastructure. These hospitals have maintained their commitment to ensuring local access to high-quality, affordable care during the COVID-19 pandemic and beyond, in spite of unprecedented financial and clinical challenges over the last two years.

We applaud you for your leadership in introducing the Rural Hospital Support Act, which will help keep the doors open at rural hospitals and allow them to continue serving their local communities during this unprecedented time of sustained financial pressure and historic changes in care delivery.

The network of providers that serves rural Americans is fragile and more dependent on Medicare revenue because of the high percentage of Medicare beneficiaries who live in rural areas. To support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges, Congress established the Medicare-Dependent Hospital (MDH) program in 1987, allowing eligible hospitals to receive the sum of their prospective payment system (PPS) payment rate, plus three-quarters of the amount by which their cost per discharge exceeds the PPS rate. These payments allow MDHs greater financial stability and leave them better able to serve their communities. Your legislation would make this important program permanent and add an additional base year MDHs could choose when calculating their payments.

In addition, the Rural Hospital Support Act would make the enhanced low-volume Medicare adjustment permanent. Medicare seeks to pay efficient providers their costs of furnishing services. However, certain factors beyond providers' control can affect the costs of furnishing services. Patient volume is one such factor and is particularly relevant in small and isolated communities where providers frequently cannot achieve the economies of scale possible for their larger counterparts.

Although a low-volume adjustment existed in the inpatient PPS prior to fiscal year 2011, the Centers for Medicare & Medicaid Services had defined the eligibility criteria so narrowly that only two or three hospitals qualified each year. The current, improved low-volume adjustment better accounts for the relationship between cost and volume, helps level the playing field for low-volume providers and improves access to care in rural areas. Your legislation permanently extends the low-volume adjustment to ensure that these providers will not again be at a disadvantage and have severe challenges serving their communities.

The sole community hospital (SCH) program plays an important role in maintaining access to care in rural communities. SCHs must show they are the sole source of inpatient hospital services reasonably available in a certain geographic area to be eligible for the program. They receive increased payments based on their cost per discharge in a base year. By allowing SCHs to choose an additional base year from which payments can be calculated, your legislation provides the increased support needed now by many rural hospitals.

Again, we are pleased to support this legislation and look forward to working with you and your colleagues to achieve its passage.

Sincerely,

/s/

Lisa Kidder Hrobsky
Senior Vice President, Advocacy and Political Affairs

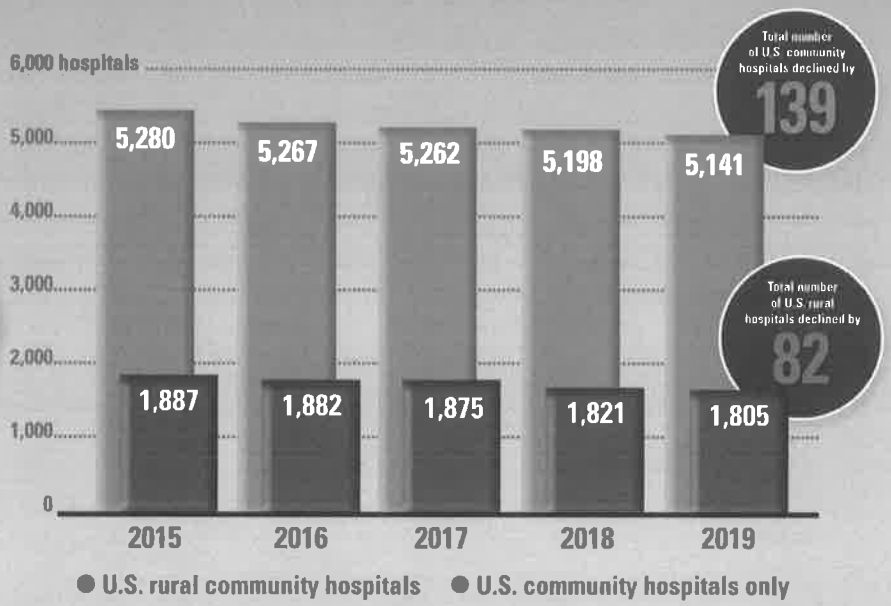
FAST FACTS | U.S. Rural Hospitals

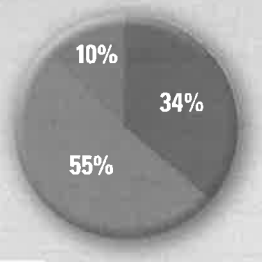
IS MY HOSPITAL RURAL?

Rural hospitals are those not located within a metropolitan area designated by the U.S. Office of Management and Budget and the Census Bureau. Community hospitals are nonfederal, acute care hospitals open to the general public. For alternate rural definitions, see https://www.ruralhealthinfo.org/am-i-rural/help#classification.

59%

of the decline in the number of U.S. community hospitals between 2015 and 2019 were RURAL HOSPITALS





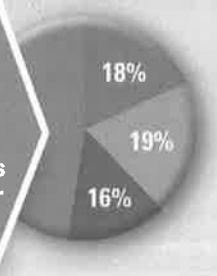
U.S. rural community hospitals, by ownership type, 2019

- State and local government *(620 total)*
- Nonprofit *(998 total)*
- Investor-owned, for-profit *(187 total)*

* Data may not total 100% due to rounding

47%

of rural hospitals have 25 or fewer staffed beds



U.S. rural community hospitals, by bed size, 2019

- Up to 25 beds *(850 total)*
- 26-50 beds *(316 total)*
- 51-100 beds *(345 total)*
- 101 beds or more *(294 total)*

SOURCE: AHA Annual Survey Database, FY2015–FY2019 | www.ahadata.com
For more information or to purchase access to AHA data | ahadatainfo@aha.org

American Hospital Association™
Advancing Health in America

California Critical Access Hospitals

The Center for Medicare and Medicaid Services (CMS) designates certain rural hospitals meeting specific criteria as Critical Access Hospitals. This graphic maps out the location of California's Critical Access Hospitals.

National Rural Health Association

The National Rural Health Association is a nonprofit, nonpartisan membership organization with more than 21,000 members consisting of diverse individuals and organizations who share the goal of improving rural health. NRHA strives to improve the health of the 60 million who call rural America home.

We fight for rural health equity

Rural populations often encounter barriers to health care that limit their ability to obtain the care they need. COVID-19 has devastated the financial viability of rural practices, disrupted rural economies, and eroded availability of care. Medical deserts are appearing across rural America, leaving many without timely access to care. Addressing rural inequities and declining life expectancy is a top priority for NRHA in 2022.

We fight for a robust rural workforce

The COVID-19 pandemic exacerbated the workforce shortage in rural America. Historically, rural areas have struggled to recruit and retain an adequate health care workforce. Seventy-seven percent of rural counties are health professional shortage areas, and close to one in 10 counties have no physicians at all. With far fewer physicians per capita, the maldistribution of health care providers between rural and urban areas results in unequal access to care and negatively impacts rural health.

We fight for strong rural health infrastructure

Federal investment in rural health programs is a small portion of health care spending, but it is critical to rural Americans. These safety net programs expand access to health care, improve health outcomes, and increase the quality and efficiency of health care delivery in rural America. Investing in strong rural health infrastructure is critical to the future of rural areas.

2022 Rural Health Champion Award Winners

Senator Shelley Moore Capito (R- W. Va.)

Representative Donald McEachin (D- Va.)

2022 Legislative Staff Award Winners

Adeola Adesina (Senator Jeff Merkley (D- Ore.))

Emily Henn (Representative Sam Graves (R-Mo.))

2022 Advocate of the Year

Robert Duehmig, Oregon Office of Rural Health

National Rural Health Association

www.ruralhealth.us | @NRHA_Advocacy

2022 Rural Health Requests to Address Rural Health Equity

1.Establish an Office of Rural Health within the CDC

In recent years, the Centers for Disease Control and Prevention (CDC) has increased its focus on the health challenges and disparities routinely encountered by 60 million rural Americans. This has become increasingly evident during the COVID-19 pandemic, as structural barriers to addressing rural health and safety needs have become more apparent. **NRHA urges Congress to establish an office within CDC devoted to addressing rural health disparities and supporting rural public health infrastructure.**

Request: NRHA urges support of S. 3149 / H.R. 5848, the Rural Health Equity Act to create an Office of Rural Health within the CDC.

2. Expand access to maternal health services

NRHA is encouraged by dialogue on Capitol Hill with the aim of expanding access to maternal health care services and reducing maternal mortality rates. Regarding that those conversations have not included rural stakeholders, despite the fact that maternal health outcomes in rural areas are much worse compared to their urban counterparts. **NRHA encourages Congress to ensure that rural communities have access to the resources they need to improve maternal health outcomes.**

Request: NRHA urges support of S. 1491 / H.R. 769, the Rural Maternal and Obstetric Modernization of Services (MOMS) Act to authorize HRSA to establish rural obstetric networks.

3. Congress should permanently expand telehealth provisions

Telehealth flexibilities were significantly expanded at the beginning of the COVID-19 public health emergency through the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Centers for Medicare and Medicaid Services 1135 waiver authority. **As we near the presumptive end of the public health emergency, it is imperative that Congress makes these flexibilities permanent to ensure rural providers are able to continue providing care through telehealth.** In particular, NRHA is supportive of continuing to allow federally qualified health centers and rural health clinics to provide distant-site telehealth services at equitable payment rates.

Request: NRHA urges support of S. 1512 / H.R. 2903, the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021 or S. 1988 / H.R. 5425, the Protecting Rural Telehealth Access Act to ensure rural providers are able to continue providing services via telehealth beyond the public health emergency.

2022 Rural Health Requests to Strengthen the Rural Health Workforce

1.Expand the Medicaid Graduate Medical Education (GME) Program

The rural health workforce is overwhelmed and under resourced. The absence of a qualified, robust workforce is one of the largest obstacles rural communities face, and this has been exacerbated by the COVID-19 pandemic. In 2022, **it is imperative that Congress provides adequate resources to ensure the next generation of physicians can train in rural communities.** It is critical that all safety net providers, like sole community hospitals and critical access hospitals, can train medical students at their facilities. Further, it is important that a relevant definition of rural is used for the Medicare GME program to place residents in areas of greatest need.

Request: NRHA urges support for S. 1893, the Rural Physician Workforce Production Act, to ensure rural providers are adequately represented in the Medicare GME program.

2. Provide supplemental appropriations to programs like the National Health Service Corps and Nurse Corps Loan Repayment Programs

As rural health care providers continue to rebound from the ongoing COVID-19 pandemic, **it is critical to ensure a reliable workforce is available in rural communities.** As Congress evaluates additional need for COVID-19 relief in 2022, NRHA urges that supplemental funding be provided for workforce programs such as the National Health Service Corps and Nurse Corps Loan Repayment Programs to grow the rural health care workforce.

Request: Support supplemental appropriation funding for workforce programs like the National Health Service Corps and the Nurse Corps Loan Repayment Programs in future COVID-19 relief legislation.

3. Expand the nursing workforce to ensure rural communities have access to care

Rural providers are facing a shortage of nursing professionals. As Congress continues to evaluate ways to improve the rural health safety net, it is imperative that the nursing workforce is enhanced. NRHA urges Congress to devote resources to ensure nursing schools are equipped to increase capacity and build out the health workforce.

Request: NRHA urges support for S. 246 / H.R. 851, the Future Advancement of Academic Nursing (FAAN) Act to authorize grants to support schools of nursing to increase the number of nursing faculty and students.

2022 Rural Health Requests to Support Rural Health Infrastructure

1. Continue relief from Medicare sequestration through the end of the public health emergency

In December 2021, Congress continued relief from Medicare sequestration through March 31, 2022. Since then, the Omicron variant has presented a new obstacle for rural health providers. Simply put, **now is not the time to reinstate a devastating two percent cut to Medicare payments for rural providers**. NRHA urges Congress to continue relief from Medicare sequestration through Dec. 31, 2022.

Request: NRHA urges support for H.R. 315 Medicare Sequester COVID Moratorium Act to continue Medicare sequestration relief through the end of the public health emergency, or until the end of 2022.

2. Implement policies to support rural safety net hospitals beyond the public health emergency

In January, the Save America's Rural Hospitals Act was introduced to **ensure critical rural providers are equipped to support their patients beyond the duration of the public health emergency.** Of note, the legislation includes provisions to permanently eliminate Medicare sequestration for rural hospitals; extend payment levels for low-volume hospitals and Medicare-dependent hospitals; make permanent increased Medicare payments for ground ambulance services in rural America; provide a fix so provider-based rural health clinics are able to receive cost-based reimbursement; eliminate the 96-hour physician certification requirement for CAHs; and reauthorize the Medicare Rural Hospital Flexibility Program.

Request: NRHA urges support for H.R. 6400, the Save America's Rural Hospitals Act to ensure critical changes to strengthen the rural health safety net.

2022 Rural Health Requests to Support Rural Health Infrastructure

3. Modernize Rural Health Clinic Program payment

With passage of the Consolidated Appropriations Act 2021, provider-based rural health clinics became subject to the same capped reimbursement rate as freestanding rural health clinics for entities established after Dec. 31, 2020. **NRHA encourages Congress to exempt all provider-based rural health clinics from this capped rate in exchange for voluntary participation in a quality reporting program**. Through adoption of this proposal, Congress will receive data on the Rural Health Clinic Program that has been historically unavailable. Additionally, this will keep provider-based RHCs stable for the creation of additional sites to meet future need.

Request: NRHA urges support for H.R. 6400, the Save America's Rural Hospitals Act to allow exemptions to reimbursement caps for rural health clinics.

4. Ensure the 340B Drug Pricing Program remains a viable lifeline

Over the last few years, several large drug manufacturers have taken actions to undermine and threaten the longevity of the 340B Drug Pricing Program. For rural providers, **the 340B Drug Pricing Program serves as a valuable lifeline to ensure they're able to provide necessary services to patients in their communities**. NRHA urges congress to provide HHS the authority to stand up to these manufacturers and protect the program.

Request: NRHA urges support for H.R. 4390, the Protect 340B Act of 2021, to ensure equitable treatment of covered entities and pharmacies participating in the 340B Drug Pricing Program.

Fiscal Year 2022 Appropriations Request

Now, more than ever before, it is crucial for Congress to support programs that address severe health care crises in rural America. Rural health care providers, who were already struggling to keep their doors open prior to COVID-19, have been hit hard by the pandemic. **Continued relief is needed to address the unique needs of rural America through the passage of a FY 2022 appropriations bill.**

Rural health discretionary spending is a relatively small amount but is vitally important for maintaining access to care for individuals living in rural America. To better meet these needs, NRHA requests a modest funding increase of 10 percent for most of our itemized requests. Additionally, NRHA urges Congress to support the following FY 2022 priority requests to significantly improve rural health care access and affordability:

Expand the USDA Rural Hospital Technical Assistance Program. This program provides direct on-the-ground assistance and is flexible enough to meet the many varied needs of rural hospitals, especially those under critical duress from the ongoing pandemic. In FY 2021, the program was funded at $2 million. The House-passed Labor, Health and Human Services, Education, and Related Agencies appropriations package maintained funding at $2 million for FY 2022. **NRHA urges Congress to increase funding for this important program to a level of $5 million in the final appropriations package**.

Include specified funding for the Rural Maternal and Obstetric Management Strategies (RMOMS) program within HRSA's Federal Office of Rural Health Policy (FORHP). In FY 2019, FORHP used the Rural Health Outreach program to evaluate ways to improve the quality of obstetric care in rural America. **NRHA calls on Congress to build into HRSA's Rural Health Outreach budget a $10 million carveout for the RMOMS program.** The House-passed Labor, Health and Human Services, Education, and Related Agencies appropriations package specified $10.4 million for FY 2022. **NRHA urges Congress to maintain this amount in the final appropriations package.**

Expand physician training in rural areas by supporting the development of new rural residency programs to address the workforce shortages faced by rural communities. Recent changes in CMS Medicare GME will expand the number of applicants but residency programs are needed to allow individuals to train in rural communities. The House-passed Labor, Health and Human Services, Education, and Related Agencies appropriations package allocated $12.7 million for the Rural Residency Planning Development program in FY 2022. **NRHA urges Congress to maintain this amount in the final appropriations package.**

Reauthorize the Medicare Rural Hospital Flexibility Grant Program to include technical assistance funding to support the buildout of the rural emergency hospital (REH) model. In the CAA 2021, Congress created the REH model to allow struggling prospective payment system hospitals and CAHs to transition to a new outpatient hospital designation. Technical assistance is critical to ensure these struggling facilities can transition efficiently. The House-passed Labor, Health and Human Services, Education, and Related Agencies appropriations package allocated $80 million for the Medicare Rural Hospital Flexibility Grant Program for FY 2022, including funding for technical assistance for hospitals transitioning to the REH designation. **NRHA urges Congress to maintain this amount in the final appropriations package.**

NRHA FY 2022 requests

(dollars in millions)

FY 2022 Appropriations Requests & Allocations					
Discretionary Funding Program	**FY 2021 Omnibus**	**NRHA's FY 2022 Request**	**President's FY 2022 Budget Request**	**HAC FY 2022 allocations**	**SAC FY 2022 allocations**
Federal Office of Rural Health Policy Programs					
Rural Health Research & Policy Development	11.1	**12.2**	11.1	11.6	11.1
Rural Health Care Services Outreach, Network & Quality Improvement Grants	82.5	**90.8**	90	90	90
Rural Hospital Flexibility Grants	55.6	**80**	57.5	80	57.5
State Offices of Rural Health	12.5	**15**	12.5	13	12.5
Telehealth	34	**37.4**	36.5	39	39
Rural Maternity & Obstetrics Management Strategies Program	5.4	**10.4**	10.4	10.4	10
Rural Residency Planning & Development	10.5	**12.7**	12.7	12.7	12.7
Rural Communities Opioid Response	110	**165**	165	140	**165**
HRSA Health Workforce Programs					
National Health Service Corps	120	**185**	185	**185**	150
Area Health Education Centers	43.3	**47.6**	47.6	50	47
Geriatric Workforce Enhancement	42.7	**46.5**	46.5	52.7	46.5
Centers of Disease Control and Prevention					
Office of Rural Health	-	**1**	0	0	0
USDA Rural Development Programs					
Communities Facilities	3.0b	**3.3b**	3.3b	3.3b	3.3b
ReConnect Broadband	635	**700**	700	990	700

NORTHERN INYO HEALTHCARE DISTRICT

Improving our communities, one life at a time.
One Team, One Goal, Your Health!

150 Pioneer Lane
Bishop,California 93514

(760) 873-5811

DATE: May 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Rich Miears, Manager of Environmental Services & Laundry

RE: Department Update

REPORT DETAIL

ENVIRONMENTAL SERVICES

The Environmental Service (ES) team operates Monday –Sunday 400am to 1230am. Our staff cleans areas from Birch Street, to the Joseph House to our OR's and PACU. We currently have 25 full-time employees in ES with zero vacant spots to fill. ES staff has been very busy with emergency OR's on the weekend.

LAUNDRY

The Laundry team operates Monday –Friday from 500am to 1530pm. We currently have 5 employees with zero spots to fill. Our chemical line is still good. We have one washer machine down that will hopefully be fixed on 5/11/22. Our staff is doing great. Our washable PPE continues to be at a great back-up level. The Laundry staff hasn't had to work on the weekends for a while now.

OTHER INFORMATION

Talent Pool- Currently has 4 employees and another joining us 5/16/22. We plan on hiring 5 more Talent Pool employees if we can get more applicants in ADP. The last application was 4/11/2022.

Screeners- We have 2 full-time temp screeners and 4 part-time temp screeners from Sierra Employment to cover Radiology 5 days per week, Main and the ED entrance 7 days per week. Kayla Hart is our Newest Temp Screener. They are all really nice and do a great job!

NORTHERN INYO HEALTHCARE DISTRICT
Improving our communities, one life at a time.
One Team, One Goal, Your Health!

150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: May 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Bryan Harper, Director of ITS/CISO

RE: Department Update

REPORT DETAIL

NEW BUSINESS

The team is deploying direct printing to all areas of the hospital. *This will increase speed and reliability.*

Team members have completed security penetration mitigation were possible. *Older systems still hamper our security posture.*

Windows updates and patches are now deployed via SCCM (System configuration manager) *This automates upgrades, installs and patching for security issues.*

The technical team is in the process of completing our VMware Platform upgrade. *This is the virtual environment for 387 servers.*

The ITS department has taken back over reporting for the District and the addition of our newest employee will allow us to be able to delivery much needed reporting and data for decision making processes.

OLD BUSINESS

Team members are working on documented issues from security risk assessment and penetration testing.

Staff have completed the build and testing of our SCCM server and patches are now being rolled out to servers and workstations again.

CE team is helping in the process of scoping for larger district-wide projects such as the OR floor replacement

NORTHERN INYO HEALTHCARE DISTRICT
Improving our communities, one life at a time.
One Team, One Goal, Your Health!

150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: May 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Larry Weber, Director of Diagnostic Services

RE: Diagnostic Services Department Update

REPORT DETAIL

NEW BUSINESS

Cardiopulmonary (CP):

- Cardiopulmonary has purchased two new C-1 Ventilators. This urgent need surfaced as a result of our current BIPAP equipment vendor notifying us that there was an unresolvable defect in our current platform that led to significant concerns for patient safety. We have now replaced four ventilation assistance devices and are comfortable with our current ability to mechanically ventilate our NIHD patients. We will re-evaluate our current fleet in the first quarter of CY 2023 to see if additional needs exist for mechanical ventilation.
- The Cardiopulmonary department has successfully recruited Isreal Villalobos as a Respiratory Therapist. These efforts have led to our CP department being fully staffed with permanent staff member.
- Our effort to provide Neonatal Intensive Care training for our respiratory therapists has finally began. Amy Stange has worked diligently for the last 18 months trying to get this training program in place that is in conjunction with Pomona Valley Medical Center's Respiratory Therapy Department. This training has NIHD Respiratory Therapists traveling to Pomona Valley and working side by side with their Respiratory Therapists on neonates that require respiratory assistance. This effort is a result of our 2021 Employee Engagement action planning and the department is appreciative of executive leadership support of this initiative.

Diagnostic Imaging (DI):

- The DI leadership team established two employee driven focus groups. One intended to continue work on driving employee engagement and the second to drive improving our patients' perception of the service they receive while in DI.
- We have begun looking at the potential of bringing Positron Emission tomography (PET) to our community. GE has helped to develop a report that demonstrates the number of PET scans completed for patients in our catchment area. Current demand appears to be

able to pay for service and am currently actively working to identify the potential for mobile PET/CT services for community.

- Working with marketing team to develop and implement an awareness campaign for Diagnostic Imaging services. We are working to develop six distinct campaigns the coincide with health awareness events such as prostate cancer awareness month, etc… In the process of developing an MRI campaign to coincide with May being National Physician Fitness and Sports month.
- Effectively transitioned the DI Clerk team to report through Patient Access. Overall transition has been good.
- DI started a Co-Ed softball team as part of their employee engagement plan. Team was sponsored by NIHD (Thank you Kelli).

Laboratory Services (the Lab):

- We have successfully transitioned to our new Sysmex platform in hematology. These analyzers are significant step forward in technology for our Laboratory Services. In addition to being much more reliable than the prior analyzers, this equipment automates many functions previously performed manually by our Clinical Laboratory Scientist (CLS) staff members.
- We have concluded the buyout of the fair market value lease of our chemistry analyzers. Thank you very much for your support of that purchase that will save the District $104,000 annually in operating expense.
- Rich Hayden, Interim Lab Manager, resigned in March and Hannah Pirner, Interim Transfusion Services Coordinator, has successfully transitioned into the role of interim lab manager. We are actively recruiting Hannah to become the permanent lab manager for NIHD.
- We have completed our Myla middleware conversion for our microbiology department. This new middle-ware automates many laboratory management reports for microbiology that leads to improved reporting of management reports such as blood culture contamination rates and Antibiograms.

OLD BUSINESS

Cardiopulmonary:

No old business for Cardiopulmonary

Diagnostic Imaging:

No old business for Imaging

Laboratory Services:

No old business for Laboratory Services

NORTHERN INYO HEALTHCARE DISTRICT
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150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811

DATE: May 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Greg Bissonette, Foundation Executive Director/Grant Writer

RE: Department Update

REPORT DETAIL

FOUNDATION

March and April saw regularly scheduled board meetings take place. In March the Foundation approved $850.00 in support of the CAREshuttle program for new tires on one of the vehicles. In March I also met with the General Manager at Perry Motors to see if they would be willing to donate towards the purchase of a new CAREshuttle van. They came back offering to take $1,000 off the purchase price. The program is in need of a third vehicle as the original one, donated to the District by Eastern Sierra Transit Authority back in 2016, has finally died. This new van will be a hybrid model and will be converted by Freedom Motors in Michigan to be a rear-entry, wheelchair accessible van. In March I also ran an awareness campaign within the District about the Foundation. I raffled off some Twin Theatre movie tickets, donated by the theatre, for those that could provide a fact they learned from reviewing the Foundation's website. Many employees learned of the website for the first time and I even had a few physicians respond as well. April saw me finalize the deal with Perry Motors for the new van and to get us in the queue as there is a waiting list on all vehicles through them. It could be several months before that order is filled. Then the van will go back to Michigan for the ADA conversion process which will take a couple of months as well. At the April board meeting it was also discussed to resume in-person meetings starting in May at the Birch St. Annex.

GRANT WRITING

During this reporting period, the District was awarded $30,000 from the Physicians for a Healthy California's Cal Vax Grant program. This funding will go towards reimbursing the District for staff time dedicated to vaccine administration. There were no new grants pursued during this period.

Administration and maintenance for all other current grants is ongoing.

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150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: May 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Neil Lynch, Purchasing

RE: Department Update

REPORT DETAIL

NEW BUSINESS

Purchasing is preparing for fiscal yearend inventory (6/30/2022). In preparation we will be analyzing inventory processes for Purchasing and Surgery departments, prepping the warehouse, and doing some item master maintenance. All of this is necessary to ensure an accurate fiscal year end valuation.

Shipping delays are back on the rise due to global supply chain strain. Your purchasing team continues to work diligently to minimize disruptions.

OLD BUSINESS

(Complete) Process review. Purchasing will be process mapping workflows to ensure accuracy and efficiency in supply chain processes with a focus on Cerner driven workflows.

(Complete) Back orders. We are experiencing significant delays across most supply chain categories. Covid-19, weather, shipping bottle necks, and manufacturing delays have made ordering difficult. Most resources are focused on minimizing delays.

(Complete) Purchasing continues to work on GPO (Group Purchasing Organization) transition. We are compiling data for analysis to determine contract compliance rate.

(Complete) GHX EDI integration has begun. IT continues has completed set up on the back end, purchasing staff is training and will be testing system through October.

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150 Pioneer Lane
Bishop, California 93514
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DATE: May 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Scott Hooker, Director of Facilities

RE: Department Update

REPORT DETAIL

MAINTENANCE/FACILITIES

New Business:

Building Separation Project has been completed. As soon as HCAI receives the final payment from NIHD, we will receive a final completion letter. Pharmacy Project has been approved. We are expecting the permit in the next week. We opened the Pharmacy Project bids on April 22nd and had decent coverage on the scope of work. We will need to go back out to bid on the following areas; casework, roofing, glass work, flooring, and electrical. Colombo Construction is confident that we will get coverage on all areas.

HCAI Projects (6 projects)

Building Separation - Complete and awaiting final completion letter.
Pharmacy Project – Approved. Work to start on June 22, 2022.
Temporary Chiller Project – This project is monitored by HCAI until we get rid of the temporary chiller. That will happen after the Chiller Plant Upgrade (or condenser plant upgrade).
Chiller Plant Upgrade / Condenser Plant Upgrade – HCAI approved the project and Colombo Construction has this project out to bid. Condenser units are on back order due to the supply chain crisis. Expected start of this project June 2022.
Omnicell Medication Cabinet Replacement Project – All but one cabinet (ICU) have been installed with change order sent to HCAI.

SECURITY

New Business:

Security is running smoothly with one open position. One potential guard needs to be interviewed, one guard out on leave. Security Officer Steve Thompson went through orientation on April 18th and will start working alongside our current officers.

Old Business:

Security is currently operating with 6 officers. Security is onsite Sunday – Thursday 600p-330a Friday and Saturday noon-400a.

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150 Pioneer Lane
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DATE: May 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Alison Murray, Director of Human Resources

RE: Department Update

REPORT DETAIL

HR Manager (Marjorie Routt): Finishing up ADP Payroll implementation. Beginning the build of ADP performance management platform. Working on a new job description format for the entire District. Working closely with the new Education specialist to orient her into her new role.

Recruitment (Brandi Simpson): Recruitment is beginning to pick up again with 50 current job postings and 42 employees onboarding over the last two months. All traveler openings have been filled. Streamlining the ADP Recruitment module. Actively working on creating a housing booklet for rentals to provide leads for new and current employees do address housing issues.

Onboarding (Sarah Rice): Streamlining the new hire and transfer notification process. Working on the onboarding process for the Board of Directors and new hires. Heavy emphasis on Payroll implementation but finally able to move back into focusing on onboarding. Reviewing the ADP Onboarding module to improve process.

Payroll (Reuben Morgenstein): ADP comprehensive Payroll implementation in process. Implementing new District policies (PTO, Standby and Overtime). Verifying and validating new payroll process and reporting.

Benefits (Carlos Madera): COVID-related leave slowing down. Regularly meeting with employees who have Leave of Absence requests and Accommodation requests. Working with ADP and Empower to set-up regular pension funding (per pay period) for 401a plan.

HR/District Education (Veronica Gonzalez): Ongoing training into the new role with review of all programs offered at the District. Review of the new hire orientation process. Strategizing ways to return to pre-COVID live training opportunities and plans.

Labor Relations (Brittney Watson): Ongoing partnership with Union and stewards to work through any labor relations issues that arise.

Human Resources (Alison Murray): Providing benefit presentation to go over the total compensation that employees receive when working at the District. Continued work on strategic planning for HR department as well as District. Heavy emphasis on preparation for union contract negotiations in 2022.

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150 Pioneer Lane
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DATE: May 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Lynda Vance, Manager of Project Management

RE: Department Update

REPORT DETAIL

NEW BUSINESS

Our team has completed our department's Mission, Vision, and Values (MVV) to reinforce what we do today, what we strive for tomorrow and the values we hold. This was a great exercise and I appreciate the support from Kelli to ensure we are aligned with the District's MVV. Brandon has been working on relocating departments to align with new workflows and adjusting spaces for changes in team sizes. It is exciting to be able to contribute to the NIHD Annual Report with the project processes and support we give our teams.

PROJECTS *(this is a summary of the high-level work, not a complete list)*

Discovery – 8 (Surgery/ PACU office changes, Dictation room update, Facilities office relocation, Strategic communication office relocation, HR and Education office relocation, OB sleep room update, Case Manager office update, RHC window workstation update)

Actively Working – 18 (**Stryker Mako Ortho Robot,** Cerner schedule security update, RHC Manager Relocation and added staff area, EMS radio and recording system Replacement, Employee Health Management System Agility, HCIQ and Valify GPO CHC Project, ADP Empower/ Payroll and Employee services, State Mandate Tracking, i2i with Cerner, Flu and NSHN tracking, Experian Pricing transparency, OneContent athena upload, Internal Med Office update, BDM Interface Cerner project, AP Clerk workstation update, Lab Assistant workstation update, CFO Admin assistant location update, Billing and HIMS office relocation)

Closing – 9 (Bronco Clinic Restart, Hematology Analyzer, Omnicell Cabinets, Myla Lab/Micro Middleware, OR and PACU Flooring, GHX, Zoll Defibrillator Replacement, Omnicell Cabinets, Smartsheet upgrade for PHI compliance)

Moves Completed - 11 (Phlebotomy draw area update, Informatics, Quality and Infection Prevention relocation, DI Coordinator offices, VCC workstation update, MedSurg assistant

Manager desk update, Peds Rehab front office update, Director of Patient Access relocated, CMO relocated, CNO Admin assistant office update, Clinical Engineering offices relocated)

On Hold Projects - 14 (FEES system, Mammo and Stereo Equipment Replacement, Copay workflow improvement, Hemodialysis for IP, Kitchen update, Wound Care, City of Hope Telehealth, SAP Concur, Door Access Badge Standard workflow, PACS Replacement, DI staff to MRI area, Onboarding Workflow Efficiency, Cerner Portal Relaunch, OneContent upgrade)

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150 Pioneer Lane
Bishop, California 93514

(760) 873-5811

DATE: May 2022

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Thomas Warner, Dietary Manager

RE: Department Update

REPORT DETAIL

NEW BUSINESS

The Dietary Department staff have been willing to cover each other's shifts due to staff illness; surgery, and L.O.A. staff continue to abide by infection control and public health mandates.

The Dietary team continues to prepare cakes and cupcakes for retirements and monthly birthday celebrations. The team prepared and assembled 175 individual cheesecakes for the April birthday celebrations.

The Dietary Department is replacing and upgrading kitchen mats for the wellness and joint health of our team members. We are also upgrading and replacing our uniforms.

Total Meals Served from the 3rd week of April:

Patient Meals: 885

Staff Meals: 6474

Clinically, the dietitians have continued with in-patient and out-patient assessments, evaluations, and education. By continuing to expand the out-patient outreach, they are taking referrals from all providers throughout the District, many coming from Wound Care, Bronco Clinic and RHC.

A Healthy Lifestyle Talk on the five Blue Zones, presented by Kalina Gardiner in March for National Nutrition Month, saw great attendance from staff and community members alike.

OLD BUSINESS

Day to day operations for the dietary department continue to include:

- Feeding staff during breakfast, lunch and dinner
- Coordinating with special event committees to organize and provide food during opportunities of celebration and acknowledgment

- Providing nuclear medicine meals
- Providing inpatient meals
- Maintaining survey readiness through observations and actions
- Enforcing social distancing recommendations while waiting in line and dining in the Cafeteria

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Bishop, California 93514

(760) 873-5811 Ext. 3415

DATE: May 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: CEO Board Report
Barbara Laughon, Manager, *Marketing, Communications, & Strategy*

RE: Department Update

REPORT DETAIL

Old Marketing Business

NIHD continued to lend its support to Prevention & Partnerships during Child Abuse Prevention Month in April. As an awareness effort, NIHD once again displayed a pinwheel garden in front of the district's two-story hospital. NIHD is honored to stand with its partners across the county recognizing the importance of families and communities working together to strengthen families to prevent child abuse and neglect. The pinwheel by its nature connotes

playfulness, joy, and childhood. It has come to serve as a physical reminder of the great childhoods we want for all children. Shown here on a perfect day for pinwheels, and wearing blue in support of the cause, are NIHD team members, back row, from left: Rosie Graves, NIHD Board of Directors Member Mary Mae Kilpatrick, Launa Strickland, Dr. Lindsey Ricci of Northern Inyo Associates Pediatrics, Certified Pediatric Nurse Practitioner Colleen McEvoy of Northern Inyo Associates Pediatrics (who also sees patients at Bishop Union High School Bronco Clinic), and Marcia Male. In front: Linda Bull, Kelly Faldowski, James Nichols, Annastasia Beaman, and Elizabeth Esparza. *Photo by Scot Swan/Northern Inyo Healthcare District*

New Marketing Business

- **Community Health Needs Assessment**: We are excited to be working closely with other team members and our Executive Team to complete the 2022 CHNA. As the topic is covered in depth elsewhere in this report, we will defer specifics to the Executive Team.

- **Annual Report**: We are working with CFO Vinay Behl to prepare our next Annual Report. Much more to come on this including an upcoming campus-wide photography on May 16, 17, and 18.

- **Social Climb**: As of April 28, NIHD has joined the Social Climb platform to help improve its brand reputation and increase our online search visibility. An exact implementation date was pending as of this writing. We are very excited to be part of this effort and thank Compliance Officer Patty Dickson, Director of ITS Bryan Harper, ITS Report Analyst Alex Duke, and CEO Kelli Davis for their support in securing this vendor partnership.

- **NIHD YouTube Channel**: This video channel is garnering great interest in the community with more than 700 subscribers as of this writing. In the last month, we've had almost 400 hours of watch time across the channel. It currently houses all videos produced within the last six months at NIHD. It also is home to recordings of the NIHD Healthy Lifestyle Talks series. These videos (including the most recent spotlight on Lab Week) can be reviewed at any time at:

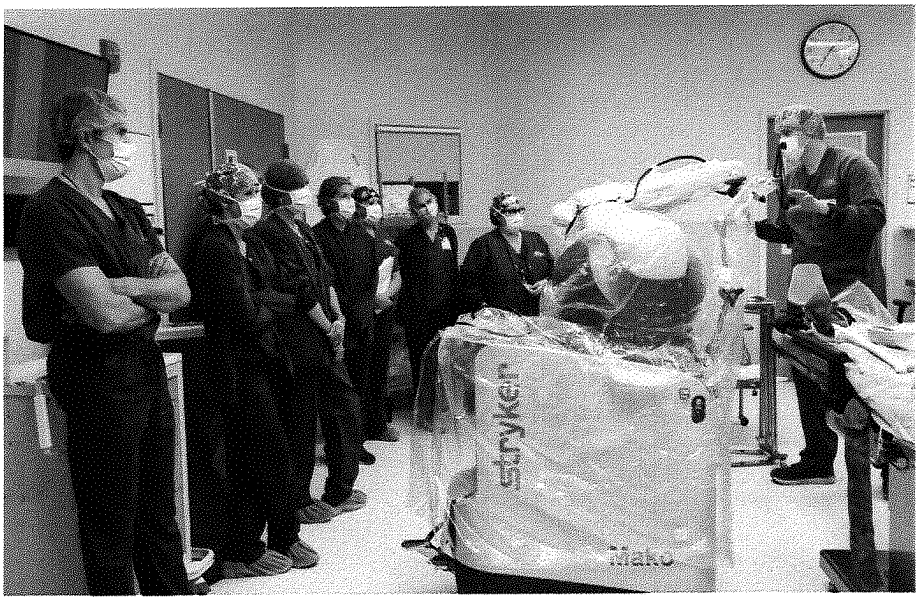
    - https://www.youtube.com/channel/UCfiAFpCrakUdTqc55LiyVxQ

- **Staffing:** Digital Marketing Specialist **Scot Swan will be leaving NIHD on May 26**. Scot has accepted a great opportunity with Dignity Health in Sacramento. Recruiting for a new Digital Marketing Specialist is under way. Digital Marketing Consultant **Amanda Long has agreed to lend a hand** until we can bring someone new on.

- **News Releases:**

    - ***NIHD surgery flooring project finishes ahead schedule***
      released March 22, 2022 spotlighting the efficiency and cost-saving efforts achieved by NIHD's Maintenance Team and the re-opening of the Surgery Suites after 2-1/2 months

    - ***NIHD and Mammoth Hospital Collaborate on Childbirth Services***
      released March 25, 2022 jointly with Mammoth Hospital



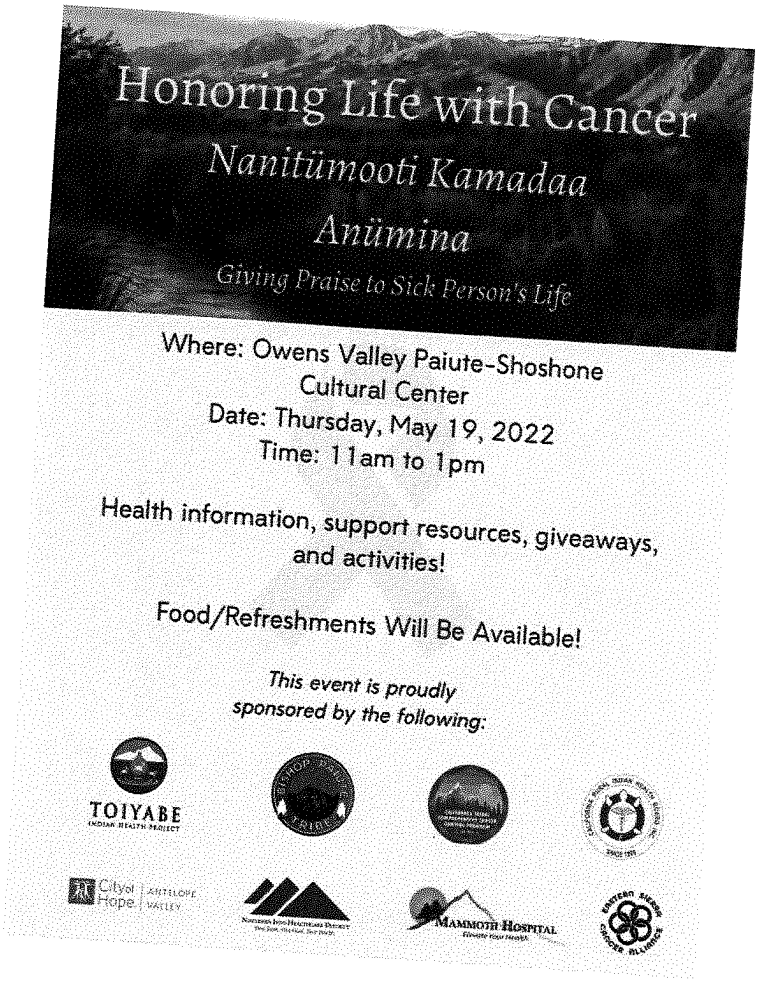
- ***Good news for bad knees: NIHD adds robot-assisted total knee surgery***
  released April 22, 2022 spotlighting NIHD's new Stryker Mako Robot-Assisted Total Knee Surgery program under the direction of Dr. Richard Meredick
- ***Opioid Addiction: Dispelling Myths, Saving Lives***
  released April 25, 2022 promoting the Healthy Lifestyle Talk presented by Dr. Anne Goshgarian

- ***NIH Auxiliary's return is a gift to the Healthcare District, community***
  released April 28, 2022 spotlighting the return of the NIH Auxiliary to the campus Gift Shop

- **Upcoming educational talks and locations**

Speaker/Topic:	**Anne Goshgarian, MD** / Opioid Addiction & Treatment
Platform/Release:	Doctor Podcast / As soon as available on NIH.org & Social
Speaker/Topic:	**Stacey Brown, MD** / Acne & Treatment
Platform/Release:	Doctor Podcast / As soon as available on NIH.org & Social
Speaker/Topic:	**David Plank, MD** / Skin Cancer Awareness
Platform/Release:	Healthy Lifestyles Talk / Tentatively May 19

- **Partnerships:**
  - **Honoring Life with Cancer**: Once again, the topic of cancer survivorship will unite local healthcare facilities with local and state tribal organizations to provide educational information and support resources. Coming together on **Thursday, May 19, 11 a.m. to 2 p.m.** for the event are Toiyabe Indian Health Project, Bishop Paiute Tribe, California Rural Indian Health Board, California Tribal Comprehensive Cancer Control Program, Northern Inyo Healthcare District, Mammoth Hospital, City of Hope, and Eastern Sierra Cancer Alliance. The event will move indoors this year to the Owens Valley Paiute-Shoshone Cultural Center on West Line Street.



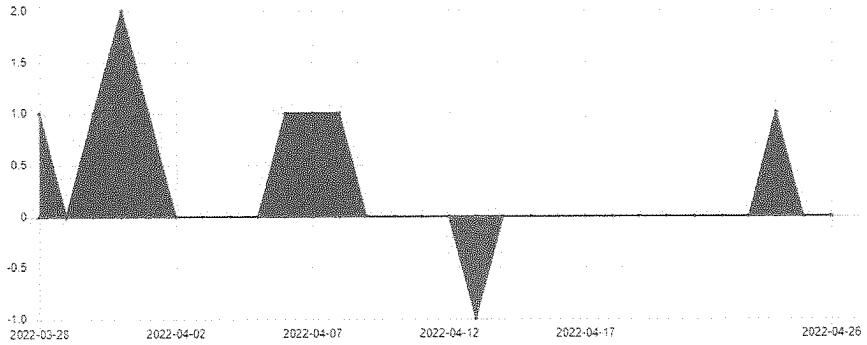
  - **NIH Foundation New CAREshuttle Campaign**: It is an honor to work with the Foundation on its latest effort to improve patient transportation in the Eastern Sierra region. Working with Greg Bissonette, the Foundation Executive Director, we developed a campaign statement handout for potential donors as the effort progresses.

Digital Marketing Updates

Total Likes	Total Reach	Post Engagement	Page Clicks	Total Fans	Post Published
966	58.7K	2.4K	1.9K	9	17
Hooray!	↑ 264% in last 1 month	↑ 70% in last 1 month	↑ 1108 in last 1 month	↓ -25% in last 1 month	Great Going!

Audience Growth

Audience Growth shows the number of fans (likes on your page) you have gained and lost each day



Audience Insights

Since Previous Period

0.84% ↑

Total Fans Increased

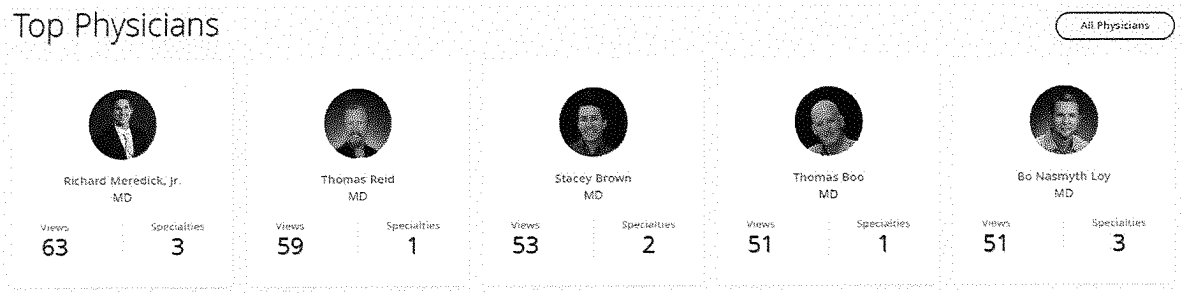
Total Likes	966
Net New Likes	8
Organic Likes	9
Paid Likes	0
Unlikes	1

Top Posts

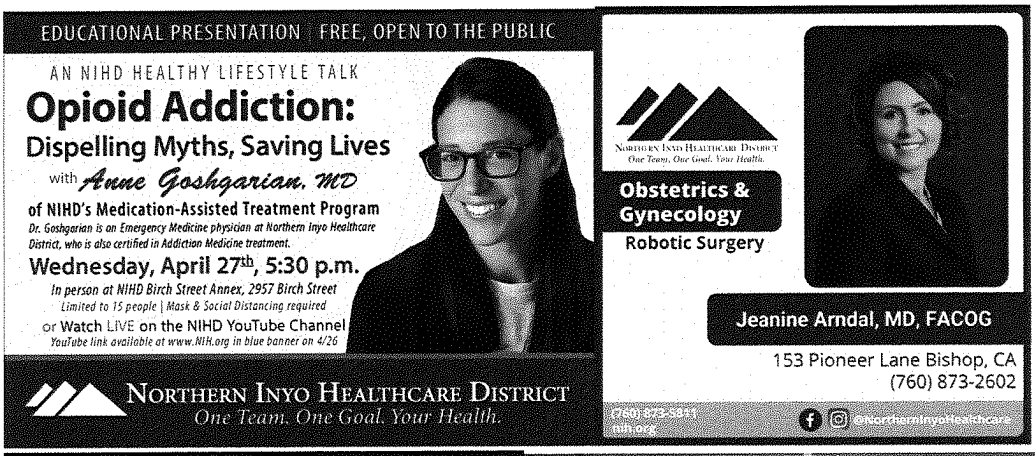
Published On		Posts	Type	Likes	Shares	Reach	Engagement
Mar 31, 2022 04:00 pm		Dr. Arndal is a board certified OB/GYN and has provided care for women in the Owens Valley since 2007 at the Rural Health Women's Clinic . She complet...		62	0	552	14%
Mar 29, 2022 07:25 pm		Happy #DoctorsDay to all of our amazing physicians here at Northern Inyo Healthcare District and those hard at work around the world. This year we sur...		45	11	1083	19%
Apr 18, 2022 12:32 am		We had some Friday Fun hosting a Golden Egg Hunt for our team. Finders could claim a gift certificate to local bakery, coffee shop, or deli...		33	0	608	15%
Mar 30, 2022 10:40 pm		Northern Inyo Healthcare District and Mammoth Hospital recently launched a collaborative effort to address the state of childbirth services at Mammoth...		19	5	803	13%
Mar 31, 2022 05:35 pm		Endometriosis is a widespread gynecological health issue. Millions of women experience this condition, yet not everyone knows the most common symptoms...		12	2	11540	3%

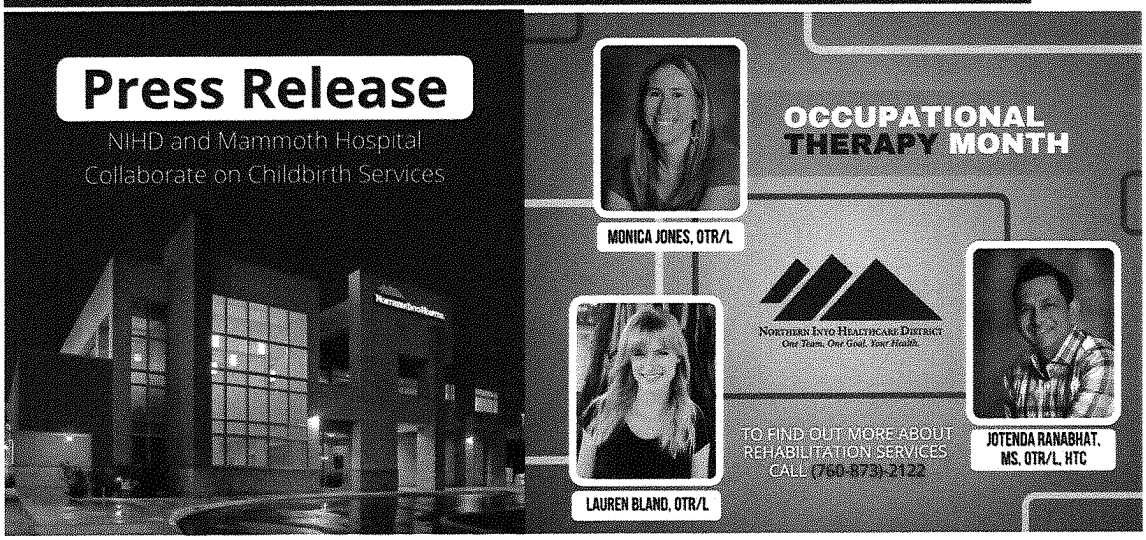
Profile Overview

Followers	Profile Views	Reach	Impressions	Website Clicks
322	69	1.4K	2.5K	5
Doing Great!	↑ 69% in last 15 days	↑ 1384% in last 15 days	↑ 2536% in last 15 days	↑ 5% in last 15 days



Recent Posts:





Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811
www.nih.org

Date: 5/3/2022
To: Board of Directors
From: Joy Engblade, MD, MMM, FACP, Chief Medical Officer
Re: Bi-Monthly CMO report

Medical Staff Department update

The Medical Staff Office has been very busy credentialing new providers. Most of this increase is due to the need for temporary or locums providers. We are looking into hiring a clerk on a temporary basis to help with the increased workload.
From a recruiting standpoint, we continue to look for a General Surgeon. We will be welcoming a new Physician Assistant to the RHC, Matt Irons, who will be joining us in May. We are excited to have Grant Meeker, MD and Jennifer Meeker, MD join our anesthesia team in late June.

Pharmacy Department update

We continue to work with Colombo Construction on the Pharmacy construction project. Plans have been approved by HCAI (formally OSHPOD) and as we finalized the paperwork, we are anxious to get started on the actual construction. Colombo has been a great partner, helping to guide us through this complex process.

We have replaced all of our OmniCell units for medication dispensing throughout the hospital and have now completed all of the seismic brackets needed per regulation.

The Pharmacy department continues to support Covid vaccination efforts, including ongoing vaccinations and monoclonal antibodies through allocations and education across the District in partnership with Inyo County.

Quality Department update

The Quality Department continues to report on a number of regulatory requirements, meeting all deadlines with the most recent reporting requirement met for Influenza. Upcoming Covid reporting continues, with the next report due in June 2022. This report includes Covid-19 Public Health metrics including: implementation of employee Covid-19 testing and vaccination in 2021, implementation of infrastructure and partnerships for Covid tests and vaccines and the implementation of a hospital surge planning and/or response. We feel prepared to report on these measures since these topics were thoroughly discussed and implemented at NIHD in 2021.

We continue to collaborate with a company called i2i, which pulls data from Athena and Cerner to help with reporting requirements. QIP continues to be a program that we are participating in, through the state.

Dietary Department

The Registered Dietitians (RD) continue to manage and make dietary recommendations for our hospitalized patients, as well as seeing and managing outpatients with dietary needs. We have completed our required policies. As a way of educating our community, Kalina Gardiner presented another Healthy Lifestyles Talk in March for National Nutrition Month on "The Blue Zones." Our RD's continue to look for more ways to serve our community and workforce at NIHD.

Covid 19

We continue to have regular Incident Command meetings and share information across the District and with our community partners but we have decreased the meeting frequency to every other week. As a team, we continue to follow the California Department of Public Health (CDPH) updates and national trends.

Physician Compensation Update

Productivity data is now becoming available through our billing department. This information will be reviewed before sending out to the providers for review. We are also leveraging our relationship with UASI, our coding partners to provide education about documentation and coding. This education will start in May or June and we will plan to continue on an ongoing basis.

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150 Pioneer Lane
Bishop, California 93514
(760) 873-5811 Ext. 3415

DATE: May 2022
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Allison Partridge, RN, MSN, Chief Nursing Officer
RE: Department Update

REPORT DETAIL

COVID-19

The District continues to manage the daily challenges that COVID-19 has presented. We are looking to begin closing our Incident Command and transitioning to full operations. This process will occur over several weeks as we closely monitor the Pandemic. NIHD continues to partner with Inyo County Public Health in administering COVID-19 vaccines and has created accessibility in the RHC and NIA clinics.

Recruitment

In collaboration with our Human Resource Team, we continue to focus on the recruitment and retention of team members to fill open vacancies throughout the District. Recruitment and retention continue to be an area of daily focus and present challenges throughout the District with a significant impact on nursing. To support the recruitment and retention of team members, NIHD is offering multiple training programs, including:

· Perinatal RN Training Program
· Operating Room RN Training Program
· ICU RN Training Program
· Acute/Subacute New Graduate Training Program
· Orthopedic Technician Training Program
· Sterile Processing Training Program

These training programs aim to support the growth and development of District team members, support the recruitment of external candidates, and support critical staffing needs.

Perinatal

Southern Mono Healthcare District (SMHD) continues to divert its Labor and Delivery patients to NIHD. Our Perinatal Department and Providers continue to collaborate with SMHD to ensure a safe handoff for these patients.

National Nurses Week

We are very excited to celebrate National Nurses Week from May 6th-May 12th. This celebration will include the 2022 Nursing Awards. This year, in addition to the Daisy award, we will also be recognizing the Rookie of the Year Award, Mission and Spirit Award, and Great Catch Award.

Each department leader has submitted a department specific report to follow.

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DATE: May 2022
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Jannalyn Lawrence, *Director of Outpatient Clinics*
RE: Department Update

REPORT DETAIL

Old Business

As COVID continues to trend downward, we are making efforts to move the Car Clinic team back inside the physical RHC building. They continue to provide same-day visits for acute issues, and we are working to accommodate patients with COVID-like symptoms in an exam room outfitted with a negative pressure unit.

We are also working toward embedding COVID vaccine process within RHC, so patients can receive the vaccine as part of a regular provider visit. This will afford providers an opportunity to discuss the vaccine with patients and offer it at time of visit, eliminating the need for patients to sign up for a stand-alone vaccine clinic through the MyTurn platform.

New Business

The RHC is now equipped with a specific set of policies required to maintain compliance with CMS regulations. This was a significant undertaking and we were fortunate to partner with Tracy Aspel, who worked tirelessly to ensure policies were cross-referenced with existing NIHD policies and moved them through committees for approval. It is a relief knowing we stand ready for regulatory surveys on this front.

We have recently formed an oversight committee to help better serve our MAT and Behavioral Health programs. With so many exciting initiatives and grant-funded opportunities, we felt it prudent to form this committee with the purpose of strategizing, providing support, and removing barriers. The group will be comprised of members from the executive team, clinic leadership, as well as provider and staff representatives from the MAT and Behavioral Health programs.

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(760) 873-5811 Ext. 3415

DATE: May 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Jose Garcia, *Language Access Services*

RE: Department Update

REPORT DETAIL

Old Business

Language Access has been working with Health Informatics, and Cerner on adding the necessary fields to capture required patients' language information. This process is in the final stages, and will be implemented in the coming weeks.

Language Access continues to work with Information Technology to ensure mobile devices used for video/voice remote interpreting, function properly when needed.

New Business

During the last quarter, the department provided interpreting services for 112 in-person patients' visits, and translated 36 documents from English to Spanish.

Language Access has been collaborating with QHR Health, and the District's leadership preparing the next Community Health Needs Assessment – CHNA; ensuring the survey in Spanish is available to the community.

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(760) 873-5811 Ext. 3415

DATE: May 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Julie Tillemans, *Perinatal Nurse Manager*

RE: Department Update

REPORT DETAIL

New Business

Northern Inyo Healthcare District Perinatal Unit continues to support Mammoth Hospital with the diversion of their Labor and Delivery patients. We are working collaboratively with the Mammoth Clinic team to ensure a seamless transition of care.

Our Team would like to thank the NIHD Foundation for purchasing the Perinatal Department a brand new, upgraded Cardiopulmonary Monitor. This device is a compact piece of equipment, essential for monitoring newborns post-delivery to support and promote the delivery of high quality newborn care.

NORTHERN INYO HEALTHCARE DISTRICT
Improving our communities, one life at a time.
One Team. One Goal. Your Health.

150 Pioneer Lane
Bishop, California 93514

(760) 873-5811 Ext. 3415

DATE: May 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Justin Nott, Med/Surg and ICU Manager

RE: Department Update

REPORT DETAIL

Med/Surg and ICU

During the last quarter, a large effort has gone into ensuring that the med/surg and ICU teams are survey ready. We have incorporated a survey readiness section into all our staff meetings and into our daily huddle reports. We also conduct monthly survey readiness tracers, which were rolled out by the Survey Readiness Department.

We have begun holding multiple skills sessions to help get all clinical staff through their annual clinical competency training. Prior to Covid, our skills session was a two-day event that all clinical staff came to, but now, to meet social distancing requirements, it is broken up into multiple sessions that takes place over a number of months.

We continue to move forward with the development of a peripherally inserted central catheter (PICC) team. The Nurses receiving the PICC training have completed their in-class and online training. They have also assisted with multiple live PICC and midline insertions.

Med/surg rooms 1-3 were converted into pre-op, infusion, and PACU during the OR PACU floor replacement project. Both the med/surg and outpatient/PACU teams did a great job working together and truly embodied the “one team, one goal” in our mission statement.

Omnicel cabinets were replaced with upgraded cabinets. This project was delayed due to the seismic anchor brackets fitting differently than they had on the replaced cabinets. The project is due to be completed by 5/6/22.

Alarm fatigue project group, headed by Brooklyn Burley, has added a new section to UORs to track alarm safety related UORs.

Med/Surg and ICU CSEs are restarting tiered code blue drills, which start as a general overview for the first sessions but over time, the drills get much more detailed.

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Bishop, California 93514

(760) 873-5811 Ext. 3415

DATE: May 2022

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Robin Christensen DON Quality/Infection Prevention

RE: Department Update

Clinical Informatics, Survey Readiness, Infection Prevention, & Employee Health

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REPORT DETAIL

Old Business

Clinical Informatics: The team continues to open and monitor Cerner Service Desk tickets for the District and work with departments to ensure that the District's needs are met. We continue to onboard new providers, students, clinical, and administrative staff weekly due to cycle-onboarding. In addition, the team continues to work with all departments to help improve workflow efficiency and optimization.

Survey Readiness: The Quality/Survey readiness team continues tracer activities throughout the District. In addition, leadership continues presenting information relevant to the regulatory requirements for their department and steps they are taking for continuous survey readiness at the weekly Accreditation Readiness Team (ART) meeting. In addition, we continue to collect and update the survey readiness binder with the required documents for CDPH and The Joint Commission.

Employee Health: The team encourages staff to get their COVID-19 vaccine, booster dose, and 2021-2022 influenza vaccine. In addition, the team collaborates with Human Resources, Medical Staff, and RHC to streamline the employee and provider onboarding process. The Employee Health team has been working diligently in preparation for the Agility Implementation.

Infection Prevention: Continues to work with Inyo County Health Department with COVID-19 related activities. Infection Prevention continues to implement measures to prevent and mitigate COVID-19 spread within healthcare facilities. In addition, the team continues to monitor and provide updates on local, state, and federal guidelines and recommendations. The Infection Prevention team played a vital role in the OR flooring project to help prevent hospital-acquired infections during the construction.

New Business

Clinical Informatics: Nicole Eddy has accepted the Clinical Informatics Nurse Specialist position and will be starting May 9th, 2022. Nicole will be partnering with Amanda Santana to help support the District with Clinical Informatics issues, training, and optimization.

Clinical Informatics will play a vital role in the new Governance and Support Committee to help focus on organizational strategic priorities and maximize the EHR system. In addition, the department is working on creating a District-wide policy and procedure for EHR downtime.

Survey Readiness: The team is preparing to expand a new group of tracer activities to other departments. The team closely monitors for any recent regulatory changes or updates and distributes the information to key stakeholders to help ensure that the District remains complaint. The Survey Readiness Team will partner with NIHD key stakeholders to help manage the on-site survey process and activities; this includes a survey response team and command center. The team will also be working on survey resources to help develop staff interview skills and decrease staff anxiety during the survey.

Employee Health: Annastasia Beaman has accepted the Temporary Employee Health Clerk to assist with implementing Agility, vaccine data collection and entry, and assisting with onboarding of new employees, providers, students, and volunteers. Agility implementation has been postponed until August due to data conversion. The Employee Health team will continue to build the system and continue weekly Agility implementation meetings. In addition, Employee Health plays a vital role in onboarding all NIHD workforce this includes new staff, providers, students, and volunteers; there has been a significant increase in onboarding throughout the District.

NIHD healthcare worker (HCW) influenza vaccine rates for 2021-2022 is 79% with 21% declination rate. NIHD Influenza rates for 2020-2021 were 89%. Overall, California hospitals reached 79% influenza vaccination among HCP in 2020-21, representing a 7% decrease compared with the 2018-19 influenza season. Among 386 reported hospitals, 88 (23%) hospitals met the 90% Healthy People 2020 goal.

Infection Prevention: Continues to report COVID-19 data to CDPH daily. Infection Prevention and Employee Health continue to collect NIHD workforce COVID-19 data to report to CMS via the NHSN portal. Healthcare Worker Influenza and COVID-19 reporting is completed; it was due **by May 15th, 2022**. NIHD COVID-19 vaccination rates are 89% of staff are fully vaccinated, and 23% have received booster doses. In addition, the team will continue to report HCW COVID-19 vaccination rates quarterly, and monthly Hospital-Acquired Infection data to NHSN. Infection Prevention continues to complete active and post discharges surveillance for any Hospital Acquired Infection’s and will resume departmental infection prevention rounding and tracer activities.

FY2022

Unit of Measure	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22
Cash, CDs & LAIF Investments	51,541,102	51,660,613	51,218,981	44,626,386	48,069,372	48,192,815	44,293,619	42,120,322	41,474,347
Days Cash on Hand	194	192	192	158	176	174	160	136	143
Gross Accounts Receivable	40,330,632	39,434,879	38,647,332	45,621,898	45,730,808	48,011,063	50,415,516	47,012,661	45,947,073
Average Daily Revenue	497,169	478,408	485,427	486,248	490,359	491,569	485,625	481,170	483,445
Gross Days in AR	81.12	82.43	79.62	93.82	93.26	97.67	103.82	97.70	95.04
Key Statistics									
Acute Census Days	215	170	196	254	306	188	290	232	228
ICU Census Days	0	7	33	11	7	0	2	0	9
Swing Bed Census Days	24	0	0	0	0	0	0	12	12
Total Inpatient Utilization	239	177	229	265	313	188	292	244	249
Avg. Daily Inpatient Census	7.7	5.7	7.6	8.8	10.4	6.1	9.4	8.7	8
Emergency Room Visits	783	745	674	766	687	706	721	625	654
Emergency Room Visits Per Day	25	24	22	25	23	23	23	22	21
Observation Days	67	54	56	56	56	67	53	43	53
Operating Room Inpatients	24	23	14	16	21	17	18	19	18
Operating Room Outpatient Cases	107	89	89	82	98	126	3	6	61
Observation Visits	64	54	50	51	45	60	51	42	53
RHC Clinic Visits	2,297	2,743	2,775	3,030	2,707	2,722	3,426	2,559	2,808
NIA Clinic Visits	1,679	1,614	1,699	1,726	1,744	1,557	1,518	1,396	1,744
Outpatient Hospital Visits	8,690	9,250	8,980	9,162	8,728	8,630	8,526	7,994	9,525
Hospital Operations									
Inpatient Revenue	2,774,294	2,563,061	3,193,923	3,361,605	3,958,181	2,404,683	3,708,290	2,908,927	3,231,022
Outpatient Revenue	11,563,898	10,530,380	10,677,079	10,581,296	10,120,970	11,882,529	8,803,380	8,539,211	11,061,511
Clinic (RHC) Revenue	1,074,051	1,155,594	1,126,962	1,206,362	1,137,285	1,136,568	1,448,892	1,067,009	1,246,889
Total Revenue	15,412,242	14,249,034	14,997,964	15,149,263	15,216,437	15,423,780	13,960,561	12,515,147	15,539,422
Revenue Per Day	497,169	459,646	499,932	488,686	507,215	497,541	450,341	446,970	501,272
% Change (Month to Month)		-7.55%	8.76%	-2.25%	3.79%	-1.91%	-9.49%	-0.75%	12.15%
Salaries	2,138,510	2,212,918	2,099,073	2,131,194	2,303,918	2,726,796	2,346,958	2,047,905	2,305,644
PTO Expenses	68,403	67,782	201,732	161,627	383,062	434,307	360,818	194,188	185,532
Total Salaries Expense	2,206,912	2,280,700	2,300,804	2,292,821	2,686,980	3,161,102	2,707,776	2,242,093	2,491,176
Expense Per Day	71,191	73,571	76,693	73,962	89,566	101,971	87,348	80,075	80,361
% Change		3.34%	4.24%	-3.56%	21.10%	13.85%	-14.34%	-8.33%	0.36%
Operating Expenses	6,882,843	7,013,237	7,294,767	7,804,027	7,724,749	8,310,179	8,099,494	7,597,308	7,906,014
Operating Expenses Per Day	222,027	226,233	243,159	251,743	257,492	268,070	261,274	271,332	255,033
Capital Expenses	345,511	111,738	219,678	216,596	44,295	501,290	1,671,393	380,900	1,341,823
Capital Expenses Per Day	11,146	3,604	7,323	6,987	1,477	16,171	53,916	13,604	43,285
Total Expenses	8,511,732	8,533,790	8,636,587	9,124,560	9,203,811	10,127,813	9,618,792	8,992,284	9,351,287
Total Expenses Per Day	274,572	275,284	287,886	294,341	306,794	326,704	310,284	290,074	301,654
Gross Margin	1,732,096	(81,114)	645,366	(132,062)	(11,789)	(660,853)	(1,047,088)	(1,923,702)	(854,403)
Debt Compliance									
Current Ratio (ca/cl) > 1.50	2.13	2.10	2.84	2.78	2.54	2.70	2.65	2.54	2.55
Quick Ratio (Cash + Net AR/cl) > 1.33	1.80	1.73	2.29	2.17	2.07	2.22	2.21	2.02	2.06
Days Cash on Hand > 75	194	192	192	158	176	174	160	136	143

NIHD - Income Statement

FY 2022	FY 2020	FY 2021	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	YTD 2022
Total Net Patient Revenue	76,229,126	86,844,620	8,614,939	6,932,123	7,940,133	7,671,965	7,712,959	7,649,326	7,052,406	5,673,606	7,051,611	66,299,067
IGT Revenues	13,729,686	20,295,927	394,000	1,106,255	530,242	394,000	394,000	2,780,184	856,511	2,676,270	1,879,305	11,010,768
Total Patient Revenue	89,958,812	107,140,547	9,008,939	8,038,378	8,470,376	8,065,965	8,106,959	10,429,510	7,908,917	8,349,876	8,930,915	77,309,835
Cost of Services												
Salaries & Wages	26,275,799	27,016,877	2,138,510	2,212,918	2,099,073	2,131,194	2,303,918	2,726,796	2,346,958	2,047,905	2,305,644	20,312,915
Benefits	18,316,171	22,382,407	1,618,760	1,635,349	1,795,655	1,801,576	2,059,894	2,085,215	2,199,930	1,799,225	1,750,987	16,746,589
Professional Fees	19,573,242	22,565,034	1,871,274	1,896,180	1,978,664	2,293,527	1,790,435	1,823,508	2,317,407	2,469,684	2,470,340	18,911,021
Pharmacy	3,105,981	4,035,279	274,517	354,714	344,942	405,802	392,006	380,870	286,978	362,249	330,943	3,133,021
Medical Supplies	4,199,962	4,136,111	277,812	255,157	358,049	369,855	451,788	497,972	184,989	159,263	244,786	2,799,671
Hospice Operations	505,000	-	-	-	-	-	-	-	-	-	-	-
EHR System	1,164,797	1,480,088	112,267	114,869	132,491	112,342	108,392	115,958	119,346	112,757	148,178	1,076,599
Other Direct Costs	4,813,483	5,810,258	589,703	544,051	585,893	689,732	618,316	679,861	643,886	646,224	655,135	5,652,802
Total Direct Costs	77,954,434	87,426,053	6,882,843	7,013,237	7,294,767	7,804,027	7,724,749	8,310,179	8,099,494	7,597,308	7,906,014	68,632,618
Gross Margin	12,004,378	19,714,494	1,732,096	(81,114)	645,366	(132,062)	(11,789)	(660,853)	(1,047,088)	(1,923,702)	(854,403)	(2,333,551)
Gross Margin %	13.34%	18.40%	19.23%	-1.01%	7.62%	-1.64%	-0.15%	-6.34%	-13.24%	-23.04%	-9.57%	-3.02%
												-
General and Administrative Overhead												-
Salaries & Wages	4,681,985	3,906,499	319,290	323,708	319,740	305,823	355,039	412,400	361,734	334,886	363,951	3,096,572
Benefits	4,150,743	3,754,395	283,420	299,665	312,500	243,511	322,152	382,695	335,529	310,036	310,978	2,800,487
Professional Fees	2,337,874	3,978,605	421,033	420,876	222,237	282,805	300,113	462,506	329,198	293,995	275,811	3,008,574
Depreciation and Amortization	4,275,662	4,094,658	370,335	358,995	347,178	358,655	347,192	369,148	334,665	298,932	331,373	3,116,473
Other Administrative Costs	1,412,451	1,396,332	234,811	117,308	140,164	129,739	154,566	190,884	158,172	157,128	163,160	1,445,932
Total General and Administrative Ove	16,858,715	17,130,488	1,628,889	1,520,552	1,341,820	1,320,533	1,479,063	1,817,634	1,519,298	1,394,976	1,445,273	13,468,038
Net Margin	(18,584,023)	(17,711,920)	103,207	(1,601,666)	(696,454)	(1,452,595)	(1,490,852)	(2,478,487)	(2,566,386)	(3,318,679)	(2,299,677)	(15,801,589)
Net Margin %	-20.66%	-16.53%	1.15%	-19.93%	-8.22%	-18.01%	-18.39%	-23.76%	-32.45%	-39.75%	-25.75%	-20.44%
Financing Expense	2,362,880	1,413,155	179,672	179,585	176,035	143,658	136,649	101,007	227,252	472,448	218,276	1,834,581
Financing Income	2,372,608	1,755,654	173,785	173,785	173,785	173,785	173,785	173,785	173,785	148,687	173,785	1,538,964
Investment Income	600,420	387,349	23,766	16,876	20,534	20,443	16,045	27,865	6,662	4,964	(1,624)	135,530
Miscellaneous Income	1712917.01	1361183.52	172,440	66,574	9,045,548	57,016	80,081	(460)	79,326	91,657	59,452	9,651,634
Net Surplus	(2,531,273)	4,675,038	687,526	(417,762)	8,897,620	(951,010)	(963,590)	401,879	(1,677,354)	(869,548)	(407,035)	4,700,726

	July-21	August-21	September-21	October-21	November-21	December-21	January-22	February-22	March 2022
Current Assets									
Cash and Liquid Capital	14,045,922	14,143,765	11,519,636	10,520,186	14,241,387	14,713,417	10,869,882	11,528,856	10,768,413
Short Term Investments	37,710,931	37,459,437	37,895,338	34,353,251	34,281,644	34,196,777	34,103,636	31,011,373	30,904,455
PMA Partnership	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	17,138,201	16,475,304	16,272,228	19,413,168	20,940,657	21,359,592	23,422,744	21,478,443	21,459,561
Other Receivables	7,663,674	9,643,932	10,601,529	13,216,871	10,901,419	9,978,572	8,858,544	11,734,556	10,098,207
Inventory	3,364,669	3,426,323	3,413,915	3,371,955	3,379,016	3,341,506	3,375,509	3,382,777	3,363,612
Prepaid Expenses	1,788,612	1,636,519	1,778,307	1,476,186	1,554,182	1,612,547	1,651,594	1,292,820	1,555,592
Total Current Assets	81,712,009	82,785,279	81,480,953	82,351,618	85,298,304	85,202,410	82,281,909	80,428,825	78,149,841
Assets Limited as to Use									
Internally Designated for Capital Acquisitions	-	-	-	-	-	-	-	-	-
Short Term - Restricted	2,499,267	2,499,373	1,639,227	61,230	61,232	61,232	61,236	1,307,758	1,307,813
Limited Use Assets									
LAIF - DC Pension Board Restricted	665,411	916,906	981,005	1,046,467	1,118,074	1,202,941	1,316,833	1,409,097	1,516,014
DB Pension	18,395,253	18,395,253	18,395,253	18,395,253	18,395,253	18,395,253	18,395,253	18,395,253	18,395,253
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-	-	-
Total Limited Use Assets	19,060,664	19,312,159	19,376,258	19,441,720	19,513,327	19,598,194	19,712,086	19,804,350	19,911,267
Revenue Bonds Held by a Trustee	3,215,549	3,375,336	3,535,124	3,694,911	4,004,827	14,392,668	14,073,128	13,804,794	1,109,439
Total Assets Limited as to Use	24,775,481	25,186,867	24,550,609	23,197,861	23,579,386	34,052,094	33,846,450	34,916,902	22,328,520
Long Term Assets									
Long Term Investment	1,502,414	1,001,121	1,000,001	997,171	996,539	1,002,414	989,654	1,729,276	1,710,676
Fixed Assets, Net of Depreciation	76,716,557	76,469,300	76,345,403	76,203,344	75,900,447	75,809,403	76,833,219	76,915,188	77,925,637
Total Long Term Assets	78,218,971	77,470,421	77,345,404	77,200,515	76,896,986	76,811,816	77,822,872	78,644,464	79,636,313
Total Assets	184,706,460	185,442,568	183,376,965	182,749,993	185,774,676	196,066,320	193,951,231	193,990,191	180,114,674
Liabilities									
Current Liabilities									
Current Maturities of Long-Term Debt	3,383,794	3,382,136	3,350,577	2,901,929	2,866,983	1,601,919	1,596,844	1,574,086	1,580,536
Accounts Payable	3,353,229	3,965,055	3,242,192	3,578,083	4,124,296	2,899,914	3,252,430	2,515,732	2,428,540
Accrued Payroll and Related	6,153,387	6,804,295	6,354,107	7,392,086	8,762,183	9,981,694	9,408,509	10,660,919	9,765,596
Accrued Interest and Sales Tax	261,043	369,624	195,444	303,558	405,047	149,454	200,365	248,727	237,243
Notes Payable	9,386,372	9,386,372	458,744	458,744	458,744	458,744	-	500,000	1,648,830
Unearned Revenue	13,653,194	13,344,456	12,972,529	12,867,638	14,815,460	14,410,638	14,439,154	14,079,239	12,848,670
Due to 3rd Party Payors	-	-	-	-	-	-	-	-	-
Due to Specific Purpose Funds	(25,098)	(25,098)	(25,098)	(25,098)	(25,098)	(25,098)	(25,098)	-	-
Other Deferred Credits - Pension	2,124,655	2,124,655	2,124,655	2,124,655	2,124,655	2,124,655	2,124,655	2,124,655	2,124,655
Total Current Liabilities	38,290,575	39,351,496	28,673,149	29,601,595	33,532,270	31,601,920	30,996,860	31,703,358	30,634,071
Long Term Liabilities									
Long Term Debt	35,607,947	35,607,947	35,257,947	35,257,947	35,257,947	47,102,947	47,102,947	47,102,947	34,572,947
Bond Premium	375,441	371,314	367,186	363,059	358,931	354,804	350,677	346,549	250,319
Accreted Interest	16,282,647	16,352,123	16,421,599	15,772,325	15,806,051	15,806,051	15,987,335	16,134,894	16,282,453
Other Non-Current Liability - Pension	45,570,613	45,570,613	45,570,613	45,570,613	45,570,613	45,570,613	45,570,613	45,570,613	45,570,613
Total Long Term Liabilities	97,836,648	97,901,997	97,617,346	96,963,944	96,993,542	108,834,415	109,011,572	109,155,003	96,676,332
Suspense Liabilities	(70,699)	(70,699)	(70,699)	(70,699)	(70,699)	(70,699)	(70,699)	-	-
Uncategorized Liabilities	629,381	656,981	656,756	705,749	733,749	712,992	703,159	691,039	770,515
Total Liabilities	136,685,905	137,839,774	126,876,552	127,200,589	131,188,862	141,078,627	140,640,892	141,549,400	128,080,918
Fund Balance									
Fund Balance	44,833,874	44,833,874	44,833,874	44,833,874	44,833,874	44,833,874	44,833,874	44,833,874	44,833,874
Temporarily Restricted	2,499,156	2,499,156	2,499,156	2,499,156	2,499,156	2,499,156	2,499,156	2,499,156	2,499,156
Net Income	687,526	269,764	9,167,384	8,216,374	7,252,784	7,654,663	5,977,309	5,107,761	4,700,726
Total Fund Balance	48,020,556	47,602,794	56,500,414	55,549,404	54,585,814	54,987,693	53,310,339	52,440,791	52,033,756
Liabilities + Fund Balance	184,706,460	185,442,568	183,376,965	182,749,993	185,774,676	196,066,320	193,951,231	193,990,191	180,114,674
	-	-	-	-	-	-	-	-	-

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Password Policy		
Owner: ITS Director - CISO	Department: Information Technology	
Scope: District Wide		
Date Last Modified: 04/11/2022	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/01/2004	

PURPOSE:

Passwords are an important aspect of computer security. They are the front line of protection for user accounts. A poorly chosen password may result in the compromise of NIHD's entire network. As such, all NIHD workforce members including but not limited to- employees, members of the Board of Directors, contractors and vendors with access to NIHD systems are responsible for taking the appropriate steps, as outlined below, to select and secure their passwords.

The purpose of this policy is as follows:

1. To establish a standard for creation of strong passwords
2. To establish a standard for the protection of those passwords
3. To establish a standard for the frequency of change of those passwords.

POLICY:

1. All passwords must be changed every 60 days.
2. Password history will remember the last 24 passwords that cannot be reused.
3. Accounts will be locked out after 8 failed attempts to prevent password spraying attempts.
4. Passwords must not be inserted into email messages or other forms of electronic communication.
5. All user-level and system-level passwords must conform to the guidelines described below.
    a. Password must contain a minimum of 12 characters and maximum of 15 characters
    b. Passwords must contain a combination of capital and lowercase letters, numbers and symbols
    c. Passwords should not contain easily recognizable words (i.e. Bishop, Inyo, NIH)
    d. ***Password exception for DMS***– Passwords can **only** contain capital or lowercase and not in combination. Example – "TgAgm487&" the password would have to be "tgagm4878&" or" TGAGM4878&"
6. Passwords are not to be shared with anyone, including administrative assistants.
7. If a password is suspected to have been compromised, report the incident immediately to the Information Technology Services Department or the District Information Security Officer.
8. NIHD workforce members cannot use the same password for NIHD accounts as they use for other non-NIHD access (e.g., personal ISP account, shopping sites, benefits, etc.).
    a.) If an employee's NIHD account(s) is compromised the ITS department will then investigate the public password breaches to verify that an employee's password(s) are not in the public domain.

b.) During an investigation of a security breach an employee may be asked - do you use the same password for any other accounts whether private or public?

9. NIHD workforce members cannot use the "Remember Password" feature of applications (e.g., Internet, Outlook OWA, etc.).

REFERENCES:

1. HIPAA Security - Security Awareness and Training Standard 164.308(a)(5)(ii)(D)
   NIST SP: 800-118, 800-12, 800-82 Rev 2, 800-53 Rev 4, 800-63-2, 800-66 4.5.3
2. The Joint Commission (CAMCAH Manual) Jan. 2022; Standard IM.02.01.03 EP 1.

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Computer Screen Lock Policy
2. Information Security and Data Integrity
3. Confidentiality
4. Computer Screen Lock Policy

Supersedes: v.3 Password Policy

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: ITS Service Desk Work Order		
Owner: ITS Director - CISO	Department: Information Technology	
Scope: District Wide		
Date Last Modified: 04/19/2022	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/01/2004	

PURPOSE:

This policy establishes an effective means of requesting, coordinating and completing Information Technology Service Desk tickets. This procedure ensures the efficiency of day to day operations of the district as well as maintaining the IT infrastructure of the facility.

POLICY:

1. Service Desk tickets such as those actions required to maintain or upgrade current systems, install new systems, printer or PC maintenance and repair, restore/install equipment, report writing, programming, network maintenance, new user account creation, new equipment, equipment disposal, telecom troubleshooting, etc. will be requested in accordance with this policy.
2. Service Desk ticket creation will be initiated via Email, phone call, SMS or chat. Service Desk Business hours are: Monday – Friday 7am – 5pm.
3. The ITS Department will categorize the Service Desk tickets into four categories:
    a). **URGENT:** Critical impact to Patient care or Business operations hospital wide. (Requires PHONE CALL first, then email to servicedesk@nih.org)
    b). **HIGH:** System and application wide interruption that effects day to day workflow. (Requires PHONE CALL first, then email to servicedesk@nih.org)
    c). **MEDIUM:** Issues that can be addressed within a reasonable amount of time during business hours. (Email servicedesk@nih.org, SMS, or chat)
    d). **LOW**: Actions initiated by a supervisor or department head that are enhancements or improvements or which may require extended IT resource allocation; i.e. projects, changes in workflow, custom pc builds, or changes to facility wide program settings; end user education. (Email servicedesk@nih.org)

    All NON-CRITICAL issues should be reported via email, intranet quick link, SMS (text w/o PHI) or chat in order to leave the phone lines available for critical patient care or business operations issues.

4. Service desk tickets are monitored and prioritized by Jr. Network Systems Analysts, and the ITS Coordinator, Manager and/or Director with occasional coverage from other ITS staff members.
5. Telephone and paging during business hours for ITS Department will be used only in Urgent cases (e.g., inability to access critical systems or email).
6. After hours' emergency calls will be placed through the Nursing House Supervisor to be assessed for importance using the ITS On Call flowsheet and routed to the ITS on call personnel if needed.

7. Any ITS equipment moves will be requested through the NIHD Project form on the located on the intranet.
8. Any new ITS equipment or new user access requests will be submitted 2 weeks prior to the start date by opening a service desk ticket.

PROCEDURE:

Incoming service desk tickets will be addressed by the Jr. Network Systems Analysts for Tier 1 troubleshooting and if escalation is needed this person will route the issue to the correct ITS or Informatics staff personnel after initial troubleshooting and/or collecting information.

Service Desk ticket requestors must provide the following information:
Full Name
Department
Call Back Number
Is the situation URGENT or HIGH?
Detailed description of incident/request
Identify application name (i.e. Outlook, EMR, Windows)
Patient Identifiers (if applicable)
Computer Name / Equipment Model numbers (if applicable)
EMR Order descriptions; accession #'s, time stamp, screen shots, etc (if applicable)
Troubleshooting steps taken

Tickets will be routed and prioritized based on the above policy.

Response times for Service Desk Tickets will be as follows (subject to change depending on staffing levels and projects):

URGENT: Requires immediate attention.
HIGH: 45-minute response time.
MEDIUM: 1-3 business day response time.
LOW: 1 to 2-week response time.

Response is defined as the Service desk person responding to the initial call either by email, ticket update, ticket reassignment or phone call.

Once the service desk ticket has been created, requestors may directly contact the technician assigned, for status updates or to provide more information (reference service desk ticket number). Service Desk ticket correspondences can be updated via ticketing system, email, phone, or chat. Users can view their tickets by logging into the web helpdesk system on the Intranet, quick links, IT Request.

Service desk escalation points will be directed to the ITS Coordinator / Manager and or ITS Director if needed.

REFERENCES: N/A

RECORD RETENTION AND DESTRUCTION: All service desk tickets are saved on the network and backed up on the server. They will be maintained for a minimum of 5 years.

CROSS REFERENCED POLICIES AND PROCEDURES: N/A

Supersedes: v.1 IT Help Desk Work Orders

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Licensure of Nursing Personnel		
Owner: Chief Nursing Officer	Department: Nursing Administration	
Scope: Registered Nurses, Licensed Vocational Nurses		
Date Last Modified: 04/15/2022	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/01/2011	

PURPOSE:

To ensure that all Northern Inyo Healthcare District (NIHD) Registered Nurses (RN) and Licensed Vocational Nurses (LVN) who practice nursing have a current active California license to practice nursing before starting work and thereafter.

POLICY:

1. RN and LVN whose job descriptions meet the requirements for nursing practice in the State of California will maintain a current license to practice as a RN or LVN.
    a. RN license granted from California Board of Registered Nurses.
    b. LVN license granted from California Board of Vocational Nurses and Psychiatric technician examinees.
2. According to California law, RN's or LVN's may be granted temporary permit licenses.
3. RN and LVN staff that does not have an active current license will not be allowed to practice nursing.
4. All licenses including temporary licenses must be renewed on or before the expiration date.
5. Graduate nurses who possess an interim Permit from the California Board of Nursing may practice professional nursing at NIHD under the supervision of an RN.
6. The Onboarding Specialist within the Human Resources Department verifies licensure with the Board of Registered Nursing and the California Board of Vocational Nurses and Psychiatric technician examinees via the primary verification.
7. The Onboarding Specialist within the Human Resources Department monitors and verifies RN and LVN licensure prior to expiration of Licensure.
8. Nurses are responsible for obtaining their own license and renewal.
9. Advanced Practice Nurse Licensure as an RN and Advanced Practice Nurse shall be maintained by the Medical Staff Office.
10. An RN or LVN with an Interim Permit who fails the examination or does not receive licensure prior to the Interim Permit Expiration, will no longer practice as a nurse.
    a. Staff failing boards may apply for any open position to which they are eligible.

PROCEDURE:

1. Upon hire or on the RN or LVN first day of employment, the RN or LVN license, Temporary license, or Interim Permit shall be viewed by the Onboarding Specialist within the Human Resources Department and the number and expiration date documented on the Licensure Tracking form (see attached) kept in the Employee's HR file.

a. Record of Interim Permit shall be kept in the same manner as the licenses. If the nurse passes the examination, the Interim Permit remains in effect until a regular license is issued or until the Interim Permit expiration date. If the nurse fails the examination, the Interim Permit shall be terminated upon notice by mail, or if the nurse fails to receive the notice, upon the date specified on the Interim Permit.

2. Each month the RN and LVN license file will be reviewed by the Onboarding Specialist within the Human Resources Department for next month expirations.
    a. Notice of need for renewal will be sent to the employee and manager via e-mail.
3. Employees who have not renewed their license by the expiration date will:
    a. Be suspended pending license verification. The employee may choose to use PTO.
    b. The RN or LVN will not be allowed to work in another position during the lapsed licensure period.
    c. The RN or LVN has four weeks to complete the requirements for licensure renewal. If licensure is not completed within the four-week time frame, the employee will be terminated for employment at Northern Inyo Healthcare District.

REFERENCES:

1. The Joint Commission (CAMCAH Manual) (Jan 1, 2022) HR 01.02.05 EP1.
2. Scope of Regulation Excerpt from Business and Professions Code Division 2, Chapter 6. Article 2 Section 2725.
3. California Board of Registered Nursing - https://www.rn.ca.gov/

RECORD RETENTION AND DESTRUCTION:

Licenses are maintained in the employee personnel file by the Human Resources Department. These will be maintained for the duration of the employment, plus 6 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Licensure of Nursing Personnel
2. Licenses and Registrations
3. Termination
4. Termination Benefits

Supersedes: v.4 Licensure of Nursing Personnel*