Northern Inyo Hospital

February 21 2018 Regular Meeting

February 21 2018 Regular Meeting - February 21 2018 Regul

Consent Agenda

Medical Staff Report

DRAFT AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

February 21, 2018 at 5:30 p.m.

In the Northern Inyo Hospital Board Room at 2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board (*Members of the audience will have an opportunity to address the Board on every item on the agenda. Speakers are limited to a maximum of three minutes each.).*
3. New Business
   A. Budget process discussion (*information item*).
   B. Urology equipment purchase (*action item*).
   C. Radiology Services Agreement with Tahoe Carson Radiology (*action item*).
   D. Information Technology Council Charter (*action item*).
   E. NIHD Project Review Board Charter (*action item*).
   F. NIHD ITS Change Advisory Board Charter (*action item*).
   G. Policy and Procedure approval, *Remote Access Policy* (*action item*).
   H. NIHD Code of Business Ethics and Conduct (*action item*).
   I. Policy and Procedure approval, *Family Members and Relatives in the Workplace* (*action item*).
   J. Policy and Procedure approval, *Auditing of Employee Access to Patient Information* (*action item*).
   K. Compliance Report for February 2018 (*action item*).
   L. Policy and Procedure approval, *Scope of Service Perinatal* (*action item*).
   M. Orientation Competency Committee Charter (*action item*).
   N. Leadership Restructure / Organizational Refocus (*information item*).
4. Old Business
   A. Athena implementation update (*information item*).
   B. Physician recruitment update, Internal Medicine Office (*information item*).

Consent Agenda (action items)

5. Approval of minutes of the January 17, 2018 regular meeting

6. Approval of Minutes of the January 25, 2018 special meeting
7. Financial and Statistical reports for November 2017
8. Financial and Statistical reports for December 2017
9. 2013 CMS Survey Validation Monitoring
10. Policy and Procedure annual approvals

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11. Chief of Staff Report; Richard Meredick, MD:

A. Policies/Procedures/Protocols/Order Sets (*action items*):

- *Accutest Rapid Mono Test*
- *Admission, Care, Discharge and Transfer of the Newborn*
- *Admission, Transfer, and Discharge Care of the Obstetrical Patient*
- *Aids/HIV Testing and Orders*
- *Anesthesia Clinical Standards and Professional Conduct*
- *Cardiac Arrest in the OR*
- *Chemotherapeutic Agents in the OR*
- *Code Blue Documentation*
- *Emergency Medical Screening of Patients on Hospital Property*
- *Entering and ED Admission*
- *HIV Testing Without Consents*
- *In-House Transport of Ventilator Dependent Patients*
- *Newborn Hearing Screening Program*
- *Observation in the Operating Room*
- *Organization-Wide Assessment and Reassessment of Patients*
- *Patient Visitation Rights*
- *Pre and Post Operative Anesthesia Visits*
- *Standard of Care – The NEST*
- *Standard of Patient Care in the Perinatal Unit*

B. Annual Approvals (*action items*):

a. ER Service Critical Indicators

b. Medicine/Intensive Care Service Critical Indicators

C. Complaints and Adverse Events reporting form for Adventist Health telemedicine providers (*action item*).

D. Internal Medicine Core Privilege form – revision (*action item*).

E. Medical Staff Appointments/Privileges (*action items*)

a. Robert Nathan Slotnick, MD (perinatology) – *Provisional Consulting Staff*

b. Michael H. Abdulian, MD (orthopedic surgery, Adventist Health) – *Provisional Consulting Staff*

c. Sarkis Kiramijyan, MD (interventional cardiology, Adventist Health) – *Provisional*

Consulting Staff

d. Sun I. Kim, MD (urology) – *Provisional Consulting Staff*

e. Erik J. Maki, MD (radiology, Tahoe Carson Radiology) – *Provisional Consulting Staff*

f. John Y. Erogul, MD (radiology, Tahoe Carson Radiology) – *Consulting Staff*

g. Edmund P. Pillsbury III, MD (radiology, Tahoe Carson Radiology) – *Consulting Staff*

F. Telemedicine Staff Appointment/Privileges – credentialing by proxy (*action items*):

As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined and allowed by 42CFR 482.22, the Medical Staff have chosen to recommend the following practitioners for Telemedicine privileges relying upon Adventist Health's credentialing and privileging decisions:

a. Talha Khawar, MD (rheumatology, Adventist Health) – telemedicine staff

b. Leon Kujmanian, MD (endocrinology, Adventist Health) – telemedicine staff

G. Medical Staff Resignations (*action item*)

a. Bishop Radiology Group

i. Arash Radparvar, MD – effective 2/12/18

ii. Young Song, MD – effective 2/12/18

iii.William I. Feske, MD – effective 2/12/18

iv. Eric W. Wallace, MD – effective 2/12/18

v. David Y. Kim, MD – effective 3/22/18

12. Reports from Board members (*information items*).

13. Adjournment to closed session to/for:

A. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation and significant exposure to litigation,2 matters pending (*pursuant to Government Code Section 54956.9*).

B. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).

C. Discussion of a real estate negotiation (*pursuant to Government Code Section 54956.8*)

D. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).

14. Return to open session and report of any action taken in closed session.

15. Adjournment.

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

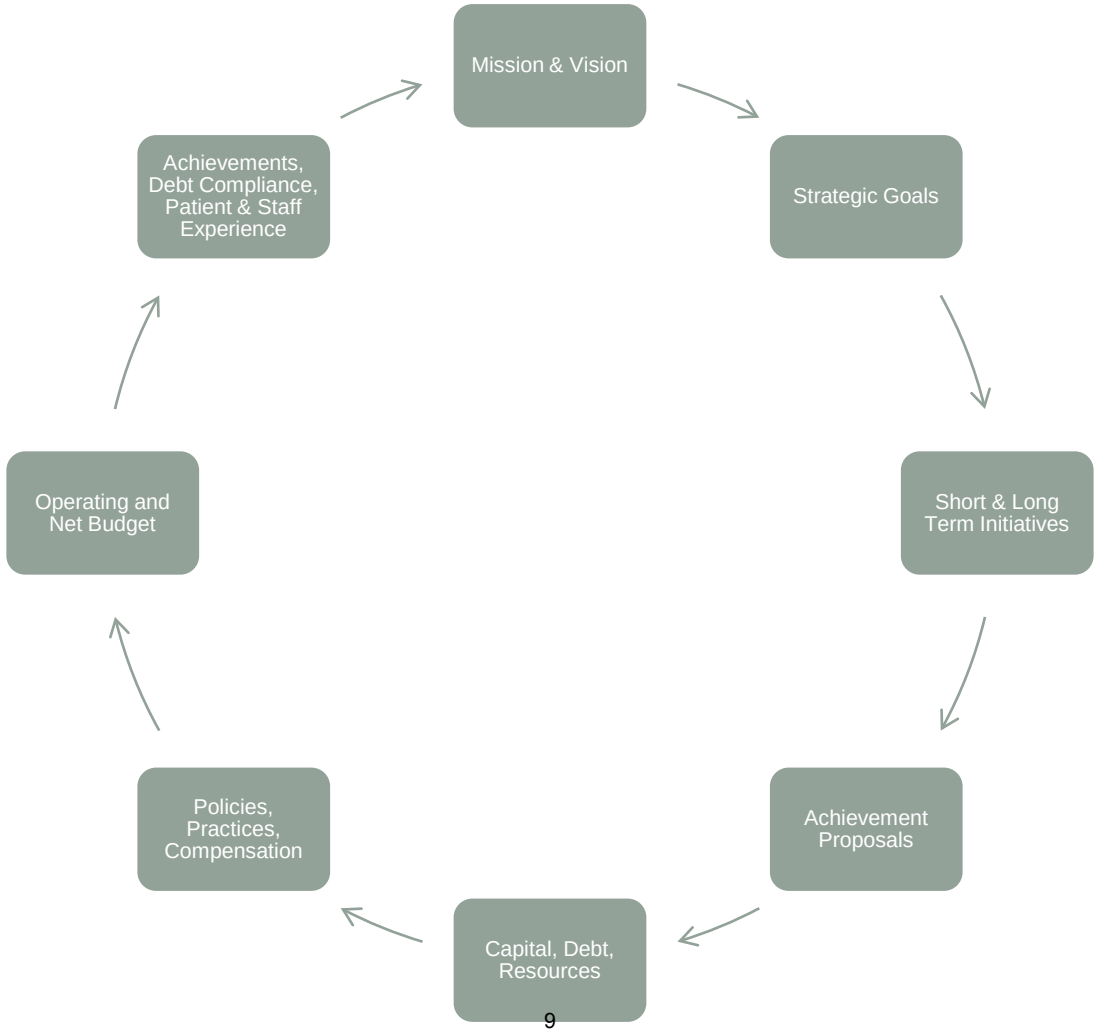
FISCAL 2019 BUDGET PROCESS

January 17, 2018

Why Change the Budget Process?

- The role of Finance (money, time, resources) in the success of an organization is a critical one.
- By adding an annual process whereby the Mission and Vision of the Organization is confirmed (or perhaps modified), then proper attention to the Finance Resources required for the Organization to meet its Mission and Vision which are supported by the Strategic Goals can increase staff knowledge of the Goals and increase the level of success in obtaining the Goals.
- The Strategic Goals being both short and long term will have an impact on both Finance Resources and development of the operating and net margin targets for the organization.

Proposed Budget Process



Proposed Budget Process

- Proposed Fiscal 2019 Calendar – January
- Discuss establishing a practice of confirming the Mission, Vision and long term and short term Strategic goals via the budget process
- Discuss and approve NIHD's compensation and benefit objectives for fiscal 2019.
- Approve high level budget objectives…margin, capital and strategic achievements
- Role out to NIHD management the budget forms with the direction and goals for fiscal 2019
- Bring first Capital and then Operations to the Board of Directors for approval with a list of expected achievements

Sample Achievement Proposals

- Consolidate “Special Purpose Funds” to book entry form and invest balances in LAIF
- Purchase of Olympus Tools to Support Urology
- Implementation of Athena in September, 2018

Budget Calendar

- January, 2018 review budget process proposal and receive Board approval to implement
- February, 2018 Mission, Vision, Strategic Objectives
- March, 2018 approve high level goals for Capital, Policies/Practices and Achievements
- April, 2018 approve overall Capital budget
- May, 2018 approve Operating Budget, funded Achievements and price changes
- June, 2018 (extra time)
- October, 2018 Audit Results Presented
- December, 2018 Proposed Budget Calendar for 2020

FISCAL 2019 BUDGET MISSION, VISION & STRATEGIES REVIEW

February 21, 2018

Mission & Vision

- Our Mission
- Improving our communities, one life at a time.
- One Team. One Goal. Your Health.

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

Strategic Objectives

- ***Providing the Right Services***
  - Primary Care
    - Family & Children's Care
    - Women's Care
  - Emergency Care
    - On Site 24/7/365
  - Diagnostic Services
  - Surgical Services
    - Available 24/7/365
  - Outpatient Treatment Services
  - Inpatient Services
    - Obstetrics Services 24/7/365
    - ICU 24/7/365
  - Specialty Services
  - Rehabilitation Services
  - All of the above in a Quality Manner in a ***Quality Environment***

Strategic Objectives

- ***Enhanced Community Focus***
  - Continue implementation of School Based Clinic
  - Partner in Community Sponsored Events
    - Goal to reach 40% + of Community Events
  - Take ownership in Community Sponsored Programs
  - Increase NIHD leaders involved in community activities

- ***Incorporate Data & Information into Our Culture***
  - New service line development based on community need data
  - Manager's budgets developed on demonstrated trends
  - Quality Metrics in all departments to support ***Providing the Right Services***
  - Establish system parameters to better measure customer, staff and department outcomes (experience & financial)

Strategic Objectives – Budget Support

- Providing the Right Services
  - Expanded on site surgical services – Urology & Orthopedics
    - Commit to full time Urology services
  - Expanded on site specialty services – Cardiology
  - Support the development of multiple Telemedicine specialties through the RHC
  - Continue recruitment of additional primary care (IM)
    - Review Same Day Program and expand if warranted
- Enhanced Community Focus
  - Expand hours of Spanish language on site interpreter services
  - Work towards primary goals
- Incorporate Data & Information into Our Culture
  - Resources to Install Athena and related products

Satisfy Prior Commitments

- Bond & Loan Payments of $2.6M.
  - Maintain key metrics in compliance with Bond Provisions
  - Capital Expenditures in line with Depreciation and Debt retirement use of cash on hand
- Capital Expenditure for Pharmacy of $900,000 to meet OSHPD requirements
- Continue Work to add Services to District through appropriate acquisition

Potential 2019 Budget Direction

- Approve expansion of ***Right Services Plan***
- Approve continued ***Enhanced Community Focus*** program implementations
- Approve ***Incorporation of Data & Information Plan for 2019***

- Recommend department budgets not increase by more than CPI inflation. And that budgets reflect changes in patient and work volumes experienced in 2018.
- Net Margin goal to be not less than 1% positive.
- Days Cash on Hand to be not less than 75 (current basis)
- Capital limited to above metrics allowances

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

NORTHERN INYO HOSPITAL
Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, California
93514
(760) 873-5811 voice
(760) 872-2768 fax

February 9, 2018

Memo To: Northern Inyo Healthcare District Board of Directors

From: Ann Wagoner, Director of Surgical Services
John Tremble, CFO

Subject: Unbudgeted Capital & Operating Expense Request

As you know, we are very pleased to have two Board Certified Urologists starting to practice at NIHD in March. Part of the process of preparing for their arrival was to work with them to determine what types of procedures they would most likely be performing when they are here each month. With the information they provided, the equipment in our inventory was examined and discussed with them to determine appropriateness and usefulness. In the process, it was determined that a number of pieces of equipment either did not exist at NIHD or were not within today's standard of care. A rental, purchase or lease analysis was done for one of the high cost pieces of equipment and purchasing was 25% cheaper than leasing.

Since our last urologist left practice at NIHD, HD (High-definition) has become standard for a number of operating room procedures. We reviewed the processors and other HD scope equipment in our inventory and determined that continuing to expand our Olympus equipment inventory makes the most sense as a number of existing pieces of equipment can be used with Urology scopes.

An initial equipment quote was procured from Olympus with a total price of $535,000 for scopes, HD equipment, lithotripsy and holmium laser. With this equipment list in hand, we engaged our GPO (Intalere) to work for increased discounts along with obtaining quotes from another vendor for alternative pieces of equipment. In this process, we have determined that we will initially rent a Lithotripsy machine when we need it and that a different holmium laser may be a better choice.

As of the drafting of this request, the total equipment and supplies request has dropped to $335,000 for equipment from Olympus and $42,000 for the holmium laser from Olympus or the competitor. We are awaiting a re-quote from Olympus and a review, from Intalere, for our purchase with our commitment to purchase 70% of the supplies for Olympus products from Olympus. The above prices do not include the cost of shipping. All of the equipment will have a minimum life of 5 years and is compatible with the training our Urology physician candidate is receiving.

Olympus America Inc.

3500 Corporate Parkway

P.O. BOX 610

Center Valley, PA 18034-0610

TEL: (800) 848-9024
FAX: (800) 228-4963

brian.manning@olympus.com

www.olympusamerica.com

Quote Number: Q-00491561

Please refer to this number on all correspondence
Effective Date: February 13, 2018

Expiration Date: March 31, 2018

Customer Information

Contact Name: ANN WAGONER

Contact Email: ann.wagoner@nih.org

Account Name: NORTHERN INYO HOSPITAL

Customer Address: 150 PIONEER LN
BISHOP, California
93514-2599
Customer Number: 20010770
(Sold To)

Payment Terms: Net 30 subject to Olympus credit approval
F.O.B.: Shipping point, unless otherwise mutually agreed upon in writing
Tax: Applicable taxes are not included in this quote and are the responsibility of the customer

Olympus Information

Representative: Brian Manning
Phone: (818) 606-2037
Email: brian.manning@olympus.com

Cage code: 32212
DUNS#: 017018859
Tax ID: 11-2416961

Comments

#	Item Type	Model And Description	Kit Component(s)	Qty	List Price	Contract Price	Unit Price	Total Price
1	New	**WA2T470A** : Telescope "OES Elite", 4 mm, 70 deg, HD,		5	$7,120.00	5,374.47	$5,374.47	$26,872.35
2	New	**WA2T430A** : Telescope "OES Elite", 4 mm, 30 deg,HD,g		5	$7,120.00	5,374.47	$5,374.47	$26,872.35

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3	New	**WA2T412A** : Telescope "OES Elite", 4 mm, 12 deg, HD,		3	$7,120.00	5,374.47	$5,374.47	$16,123.41
4	New	**A20915A** : A20915A CYSTO SHEA TH 25FR		2	$1,450.00	1,110.24	$1,110.24	$2,220.48
5	New	**A20914A** : A20914A CYSTO SHEA TH 22.5 F		2	$1,450.00	1,110.24	$1,110.24	$2,220.48
6	New	**A20913A** : A20913A CYSTOURETHROSC OPE SHEATH 21 FR		2	$1,450.00	1,110.24	$1,110.24	$2,220.48
7	New	**A20911A** : A20911A CYSTO SHEATH 17 FR		2	$1,450.00	1,110.24	$1,110.24	$2,220.48
8	New	**A20925A** : A20925A VISUAL OBTURATOR 25 FR		2	$950.00	690.13	$690.13	$1,380.26
9	New	**A20924A** : A20924A VISUAL OBTURATOR 22.5 FR		2	$950.00	690.13	$690.13	$1,380.26
10	New	**A20923A** : A20923A VISUAL OBTURATOR 21 FR		2	$950.00	690.13	$690.13	$1,380.26
11	New	**A20977A** : A20977A CYSTO BRIDGE DOUBLE CHANNEL		2	$1,070.00	775.87	$775.87	$1,551.74
12	New	**A20976A** : A20976A CYSTO BRIDGE SINGLE CHANNEL		2	$880.00	637.01	$637.01	$1,274.02
13	New	**A20714A** : A20714A OPT GRSPING FRCPS DBLE ACT 12DEG		2	$2,550.00	1,857.84	$1,857.84	$3,715.68
14	New	**A20713A** : A20713A BIOPSY FRCPS SPOON TYPE OPTICAL		2	$2,550.00	1,857.84	$1,857.84	$3,715.68
15	New	**A20712A** : A20712A BIOPSY FRCPS SPOON OPT 12 DEG		2	$2,550.00	1,857.84	$1,857.84	$3,715.68
16	New	**03664** : 03664 ADAPTER FOR ELLIK EVACUA TOR		5	$120.00	88.41	$88.41	$442.05
17	New	**75U** : 75U UNIVERSAL STOPCOCK LUER LOCK		6	$185.00	94.81	$94.81	$568.86
18	New	**ST-CR2** : ST-CR2 CYSTOSCOPY RESECTION TRAY - DO UB		5	$1,300.00	933.74	$933.74	$4,668.70
19	New	**00123** : 00123 FLEXIBLE BIOPSY FORCEPS 7FR		2	$920.00	704.51	$704.51	$1,409.02
20	New	**00121** : 00121 FLEXIBLE FOREIGN BODY FO RCEPS 7F		2	$920.00	704.51	$704.51	$1,409.02

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21	New	**253F8** : 253F8 FLEX FULG ELECT SOMED TIP 37 CM		2	$215.00	112.95	$112.95	$225.90
22	New	**253F6** : 253F6 FLEX FULG ELECT DOMED TIP 37 CM		2	$215.00	112.95	$112.95	$225.90
23	New	**A22040T** : A22040T INNER 24 FR W/ TIMBER FOR 26FR		2	$2,190.00	1,516.89	$1,516.89	$3,033.78
24	New	**A22042T** : A22042T SHEATH INNER W/ TIMBER 26FR		2	$2,190.00	1,516.89	$1,516.89	$3,033.78
25	New	**A22022A** : A22022A OUTER SHTH 2 STOPCOCKS ROT 28FR		2	$2,110.00	1,518.37	$1,518.37	$3,036.74
26	New	**A22026A** : A22026A OUTER SHEATH 2 STPCCK ROT 26FR		2	$2,110.00	1,510.82	$1,510.82	$3,021.64
27	New	**A22054A** : A22054A IRRI PORT 1 VERTICL STPCCK FIXED		2	$550.00	362.59	$362.59	$725.18
28	New	**A22072A** : A22072A OBTURATOR OPTICAL 26 FR		2	$880.00	637.01	$637.01	$1,274.02
29	New	**A22071A** : A22071A OBTURATOR OPTICAL 24 FR		2	$880.00	637.01	$637.01	$1,274.02
30	New	**A42091A** : A42091A OES-PRO Working Insert 8.5mm 8Fr		2	$1,460.00	1,108.11	$1,108.11	$2,216.22
31	New	**WA22367A** : WA22367A PASSIVE WORKING ELEMENT TURIS		2	$3,610.00	2,535.96	$2,535.96	$5,071.92
32	New	**WA00014A** : WA00014A HF CABLE BIPOLAR 4M FOR ESG-400		3	$370.00	262.42	$262.42	$787.26
33	New	**WA33026A** : WA33026A PCN Adapter Ellik		4	$240.00	177.03	$177.03	$708.12
34	New	**WA33036A** : WA33036A PCN Percutaneous Nephroscope		1	$8,500.00	6,385.95	$6,385.95	$6,385.95
35	New	**WA33025A** : WA33025A PCN Obturator for WA33035A/37A		1	$650.00	496.31	$496.31	$496.31
36	New	**A3342** : A3342 ATTACHEMENT W/ AUTOVALVE FOR A3336		1	$425.00	328.77	$328.77	$328.77
37	New	**A4558** : Sealing cap, 2 mm, green for A3342,		1	$47.00	36.20	$36.20	$36.20

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		10/p						
38	New	**A00001A** : A00001A VALVE 5.5MM CHANNEL 10PCS		1	$43.00	22.52	$22.52	$22.52
39	New	**WA63819A** : WA63819A PCN Grasping Forceps-3-Nail		1	$1,070.00	785.64	$785.64	$785.64
40	New	**WA63817A** : WA63817A PCN Grasping Forceps-3-NailLum		1	$1,070.00	785.52	$785.52	$785.52
41	New	**WA63815A** : WA63815A PCN Grasping Forceps-Toothed		1	$1,070.00	785.52	$785.52	$785.52
42	New	**WA63813A** : WA63813A PCN Grasping Forceps-Lumen		1	$1,070.00	785.52	$785.52	$785.52
43	New	**WA63810A** : WA63810A PCN Grasping Forceps-ToothedLum		1	$1,070.00	785.52	$785.52	$785.52
44	New	**MR-6LA** : MR-6LA URETEROSCOPE, 43cm		1	$10,390.00	7,840.51	$7,840.51	$7,840.51
45 *	New	**URF-P6** : URF-P6 SUPER-SLIM FLEXIBLE FIBEROPTIC UR		1	$19,990.00	Not available	$12,000.00	$12,000.00
46	New	**URF-V2** : URF-V2 SLIM FLEXIBLE VIDEO URETEROSCOPE		2	$24,990.00	18,130.00	$18,130.00	$36,260.00
47 *	New	**CH-S190-08-LB** : CH-S190-08-LB HD ULTRA-LIGHT URO CAMERA		3	$18,380.00	Not available	$18,380.00	$55,140.00
48	New	**WA03300A** : Light-guide cable, 2.8 mm, 3 m, CF type		6	$721.00	494.40	$494.40	$2,966.40
49	New	**MAJ-2092** : MAJ-2092 MAJ-2092 Luer-Split,CYF/URF IRR		5	$195.00	138.22	$138.22	$691.10
50	New	**13839** : 13839 Aptimax Sterrad Sterilization Tray		5	$670.00	542.14	$542.14	$2,710.70
51	New	**99239** : 99239 APTIMAX STERRAD Ster. Tray Mat		5	$270.00	192.88	$192.88	$964.40
52	New	**WB50402W** : WB50402W ESG-400 Footswitch Double Pedal		1	$1,500.00	1,215.00	$1,215.00	$1,215.00
53 *	New	**WB91051W** : WB91051W ESG-400		1	$30,000.00	Not available	$30,000.00	$30,000.00

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#	Item Type	Model And Description	Kit Component(s)	Qty	List Price	Contract Price	Unit Price	Total Price
		ELECTROSURGICAL GEN						

* DENOTES OPEN MARKET ITEM
Pricing may be based on a local agreement or the following contract(s):
Intalere VH11466 URO T3
Intalere VH10560 Tier 2
Intalere VH11466 URO Dsp T3
Intalere VQ08800 Srg T1
Intalere VQ08800 TB T1

NORTHERN INYO HOSPITAL

Signature: _____

Name: _____

Title: _____

Effective Date: _____

Purchase Order #: _____

Total List Price: (Before Trade-Ins)	$367,856.00
Total Net Price: (Before Trade-Ins)	$290,981.32
Total Trade-In Value:	$0.00
Sub Total:	$290,981.32
Freight:	$528.02
Grand Total:	**$291,509.34**

I. Olympus Standard Terms and Conditions apply to this quote, unless otherwise mutually agreed upon in writing
II. Errors & Omissions Excepted. Price quotes and the total package prices are for the quoted items only.
III. Changes and additions to, or deletions from this quote may cause pricing adjustments.
IV. Service manuals and additional operator manuals are not included and may be ordered by contacting the Customer Care Center at (800) 848 9024.
V. If freight charge is included, the freight charge may not necessarily reflect the exact charge paid by Olympus to the carrier due to the volume incentive discount agreements entered into between Olympus and carrier, unless otherwise mutually agreed upon in writing.

Based on the products purchased, the following terms may apply:

I. ET1457 promotional kit: This package pricing is contingent upon product availability and on customer's purchase of all items included in the package. Return of any products under the promotion package pricing may increase the price for the other items purchased under the promotion package pricing. Promotion is subject to termination at any time.

II. Certified Pre Owned promotional MP1465: This promotional package must be purchased in conjunction with the BTTF3 promotional package. Return of any items within this promotional package may trigger pricing changes to the remaining items. Promotion is subject to termination at any time.

III. Quotes containing the following item numbers or promotional discount codes are eligible for the 160 Service Contract Upgrade Promotion (GIF-H180J-160SVCT, GIF-H180-160SVCT, GIF-Q180-160SVCT, CF-H180AL-160SVCT, CF-Q180AL-160SVCT, PCF-H180AL-160SVCT, PCF-Q180AL-160SVCT, and 160 to 190 Customer Loyalty). In order to receive the benefit of this promotion, customers must have an active service agreement which covers a corresponding like-type 160 generation endoscope. By accepting this promotional offer, Customer acknowledges and agrees that any applicable trade-in 160 scopes will be removed from their service agreement and replaced with a corresponding like-type promotional 180 or

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brian.manning@olympus.com

www.olympusamerica.com

Quote Number: Q-00491561

Please refer to this number on all correspondence
Effective Date: February 13, 2018

Expiration Date: March 31, 2018

190 generation endoscope ("Replacement Scope"). Once the Replacement Scope is shipped, Olympus will send Customer notification of the updated service agreement. Except as specifically modified by the above, the terms and conditions of the service agreement remain in full force and effect.

IV. ScopeLocker storage product: Please take note of the ScopeLocker's specifications and dimensions and carefully measured the space where the ScopeLocker will be installed to ensure a good and proper fit. By submitting payment and/or a purchase order for any ScopeLocker, customer acknowledges and agrees that Olympus' standard return goods policy does not apply. ScopeLockers may only be returned if they have been delivered to the customer damaged. Customer is responsible for noting and reporting any external shipping damage prior to signing the carrier's receipt form for the ScopeLocker. Once customer signs the carrier's receipt form for the ScopeLocker, it is understood that the customer has inspected the shipment and has found no evidence of external shipping damage. Customer has seven (7) days after customer's receipt of the ScopeLocker to notify Olympus of any internal shipping damage which was undetectable at time of product receipt. Only returns with a valid Return Merchandise Authorization (\"RMA\") number issued by Olympus will be accepted and eligible for return. All authorized returns must be sent prepaid to Olympus or its designee and the RMA number must be prominently displayed on the shipping carton and all paperwork. Merchandise returned with proper RMA identification, with all accompanying items and manuals (as shipped to customer), shall be credited at the original customer's purchase price. No returns will be accepted more than 14 days from date of invoice. Credits will be given against customer's account; no cash refunds will be issued.

V. Used Products: All used products carry a 90 day limited warranty, supplied with your order. These products are designated as 'Used' as the item type.

VI. Promotion MP1608 190 Demo Value Add Promotion -- This promotion requires the purchase of at least one (1) kit from each of "Column A," "Column B," and "Column C." If this quote contains any item from "Column A," at least one (1) kit from each of the "Column B" and "Column C" must be included in this quote. Quotes and orders containing a "Column A" kit without at least one (1) "Column B" kit and one (1) "Column C" kit are invalid and will not be honored. Return of any items within this promotion may trigger pricing changes to the remaining items. Quotes under this promotion are subject to inventory availability. This promotion is subject to termination at any time.

NORTHERN INYO HEALTHCARE DISTRICT

RADIOLOGY
COVERAGE AND ADMINISTRATIVE SERVICES AGREEMENT

This Radiology Coverage and Administrative Services Agreement ("**Agreement**") is effective as of April 1, 2018 (the "**Effective Date**"), between Northern Inyo Healthcare District (the "District") and Tahoe Carson Radiology ("**Group**").

RECITALS

A. District owns and operates a general acute care hospital located at 150 Pioneer Lane, Bishop, CA 93514 ("**Hospital**") and operates a Radiology Department (the "**Department**") for the provision of professional radiology services to hospital inpatients and outpatients ("**Professional Services**"). District desires to ensure the availability of experienced physicians to meet the needs of Hospital, its medical staff ("**Medical Staff**'), and its patients for these services.

B. District is also in need of an experienced, qualified physician to serve as Radiology Medical Director for the Department, to provide certain administrative services to the Department and to act as a liaison between the Department, the Medical Staff and other departments within the hospital.

C. Group is a professional corporation that employs physicians who are duly licensed to practice medicine in California, who are experienced in and are board certified or eligible in radiology (the "**Specialty**"), and who are qualified to provide the services required under this Agreement (each, a "**Physician**," collectively, the "**Physicians**").

D. District wishes to contract with Group, and Group wishes to contract with District, to provide a physician to serve as Radiology Medical Director for the Department and to provide Physicians to provide coverage services upon the terms and conditions set forth in this Agreement.

NOW, THEREFORE, the parties agree as follows:

SECTION 1. GROUP SERVICES

1.1 Coverage Services.

(a) **Services.** Hospital hereby retains Group to provide all Coverage Services (as hereinafter defined) to the Hospital for inpatients and outpatients on an exclusive basis. Group shall be responsible for providing a sufficient number of Physicians to provide on-site and on-call coverage services as required for patient care and operation of the Department and as described on **Exhibit A** attached ("**Coverage Services**"). Group shall be permitted to provide the Coverage Services via the on-site presence of Physicians or via teleradiology using its Physicians and/or a Teleradiology Service Provider (as hereinafter defined) as specified on **Exhibit A** hereof. In the event District desires, during the term of this Agreement, to provide Coverage Services at a location other than Hospital, District shall offer the opportunity to provide such Coverage Services to Group by notice to such effect (the "Offer Notice," which notice shall include District's proposed terms and conditions of the arrangement) before offering such opportunity to any other person. Group may accept or reject such offer or it may respond with a proposal to provide such Coverage Services under alternative terms and conditions, all by notice to District. If District and Group do not enter into a written agreement for the provision of such Coverage Services within twenty-one (21) days following the Offer Notice, District may then offer the opportunity to provide such Coverage Services to another person, but not on terms more favorable to such other person than the most favorable terms that District offered to Group.

(b) **Coverage Schedule.** At least two (2) weeks prior to the first day of each month, Group shall provide Hospital with an electronic coverage schedule ("**Coverage Schedule**") listing the names of Physicians who will provide Coverage Services each day that month, including whether Coverage Services will be provided on-site or on-call. Group shall ensure that the electronic Coverage Schedule is modified in a timely manner (by the day preceding the Coverage Schedule day in question) so that it is accurate with respect to each day Coverage Services are provided.

(c) **Physicians.** Group shall engage a sufficient number of Physicians that Group in its discretion determines are needed to provide Coverage Services under this Agreement. A list of those Physicians who Group anticipates will provide Services for Hospital under the terms of this Agreement is attached hereto as **Exhibit B**. Group shall immediately give Hospital written notification in the event that any Physician appearing on **Exhibit B** resigns or otherwise fails to satisfy the qualifications for services as a Physician hereunder. In the event Group desires to add a Physician to **Exhibit B**, Group shall ensure that any such physician meets the qualifications set forth in this Agreement and shall immediately notify Hospital, in writing, of such proposed addition. Such a Physician shall be added as a Physician hereunder unless Hospital objects within seven (7) days of receiving notice of the new Physician from Group, which objection shall not be unreasonably made. All obligations and prohibitions imposed on Group pursuant to this Agreement are equally applicable to each Physician engaged by Group to provide Coverage Services. Notwithstanding the foregoing, Group shall be permitted to use (i) the Teleradiology Service Provider to provide final interpretations and (ii) coverage staff (locum tenens physicians) to supplement its Physicians hereunder on a temporary basis provided that such coverage staff satisfies the professional qualifications of Section 2.1.

(d) **Teleradiology Services**. The Parties acknowledge and agree that some Coverage Services will be provided, at Group's sole cost and expense by Quality Nighthawk Services, or a similar after-hours radiology services provider selected by Group and approved by District, in advance, with such approval not being unreasonably withheld ('Teleradiology Service Provider") provided that all Physicians providing Coverage Services through the arrangement with the Teleradiology Services Provider satisfy the professional qualifications of Section 2.1. Group shall be financially responsible for all compensation due and owing to the Teleradiology Service Provider for providing Coverage Services to Hospital. Group shall ensure that Teleradiology Service Provider shall comply with all laws, rules, regulations and Medical Staff bylaws and rules and regulations regarding the provision of professional services to Hospital patients via telemedicine. Hospital shall credential the providers providing services to Hospital patients by the Teleradiology Service Provider pursuant to its established policies and procedures. Group shall ensure that any Teleradiology Service Provider shall not bill Hospital nor any Hospital patient for the professional services provided by Teleradiology Service Provider to Hospital patients under the terms of this Agreement.

1.2 Administrative Services.

(a) **Services.** Group shall provide a Physician or Physicians to serve as Radiology Medical Director ("**Medical Director**"). The Medical Director shall be responsible for carrying out Group's administrative responsibilities described in **Exhibit C** and for the overall supervision and operation of the Department, to act as a liaison between the Department, the Medical Staff and other departments within the District and to oversee Group's performance of this Agreement (collectively, "**Administrative Services**"). To the extent allowed by law, the Medical Director shall be responsible to the Hospital's Chief Medical Officer ("**Administrator**") for performance of services under the Agreement.

(b) **Approval.** Group has initially engaged Ryan Berecky, M.D. to serve as the Medical Directors and this Physician is hereby approved and accepted by District. The Medical Director may delegate to other Group Physicians select Administrative Services provided the approved Medical Director retains ultimate responsibility.

(c) **Hours.** The Medical Director shall devote as much time as is reasonably necessary and adequate each month to provide the Administrative Services described in this Agreement.

(d) **Substitute Medical Director.** Group shall cause the Medical Director to inform the Administrator of any extended periods (i.e., one week or more) during which the Medical Director will be unavailable due to vacation, professional meetings, or other personal or professional commitments. During all periods of the Medical Director's unavailability, Group shall engage and provide a substitute Group Physician to serve as Medical Director ("Substitute Medical Director"). For periods of the Medical Director's unavailability more than four (4) weeks, Group shall secure District's prior written approval for the Substitute Medical Director, which approval shall not be unreasonably withheld.

SECTION 2. STANDARDS OF PERFORMANCE

2.1 Professional Qualifications. Each Physician providing Coverage Services or Administrative Services shall at all times meet the following professional qualifications and Group shall promptly notify District when it acquires knowledge of any event causing or likely to cause a failure by any Physician to meet these professional qualifications:

(a) Hold an unrestricted license to practice medicine in the State of California;

(b) Be permitted to prescribe medications and hold a valid Drug Enforcement Agency permit;

(c) Hold a certificate or evidence of eligibility for certification by the American Board of Radiology, or be so certified within three (3) years of eligibility;

(d) Be a member of the Medical Staff in good standing; additionally, the Radiology Medical Director shall be an active member in good standing of the Medical Staff and be subject to all of the attendant privileges, responsibilities and conditions of such membership; and

(e) Be eligible to provide services to beneficiaries under the Medicare and Medi-Cal programs as a participating provider.

2.2 Representations and Warranties. Group represents and warrants to District that:

(a) Neither Group nor any Physician is bound by any agreement or arrangement which would preclude Group from entering into this Agreement, or Group or any Physician from fully performing the Coverage Services or the Administrative Services;

(b) No Physician's license to practice medicine in the State of California or in any other jurisdiction has ever been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or restricted in any way;

(c) No Physician's medical staff privileges at any health care facility have ever been denied, suspended, revoked, terminated, voluntarily relinquished under threat of disciplinary action, or made subject to terms of probation or any other restriction;

(d) No Physician or Teleradiology Service Provider (or their provider physicians) have ever been convicted of an offense related to health care, or listed by the Medicare or Medi-Cal programs or any other federal or state agency as debarred, excluded or otherwise ineligible for any federal or state program participation; and

(e) Group has no information that would reasonably indicate that any Physician is not able to perform the services required under this Agreement.

2.3 Compliance with Rules and Laws. Group shall comply, and shall ensure that Physicians

comply, with all written policies, bylaws, rules and regulations of Hospital and the Medical Staff and applicable standards and recommendations of the Joint Commission. Group also shall comply, and shall ensure that Physicians comply, with all applicable provisions of federal, state and local laws, rules and regulations, as well as rules and regulations of all governmental agencies having jurisdiction over: (i) the operation of the Hospital (ii) the licensing of health care practitioners; and (iii) the delivery of services to patients of governmentally regulated third party payors whose members/beneficiaries receive care from Hospital. This shall specifically include compliance with applicable and relevant provisions of Title 22 of the California Code of Regulations.

2.4 **Quality Improvement and Risk Management**. Group and each Physician shall participate in:

(a) The quality improvement and risk management programs of Hospital and serve on such quality improvement or risk management committees as may be reasonably required;

(b) On-going quality improvement monitoring activities, such as audits, reviews or investigations, conducted by Hospital in order to evaluate and enhance the quality of patient care. The appropriate review mechanism shall be applied in accordance with the provisions of the Medical Staff Bylaws, accreditation organizations and applicable laws;

(c) Risk management activities designated to identify, evaluate and reduce risk of patient injury associated with care.

(d) Performance Improvement and Peer review activities consistent with hospital licensing and accreditation standards;

(e) The development of and adherence to protocols for the Department, which support evidence-based care, best practices and patient satisfaction.

(f) Regularly consult with the Administrator, Medical Executive Committee and/or other designated party or committees on matters related to the Department including productivity, quality, service and patient satisfaction.

(g) Meet the requirements of Meaningful Use and code patient visits and procedures for billing purposes in a timely fashion.

2.5 **Corporate Compliance Program.** Group and each Physician shall comply with Hospital's corporate compliance program, which shall be provided to the Group prior to the Effective Date and thereafter as amended. Group and Physicians shall cooperate with any corporate compliance audits, reviews and investigations that relate to Group or any Physician and/or any of the services provided by Group or any Physician under this Agreement. In addition, as requested by District, Group and Physicians shall participate in corporate compliance-related seminars and educational programs sponsored by District.

2.6 **Best Efforts.** Group shall devote its best efforts toward carrying out the terms of this Agreement and shall cause Physicians to devote sufficient time to support the efficient and effective operation of the Department.

2.7 **Non-Discrimination.** Group and each of its Physicians shall provide services under this Agreement without regard to any patient's race, color, creed, ethnicity, religion, national origin, ancestry, citizenship, marital status, age, sex, sexual orientation, preexisting medical condition, physical or mental handicap, financial status, insurance status, economic status, or ability to pay for medical services.

2.8 **Group's Annual Report.** Upon request of the Hospital made no later than the 7th month after the Effective Date, Group agrees to provide an annual report to the Administrator in the 10th month after the Effective Date. The annual report shall include an explanation of Physician staffing and qualifications,

call frequency while providing coverage services, patient survey results, any material issues related to the Department, and opportunities for performance improvement.

2.9 Removal of Physicians. District may request the immediate cessation of Coverage Services or Administrative Services by any Physician for failure to satisfy the professional qualifications of Section 2.1 or for other reasonable reasons related to his or her performance of Coverage Services upon written notice to Group specifying the reasons thereof. The parties shall immediately identify and attempt to mutually agree upon an appropriate response to the issue raised by the District (e.g. additional education, counseling, termination of employment or engagement with Group, or such other response as may be reasonable under the circumstances). If District and Group cannot mutually agree upon an appropriate response within five (5) business days of District's written notice to Group and/or District is not reasonably satisfied with the results of such response and notifies Group in writing of such dissatisfaction, Group shall temporarily remove such Physician from the Coverage Schedule and/or not assign such Physician responsibilities for providing Administrative Services until (and if) such specific issues have been resolved to District's reasonable satisfaction. District and Group administration shall then meet and discuss alternative staffing arrangements. The parties acknowledge and agree that nothing herein shall affect the rights of a Physician under Hospital's Medical Staff Bylaws, including the right to due process and a hearing thereunder if such Physician is subject to removal pursuant to this Section 2.9. The removal of a Physician pursuant to this Section 2.9 shall not serve as the basis for termination of this Agreement in the event that Group has provided or will be able to provide Coverage Services hereunder through other Physicians or the Teleradiology Service Provider in lieu of the Physician to whom the terms of this Section 2.9 apply.

SECTION 3. PREMISES

3.1 Equipment, Supplies, Etc. District shall operate the Department with all customary and necessary equipment, furniture, computers, supplies, maintenance, cleaning, utilities and qualified personnel reasonably required for operation of the Department. The selection, deletion and purchasing of additional or replacement equipment and the selection, removal and retention of personnel shall be the exclusive function of District, with input from the Radiology Medical Director as requested by the Administrator.

3.2 Use of District Facilities. Except as set forth in this Section 3.2, any facilities, equipment, supplies, or personnel provided by District shall be used by Group and Physicians solely to provide services under this Agreement and other occasional informal radiology consultation services. District hereby acknowledges and agrees that Group and its Physicians will throughout the term of this Agreement provide professional services at locations other than the Hospital and that certain studies generated at the Hospital may be interpreted by Group and/or its Physicians and Teleradiology Service Providers at offsite locations via teleradiology or other means of transmission. In addition to and notwithstanding anything to the contrary contained herein, Group may provide at any District facility at which Group provides Coverage Services hereunder, outside radiology services for third parties that are unrelated to the Coverage Services being provided hereunder to the District, including but not limited to the interpretation of outside radiology studies, so long as these outside services do not have a material adverse impact upon the delivery of the Coverage Services by Group to Hospital as described herein and are provided using workstations and other equipment owned and operated by Group separately from the District's equipment provided hereunder. Provided, however, that Group shall be permitted to use Hospital's internet connectivity to provide the outside services described in the immediately preceding sentence.

a. 3.3 Provision of Services via Teleradiology. Group shall at its sole cost and expense provide all technical services, networking, and information technology (including but not limited to hardware, software, and support) needed by group to provide remote interpretive services by group or any company contracted by group, whether the service is intended to provide preliminary or final interpretations for district patients. Any provision of service provided on-site or via teleradiology by any PACS or RIS system not currently supported by Districtwill be required to interface with district supported system that results in the automatic flow of images and reports to and from systems. The development and implementation of needed interfaces will be a joint cost between district and group. Group

will cover costs associated with group supported systems and District will cover costs associated with district supported systems.

SECTION 4. BILLING AND COMPENSATION

4.1 **Compensation.** District shall pay Group in accordance with **Exhibit D**.

4.2 **Billing for Services.**

(a) **Fee Schedule.** Group will establish a schedule of fees for the professional components of Radiology Services provided under this agreement. This schedule of fees is subject to District approval.District will establish a schedule of fees for the technical components of Radiology Services. All fee schedules will be consistent with the customary fees in the community for the services involved. In no event will fees to Medicare patients exceed the applicable fees or charges published by the Centers for Medicare and Medicaid Services under the then current Medicare Physician Fee Schedule for the Hospital's location.

(b) **Hospital Billing.** District shall bill and collect for the professional and technical component of medical services delivered to all Department patients. Group hereby assigns to Hospital the right to collect such charges for its Physicians and its Teleradiology Service Providers; for the avoidance of doubt, all references to Group's charges hereunder shall include charges for services rendered by Group and its Physicians and/or Teleradiology Service Providers. Hospital's charges to the patient shall be separate and distinct from the charges by Group. In the event Hospital bills patients through a single invoice combining Hospital and Group charge, the billing shall clearly distinguish Group professional fees and shall disclose that the District has authority to bill for professional services provided by group. Hospital shall use its commercially reasonable best efforts in the billing and collection of the professional component services provided by Group's Physicians and Teleradiology Service Providers. The parties agree that District's collection of professional fees during the term of this Agreement are not anticipated to exceed amounts paid by District to Group for professional services pursuant to this Agreement, and as a result, all fees collected for professional services provided under this agreement will be the property of District.

(c) **Billing Records.** District shall keep and maintain, complete and accurate records of all charges and billings, and Group shall have the right to examine, inspect or make copies of the records of district pertaining to such charges and billings, at its own expense if such access is requested by Group to confirm the amounts billed and collected by the District hereunder or as necessary to comply with any laws, rules or regulations.

4.3 **Expenses.** Neither Group nor any Physician shall incur any financial obligation on behalf of District without District's prior written consent, which consent shall be in District's sole and absolute discretion. Group and Physicians shall be solely responsible for the following: (a) Physician compensation and benefits; (b) professional license fees and professional association membership fees and dues; (c) professional conventions and meetings; (d) professional liability insurance (even though the cost of such insurance increases over the term of this Agreement); and (e) all compensation attributable to any employees, subcontractors, back-up physicians or teleradiology service providers engaged by Group or a Physician.

SECTION 5. TERM AND TERMINATION

5.1 **Term.** The term of this Agreement shall commence on the Effective Date and continue for a period of five (5) years. This Agreement will automatically renew for one additional five (5) year term unless notice of intent not to renew is provided to either party no less than one-hundred eighty (180) days prior to the end of the first term.

5.2 Without Cause Termination. Neither party may elect to terminate this Agreement, without cause.

5.3 Immediate Termination by District. District may terminate this Agreement immediately by written notice to Group upon the occurrence of any of the following events:

(a) The inaccuracy of any representation of Group in Section 2.2 (Representations and Warranties) or failure of Group to remove a Physician after requested by District pursuant to Section 2.9 (Removal of Physicians);

(b) Loss or restriction of Hospital's license or accreditation, or destruction of the Hospital or the portion(s) thereof dedicated to the operation of the Department, such that District is not able to continue the uninterrupted operation of the Department;

(c) Either party becomes insolvent or declares bankruptcy;

(d) If professional liability insurance is not available for Physicians performing Group's Coverage Services under this Agreement;

(e) The dissolution or discontinuance of the operations of Group.

5.4 Termination for Cause. Upon material breach of any term of this Agreement by a party (the "Breaching Party"), the other party may immediately terminate this Agreement by notice to the Breaching Party to such effect, *provided* that, except for a breach described in Section 5.3 or any breach that causes immediate jeopardy to patient care, the party shall have first provided notice of such breach to the Breaching Party and the Breaching Party shall have failed to cure the breach within ninety (90) days after such notice.

5.5 Legal Jeopardy. In the event legal counsel for either party advises that this Agreement or any practices which could be or are employed in exercising rights under this Agreement may violate any existing or future law or regulation, or will jeopardize the District's tax exempt status, or jeopardize either party's participation in, or result in fines or penalties under, the Medicare or Medicaid programs or any other third-party payor program, whether governmental or non-governmental, or any accreditation or certification program, the parties in good faith shall undertake to revise this Agreement to comply with such law(s). In the event that the parties are unable to reach agreement on new terms within 30 days of communicating the non-compliance to the other party, either party may immediately terminate the Agreement. Both parties recognize and agree that the rules governing compensation arrangements approved by the Centers for Medicare and Medicaid Services may change during the term of this Agreement. If any portion of the compensation set forth in this Agreement is likely to be materially affected by such modifications to the extent that the compensation hereunder is no longer equal to fair market value, the parties will work diligently and in good faith to modify such compensation to comply with the law and to approximate as closely as possible the economic relationship described in this Agreement.

5.6 Effect of Expiration or Termination.

(a) **Continuation of Patient Services.** Upon expiration or other termination of this Agreement, the parties shall be relieved and released from any further duties and obligations under this Agreement except for those obligations that have accrued as of the date of termination or specifically continue beyond the end of the term. Notwithstanding the foregoing, except for termination due to legal jeopardy or risk to patient welfare, if circumstances applicable to particular patients require the continuation of such services after the effective date of this Agreement's termination, Group shall continue to provide for a reasonable period (not to exceed thirty (30) days beyond the date of termination) Coverage Services to any patient for whom Group had professional responsibility.

(b) **Procedural Rights.** Continuation of this Agreement is not a condition of Medical Staff membership. Therefore, this Agreement may be terminated in accordance with its terms or individual Physicians excluded pursuant to Section 2.9 without the necessity of a hearing before the District's Board of Directors, a committee of the Medical Staff, or any other body. Physicians' Medical Staff membership and clinical privileges shall continue unless or until terminated in accordance with the Medical Staff Bylaws. Group represents and warrants that all Physicians are aware of and accept this condition.

SECTION 6. INSURANCE AND INDEMNITY

6.1 Insurance for Administrative Services. District shall provide coverage for the Administrative Services provided by Group under this Agreement through its standard policy of insurance or self-insurance in amounts of One Million Dollars ($1,000,000) per claim and Three Million Dollars ($3,000,000) in the annual aggregate. This insurance shall be applicable only to Administrative Services and not to any Coverage Services nor any professional services provided to patients.

6.2 Professional Liability Insurance. Group at its sole cost and expense shall maintain professional liability insurance for services rendered by Group and each Physician in the Department in the minimum amount of One Million Dollars ($1,000,000) per claim and Three Million Dollars ($3,000,000) in the annual aggregate from an insurance company which is acceptable to District, with such acceptance not being unreasonably withheld. Upon District's request, Group shall provide to District a copy of the Certificates of insurance evidencing the insurance coverage required under this Section. Such insurance policy or policies shall also provide for not less than thirty (30) days' notice to District of any cancellation, reduction, or other material change in the amount or scope any coverage required under this Section. If Group's professional liability coverage is on a "claims made" rather than an "occurrence" basis, and such coverage is later terminated, or converted to an occurrence coverage (or vice versa), Group shall at its expense obtain prior acts or tail coverage (as applicable) with the same liability limits required above covering all periods that this Agreement is or has been in force.

6.3 Indemnification. Each party shall indemnify, defend and hold harmless the other party from any and all liability, loss, claim, lawsuit, injury, cost, damage or expense whatsoever (including reasonable attorneys' fees and court costs) arising out of, incident to or in any manner occasioned by the performance or nonperformance of any duty or responsibility under this Agreement by such indemnifying party or by any of the indemnifying party's directors, trustees, officers, employees, shareholders, agents, contractors or subcontractors, as applicable, specifically including but not limited to any liability associated with Hospital's or District's billing for the Coverage Services provided by Group hereunder. The foregoing indemnity provisions shall not be operative to the extent and where to be operative would result in denial of coverage by any insurer or under any insurance policy that denies coverage for contractually assumed liability, and neither party shall be liable to the other party hereunder for any claim covered by third party insurance, except to the extent that the liability of such party exceeds the amount of such third party insurance coverage. Each party shall make its best efforts to obtain any waivers or riders on insurance policies covering such party as may be necessary to remove any limitations or restrictions in such policies with regard to coverage for the contractual indemnities provided under the terms of this Section.

SECTION 7. MEDICAL RECORDS

7.1 Creation of Medical Records. Group and Physicians shall cause a complete medical record to be created and maintained for each patient evaluated and/or treated by Group. Group and Physicians shall complete these medical records within the time frame as specified by Medical Staff Bylaws, Rules and Regulations and/or related written Hospital policies and procedures. All medical records shall be kept current and complete and prepared in compliance with all state and federal regulations, the regulations of all accreditation institutions in which District participates, the Medical Staff bylaws, and Hospital's rules and regulations.

7.2 Patient Records. Any and all patient records and charts produced as a result of either

party's performance under this Agreement shall be and remain the sole property of District. Both during and after the term of this Agreement, Group shall be permitted to inspect and/or duplicate, at Group's expense, any individual chart or record to the extent necessary to meet professional responsibilities to such patient(s) and/or to assist in the defense of any reimbursement inquiry or malpractice or similar claim to which such chart or record may be pertinent; provided, however, that such inspection or duplication shall be conducted in accordance with applicable legal requirements and pursuant to commonly accepted standards of patient confidentiality. Group shall be solely responsible for maintaining patient confidentiality with respect to any information obtained by Group pursuant to this Section. This provision shall survive the expiration or termination of this Agreement for any reason.

7.3 **Record Requirements.** Each party agrees in connection with the subject matter of this Agreement to cooperate fully with the other party in order to assure that each party will be able to meet all requirements for record keeping associated with public or private third-party payment programs.

SECTION 8. ACCESS TO BOOKS AND RECORDS

8.1 **Access.** Group shall maintain and make available all necessary books, documents and records in order to assure that District will be able to meet all requirements for participation and payment associated with public and private third party payment programs, including, but not limited to, matters covered by Section 1861(v)(1)(1) of the Social Security Act, as amended. With respect to Section 1861(v)(1)(1), it is agreed:

(a) Until expiration of 4 years after furnishing services pursuant to this Agreement, Group shall make available upon written request of the Secretary of Health and Human Services or the U.S. Comptroller General, or any of their duly authorized representatives, this Agreement, books, documents, and records of Group that are necessary to verify the nature and extent of costs incurred by District under this Agreement.

(b) If Group carries out any of the duties of this Agreement with a value of $10,000 or more over a 12 month period through a subcontract with a related organization, such agreement must contain a clause to the effect that until the expiration of 4 years after the furnishing of services under the subcontract, the related organization shall make available, upon written request of the Secretary of Health and Human Services, the U.S. Comptroller General, or any of their duly authorized representatives, the subcontract, and any books, documents and records of the related organization that are necessary to verify the nature and extent of costs incurred by District under this Agreement.

8.2 **Limits.** The availability of Group's books, documents, and records shall be subject at all times to all applicable legal requirements, including, without limitation, such criteria and procedures for seeking and obtaining access that may be promulgated by the Secretary of Health and Human Services by regulation.

SECTION 9. INDEPENDENT CONTRACTOR RELATIONSHIP

In the performance of all Coverage Services and Administrative Services and other obligations under this Agreement, it is mutually understood and agreed that (a) Group and the Physicians are at all times acting and performing as independent contractors with respect to the District; (b) no relationship of partnership, joint venture, or employment is created by this Agreement; (c) neither the District nor Group (or any Physician) will hold itself out or act as agent of the other party, or have the power to obligate the other party to third parties in any way without the express written consent of the other party; and (d) neither Group nor any Physician may make any claim against the District under this Agreement for social security benefits, workers' compensation benefits, disability benefits, unemployment insurance benefits, health benefits, vacation pay, sick leave, or any other employee benefits of any kind. It is the express intention of the parties that Group, in providing medical services under this Agreement, shall perform said services independently of any direction and control of the District except that Group agrees to perform all

services in accordance with the specifications of this Agreement. Group and the Physicians shall owe their first duty to the patients seen under the terms of this Agreement, shall be responsible for them and shall exercise independent medical judgment regarding their care and treatment. The District shall not supervise or oversee the performance of services under this Agreement, except to the extent of quality assurance and peer review undertaken for all physicians on District's Medical Staff.

SECTION 10. CONFIDENTIALITY

10.1 District Information. Group recognizes and acknowledges that, by virtue of entering into this Agreement and providing services to District hereunder, Physician and Group may have access to certain information of District that is confidential and constitutes valuable, special and unique property of District. Group agrees that neither Group nor any Physician will at any time, either during or subsequent to the term of this Agreement, disclose to others, use, copy or permit to be copied, without District's express prior written consent, except pursuant to Group's or a Physician's duties hereunder or as compelled by law or order of court, any confidential or proprietary information of District, including, but not limited to, information that concerns District's patients, costs, prices and treatment methods at any time used, developed or made by District, and that is not otherwise available to the public.

10.2 Terms of this Agreement. Except for disclosure to Group's legal counsel, accountant or financial advisors (none of whom shall be associated or affiliated in any way with District or any of its affiliates) neither Group nor any Physician shall disclose the terms of this Agreement to any person who is not a party to this Agreement, unless disclosure thereof is required by law or otherwise authorized by this Agreement or consented to in writing by District.

10.3 Patient Information. Group shall not disclose, and shall ensure that the Physicians not disclose, to any third party, except where permitted or required by law or where such disclosure is expressly approved by District in writing, any patient or medical record information regarding District patients, and Group shall comply with all federal and state laws and regulations, and all rules, regulations, and policies of District and its Medical Staff, regarding the confidentiality of such information, including, but not limited to, the Federal Health Insurance Portability and Accountability Act, Public Law 104-191 ("HIPAA") and Subtitle D of the Federal HITECH Act ("HITECH Act," 42 U.S.C. §17921 et seq.) and the regulations promulgated there under by the U.S. Department of Health and Human Services (the "HIPAA Regulations," 45 C.F.R. Part 160, et seq.), as amended from time to time.

10.4 Business Associate Requirements. By signing this Agreement, Group hereby agrees to comply, and to require that any Radiology Medical Director and Substitute Medical Director comply, with the business associate requirements ("Business Associate Requirements") as they appear in the HIPAA security and privacy regulations (in current or amended form) regarding using and disclosing patient-identifiable health care information that is received from District in the course of furnishing Administrative Services under this Agreement. The Business Associate Requirements in effect at the time of the Effective Date of this Agreement are set forth in **Exhibit F** attached.

10.5 Hospital Responsibilities. Hospital shall retain administrative and professional responsibility for Hospital services rendered.

SECTION 11. ARBITRATION

Any controversy or claim arising out of or relating to this Agreement, or the making, performance or interpretation of it, will be settled by arbitration in Inyo County, California. The arbitration will be conducted pursuant to the provisions of Part 3, Title 9, Chapters 1 through 5 of the California Code of Civil Procedure commencing with Section 1280, or such California State legislation then in effect, as amended. The party wishing to institute arbitration pursuant to this provision will give notice to the other party of its intent to commence arbitration and will designate in the notice an arbitrator on behalf of such party. Within thirty (30) days after the date of the notice of intent to

arbitrate a controversy or claim, the other party will give notice of its nomination of an arbitrator on its behalf. Within thirty (30) days thereafter, each of the arbitrators nominated will designate a third, neutral arbitrator. The decision of the two arbitrators as to the selection of the third, neutral arbitrator will be final and binding upon the parties. The arbitration will be enforceable as provided by California law. Each party will bear the costs of the arbitrator selected by it, and the fee for the third, neutral arbitrator will be shared equally by the parties unless the arbitration tribunal determines otherwise. The prevailing party will be entitled to reasonable attorneys' fees and costs as a part of the arbitration award.

SECTION 12. NOTICES

Any notices or other communications permitted or required by this Agreement shall be made in writing and deemed made on the day personally delivered in writing or via overnight delivery by a mutually recognized carrier or 3 days after mailed by certified mail (or first class mail), postage prepaid, to the other party at the address set forth below or to such other persons and addresses as either party may designate in writing:

If to District: **Northern Inyo Healthcare District,**
150 Pioneer Lane
Bishop, CA 93514
Attn: Chief Executive Officer

If to Group: **Tahoe Carson Radiology**
Attn. Administrator
PO Box 2830
Carson City, NV 89702

SECTION 13. MISCELLANEOUS PROVISIONS

13.1 **Governing Law.** This Agreement shall be construed and enforced in accordance with the laws of the State of California.

13.2 **Force Majeure.** Either party shall be excused from any delay or failure in performance under this Agreement caused by reason of any occurrence or contingency beyond its reasonable control, including, but not limited to, acts of God, acts of war, fire, insurrection, labor disputes, riots, earthquakes, or other acts of nature. The obligations and rights of the party so excused shall be extended on a day-to-day basis for the time period equal to the period of such excusable interruption. In the event the interruption of the excused party's obligations continues for period in excess of thirty (30) days, the other party shall have the right to terminate this Agreement upon ten (10) days' prior written notice to the excused party.

13.3 **Assignment/Subcontracting.** Neither party shall assign or subcontract their rights, duties, or obligations, under this Agreement, either in whole or in part, without the prior written consent of the other. Notwithstanding the foregoing, the District will have the right to assign its interest in this Agreement to an entity wholly owned, controlled by, or under common control with the District. Any such assignee will assume all of the rights and obligations of the District under this Agreement. In the event that the District is sold to, or affiliates with, another entity or in the event that the District's duties under this Agreement devolve upon some other entity during the term of this Agreement, the District will assign its rights and duties under this Agreement to the newly responsible entity.

13.4 **Severability.** If any provision of this Agreement is held to be invalid, void, or unenforceable, the remaining provisions will remain in full force and effect, unless the provision in question contained a

material right or duty of a party under this Agreement.

13.5 Entire Agreement. This Agreement and the Exhibits attached contain all the terms and conditions agreed upon by the parties regarding the subject matter of this Agreement and supersede any prior agreements, oral or written, and all other communications between the parties relating to such subject matter.

13.6 Other Agreements. District represents that its contracts database includes copies of all other agreements under which Group, or any Physician contracting with Group (or any immediate family member of any such Physician), provides services to District.

13.7 No Third Party Rights. The parties do not intend the benefits of this Agreement to inure to any third person not a signatory to this Agreement. Notwithstanding anything contained herein, or any conduct or course of conduct by any party to this Agreement, before or after signing this Agreement, this Agreement shall not be construed as creating any right, claim or cause of action against either party by any person or entity not a party to this Agreement.

13.8 Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument. The parties agree that a facsimile or electronic (e-mail) transmission of an executed counterpart of this Agreement shall have the same binding effect on the signatory as an executed and delivered original thereof.

13.9 Survival. The provisions of Sections 2.5 (Corporate Compliance Program), 4.2(c) (Group Billing), 4.2(d) (Billing Records), 4.3 (Expenses), 5.5 (Effect of Expiration or Termination), 6 (Insurance and Indemnity), 8 (Medical Records), 9 (Access to Books and Records), 11 (Confidentiality), 12 (Arbitration), 13 (Notices), 14 (Miscellaneous) and Exhibit D shall survive termination of Agreement.

13.10 Waiver. No waiver of any obligation under this Agreement shall be enforceable unless set forth in a writing signed by the party against which enforcement is sought.

13.11 Amendments. Any amendment to this Agreement shall be made in compliance with applicable law and regulations, including but not limited to the Stark law. No amendment or modification of this Agreement shall be enforceable unless set forth in a writing signed by both parties.

13.12 New Agreements. If this Agreement is terminated during its first year, for any reason, the parties shall not enter into a new agreement for the same or substantially similar services of the Group until a full year has passed from the Effective Date of Agreement.

13.13 Non-Solicitation. Each party agrees that during the term of this Agreement and for a period of one (1) year thereafter, it will not directly or indirectly, utilize the confidential or trade secret information of the other party to solicit or induce any employee, agent or contractor of the other to terminate their then-existing employment or contractual relationship with such party, including but not limited to the Physicians and the Teleradiology Service Providers of Group. A party that violates this Section 13.13 hereby agrees that the breaching party may obtain preliminary and permanent injunctive relief for a violation or threatened violation of any such restrictions without having to prove actual damages or to post a bond, and the non-breaching party shall also be entitled to an equitable accounting of all earnings, profits and other benefits arising from such violation, including but not limited to costs and reasonable attorneys' fees, which rights shall be cumulative and in addition to any other rights or remedies to which the non-breaching party may be entitled in law or equity.

IN WITNESS WHEREOF, the parties have executed this Agreement on the dates set forth below to be effective as of the Effective Date.

DISTRICT:	**GROUP:**
NORTHERN INYO HOSPITAL DISTRICT	**Tahoe Carson Radiology**
_____	_____
By: _____	By: _____
Its: _____	Its: _____

MEDICAL DIRECTOR ACKNOWLEDGMENT

The undersigned Physician hereby acknowledges receipt of a copy of this Agreement and accepts the position, and agrees to carry out the duties, of Medical Director as set forth in this Agreement.

Date: _____ _____

By: _____, M.D.

EXHIBIT A

COVERAGE SERVICES

Group shall be responsible to perform the following Coverage Services:

(1) Group shall provide, through its own employed or contracted Physicians (and including physicians associated with the Teleradiology Service Provider), Professional Services to patients upon appropriate request or referral from other health care practitioners at Hospital. Group shall develop a system for assuring the availability of Physicians on-site or on-call to Hospital and the Department to ensure that an appropriate level of Professional Services are available 24 hours per day, 7 days per week, 52 weeks per year according to a schedule mutually agreed upon by both parties.

(2) **Group shall, at a minimum, provide Coverage Services as follows:**

On Site Radiologist physically present within NIHD's department of Radiology credentialed with NIHD to perform, and able to successfully perform, radiology procedures outlined in Exhibit E.	Monday 10am – 5pm Tuesday – Thursday 8am – 5pm Friday 8am – 12pm (noon)
Teleradiology	Monday – Thursday 5pm – 8am
Teleradiology	Friday 12pm (noon) – Monday 10am
Teleradiology	all NIHD observed holidays
***** Teleradiology can be provided by Group or contracted teleradiology company.	

(3) Group shall provide one (1) Physician from Group who shall be on-site as may be requested by Hospital in cases of natural disaster or other emergent Patient need from 10 a.m. on Monday through 12pm (noon) on Friday.

(4) Although Group may have a Physician on-site at Hospital when required above, Group shall have the discretion to have a particular study interpreted via teleradiology by another Physician or a Teleradiology Service Provider with a particular expertise in a particular study.

(5) Coverage Services include only those services described on Exhibit E.

EXHIBIT B

GROUP PHYSICIANS

EXHIBIT C

ADMINISTRATIVE SERVICES

Group shall ensure that the Medical Director shall perform the following administrative services:

1. Implement the Medical Staff's policies and procedures as they relate to the Department;
2. Assist Hospital in the development and implementation of appropriate performance improvement activities and benchmark measures with respect to the radiologic services;
3. Assist Hospital in the organization and implementation of an effective utilization management program with respect to radiologic services;
4. Coordinate and consult with the Medical Staff and the staff of the Hospital regarding the efficiency and effectiveness of radiologic services, and make recommendations regarding improving outcomes and performance indicators;
5. Perform or have performed at Hospital's expense a review of claims to ensure that the delivered care is commensurate with community standards and that bills accurately reflect the care delivered by the Physicians performing services on behalf of Group.
6. Develop, review, and provide training programs for Physicians participating in services at the Hospital;
7. Assist Hospital with ensuring that the Department is operated in accordance with all requirements of the Joint Commission and all applicable licensing requirements, and all other relevant requirements promulgated by any federal, state or local agency;
8. Prepare such reports and records as may be required by this Agreement or as reasonably required by Hospital or the Medical Staff;
9. Participate in Hospital and Medical Staff committees as requested by Hospital;
10. Participate in continuing medical education, research and teaching activities as agreed to by Hospital and Group;
11. Advise and assist in the development and annual review of protocols and policies for the radiologic service;
12. Monitor the compliance of Physicians performing services hereunder with written Hospital and Medical Staff rules and bylaws;
13. Participate in the development and monitoring of schedules for all professional services provided in the Department to ensure that the safety of patients, providers, and staff and the needs of patients and their attending physicians take precedence over other Group concerns;
14. Monitor, evaluate, and report no less than quarterly on the clinical abilities and performance of all physicians performing services on behalf of Group hereunder through a formal peer review process;
15. Ensure that all Physicians performing services on behalf of Group hereunder communicate and coordinate care with referring physicians on a timely basis;
16. Participate with Hospital management to plan radiologic services and develop an annual budget.
17. Serve as the Radiation Safety Officer.
18. Supervise and train radiology personnel in conjunction with Hospital's Director of Diagnostic Imaging.

EXHIBIT D

COMPENSATION

Base Compensation: District will provide group an annual income guarantee of $1,200,000 during years one – five of the contract. This income guarantee shall be paid in equal monthly allotments of $100,000 and will be submitted to group on or before the 15th day of each month.

Annual Price adjustments: There shall be no automatic price adjustments during the initial or any subsequent term of this agreement. To confirm that collected professional fees do not exceed the income guarantee, either party may request a reconciliation of professional fees collected as a result of this agreement and compare that to the income guarantee of this agreement. If during any term of this agreement, reconciliation demonstrates that the collected professional fees exceed the income guarantee; both parties agree to negotiate in good faith prior to the renewal of the next term.

Reductions from Base Compensation:

District shall have the right to reduce payments to group's base compensation as follows:

1. **On-Site coverage lapses:** Excluding periods where all travel routes from Group's home office to hospital are restricted due to weather, District shall have the right to reduce base compensation by one thousand five hundred dollars ($1500) for each occurrence where on-site radiology coverage requirements are not fulfilled (excluding tardy arrival less than 60 minutes in duration). In the event that the number of occurrences exceeds ten (10) in any rolling 12 month period, the penalty for subsequent events will be three thousand dollars ($3,000) per occurrence and group will be considered in breach of the terms of the agreement.

2. **Tardy Arrivals of on-site Radiologists of less than 60 minutes in duration**: District shall have the right to reduce payments to group's base compensation for each occurrence where the on-site radiologists are not in the department on or before the scheduled time. Occurrences that involve more than 60 minute delay will be considered a lapse of on-site coverage and will be adjusted per the "on-Site Coverage lapses" section of this agreement.

Number of occurrences in rolling 12 month period	Reduction in payment to group (per occurrence)
1-5	$250 / occurrence
6-10	$500 / occurrence
11-15	$1000 / occurrence – breach of contract
16 and more	$1500 / occurrence

Housing. District will provide housing for Group within one of its currently leased properties. The value of the rent will be reported as taxable income. In addition to the provision of housing, District will reimburse for other lodging required by group for the provision of on-site services in an amount not to exceed ten thousand dollars ($10,000) annually after receipt of invoice and associated receipts requesting reimbursement.

EXHIBIT E

SERVICES

1. **Services.** During the term of this Agreement, Group shall provide the following services for Hospital patients:

    a. Professional interpretations of Diagnostic Imaging Studies including, but not limited to:
        a. Plain Film X-Ray
        b. Mobile and fixed fluoroscopic examinations
        c. Computed Tomography Studies
        d. Magnetic Resonance Imaging Studies
        e. Nuclear Medicine Procedures
        f. DEXA scans
        g. Ultrasound examinations
        h. Coronary Artery CT
        i. Lung Cancer Screening Exams

    b. Diagnostic Imaging Diagnostic and/or Therapeutic Procedures
        a. Paracentesis
        b. Thoracentesis
        c. Abscess Drainage
        d. FNA Biopsy
        e. Lymph Node Biopsy
        f. Hysterosalpingiogram
        g. Major joint injections
        h. PICC placements
        i. Arthrocentesis – Major Joint
        j. Lung / mediosteinum biopsy
        k. Liver Biopsy
        l. Cervical Myelograms
        m. Lumbar Myelograms
        n. Lumbar Punctures

2. **Excluded Services.** District and Group agree that the Services shall exclude the following services:

    a. Breast Imaging including Screening and Diagnostic mammograms, MRI exams of Breast, Ultrasound of breast, and all breast biopsy services.
    b. Radiologic Interventional Pain Management Services referred by High Sierra Imaging and interventions.

3 **First Right of Refusal for Excluded Services** Group shall have the first right of refusal and exclusive right for services currently excluded under this agreement shall the current provider of services become unavailable to provide the excluded services for a period in excess of 60 days or if notice of intent to terminate is received or given to current provider

EXHIBIT F

NORTHERN INYO HEALTHCARE DISTRICT BAA

See attached.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: IT Council Charter	
Scope: Northern Inyo Healthcare District	Manual:
Source: Director Information Technology Services	Effective Date:

COMMITTEE PURPOSE:

The NIHD IT Council members are the resources for projects and data requests. Approved projects will be delivered to the IT Council for review. Custom report requests will be reviewed for redundancy and data identification.

Reports to: Data and Information Committee

Membership:

The IT Council is comprised of the following:

- Director of ITS – chair
- Business Office Analyst
- Quality representative
- Clinical Informatics representative
- HIM representative
- Accounting representative
- ITS Analyst – Clinical
- ITS Analyst – Business
- ITS Manager

Adhoc members invited as needed dependent on agenda

- Perinatal Nurse representative
- HR representative
- Rehab representative
- Admission Services representative
- Lab representative
- DI representative
- Administrative Assistant Manager RHC/NIA
- Purchasing Representative
- Maintenance Representative

Convenes: Every other month

COMMITTEE RESPONSIBILITIES

- Develop and implement data analytics plan to support the NIHD strategic plan
- Identify the resources needed to implement projects approved by the NIHD Project Review Board
- Reviews data requests with the task of identification of where the data is stored in current databases. Identify the "source of truth".

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: IT Council Charter	
Scope: Northern Inyo Healthcare District	Manual:
Source: Director Information Technology Services	Effective Date:

- Identifies education needs for NIHD applications
- Review/Approve ITS Policies and ensuring the policies support the strategic mission of NIHD

Approval	**Date**
Data and Information Committee	**12/14/17**
Exec Team	**1/4/2016**
Board of Directors	**2/17/16**

Developed: 12/1/2015
Reviewed:
Revised: 11/15/2017

Responsibility for review and maintenance: Director of Information Technology Services
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: NIHD IT Project Review Board Charter	
Scope: District Wide	Manual:
Source: Director of Information Technology Services	Effective Date:

COMMITTEE PURPOSE

The NIHD Project Review Board shall provide oversight of information technology investments by monitoring, evaluating and approving actions related to IT investments and prioritization of projects and services.

This oversight positions ITS to deliver business value by aligning IT initiatives and operations to the current and future strategic objectives of Northern Inyo Healthcare District.

Additionally, this oversight ensures the business units are effectively supported and have the technology they need to enable their goals.

Reports to: Data and Information Committee

Membership:

- Director of Information Technology Services (chair)
- ITS Project Manager
- Revenue Cycle Director or CFO
- Admission Services Manager
- Administrative Director of NIA/RHC clinics
- Facilities or Maintenance Representative
- ITS Manager
- Clinical Informatics Manager
- Quality Coordinator
- Director of Diagnostic Services
- HIM Manager
- ad hoc as requested for specific projects.

Meeting invitees also include the NIHD Executive Team to attend as desired.

Convenes: Quarterly

COMMITTEE GOALS

1. To foster collaboration through shared accountability for IT investments, project, risk and service decisions and performance.
2. To align funding and prioritization of projects with NIHD objectives.
3. To maximize business value through effective project management and allocation of NIHD resources.

COMMITTEE RESPONSIBILITIES

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: NIHD IT Project Review Board Charter	
Scope: District Wide	Manual:
Source: Director of Information Technology Services	Effective Date:

- Serve as the NIHD project approval review board, ensuring that projects support the strategic mission of NIHD.
- Oversee the effective evaluation, selection, prioritization and funding of competing projects.
- Assess infrastructure and resources; current and proposed need for the future end goal.
- Review major obstacles to project completion

Approval	**Date**
Data and Information Committee	**11/15/17**
Executive Team	
Board of Directors	

Developed: 10/10/2017
Reviewed:
Revised:

Responsibility for review and maintenance: Director of Information Technology Services
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: NIHD ITS Change Approval Board Charter	
Scope: District Wide	Manual:
Source: Director of Information Technology Services	Effective Date:

COMMITTEE PURPOSE

The NIHD ITS Change Approval Board (CAB) is the governing authority for Change Management procedures, metrics, and documentation. The committee provides oversight of changes that affect NIHD applications, hardware, and infrastructure with the objective of providing a stable environment, minimize the impact of changes on the user community and support the seamless integration of changes across business units, service categories, and system platforms through the use of a common change management approval process.

Reports to: Data and Information Executive Committee

Membership includes representative from the following areas:

- Director of Information Technology Services (chair)
- ITS Project Manager
- ITS Manager
- Accounting
- Business Office
- Admission Services
- Clinical Informatics (nursing)
- HIM
- Outpatient Clinics (RHC and Specialty Clinics)
- Pharmacy
- Diagnostic Services
- Information Technology Analysts as required
- ad hoc as requested for specific changes.

Meeting invitees also include the NIHD Executive Team to attend as desired.

Convenes: Weekly

COMMITTEE GOALS

1. Ensure all changes requests are given the necessary due diligence in order to receive the desired outcomes.
2. Assess potential risk of any change requests making recommendations based upon risk management recommendations
3. Ensure all changes to NIHD systems have followed the change management policy and procedure.

Title: NIHD ITS Change Approval Board Charter	
Scope: District Wide	Manual:
Source: Director of Information Technology Services	Effective Date:

COMMITTEE RESPONSIBILITIES

- CAB members will review the requested changes prior to the regularly scheduled CAB meetings on the NIHD approved change tracking system and check for the following:
  - Dependencies
  - Impact to their business unit
  - Required resources to implement change
  - Risk
  - Contact any relevant SME's with questions and may request they attend the CAB meeting.
- Reviewing changes for environment stability and to minimize the impact of changes on the user community.
- Identify the need for user community notification and education prior to change implementation.
- Identification of impact to downstream systems prior to change implementation.
- CAB members should have an idea of their approval disposition by the time they enter the CAB meeting. This will ensure that the meeting runs smoothly and time is not wasted on assessing and clarifying documentation that should have been reviewed prior to the meeting.

Approval	**Date**
Data and Information Committee	
Executive Team	
Board of Directors	

Developed:
Reviewed:
Revised:

Responsibility for review and maintenance: Director of Information Technology Services
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Remote Access Policy	
Scope: District Wide	Department: Information Technology Services
Source: Director of Information Technology Services	Effective Date:

PURPOSE:

The purpose of this policy is to define standards for connecting to the Northern Inyo Healthcare District (NIHD) network from any area located outside of the NIHD's physical location(s).

DEFINITIONS:

NIHD Physical Location: 150 Pioneer Lane, Rural Health Clinic buildings, Pioneer Medical Building, Birch Street Building and any other affiliated district properties.

Access: the ability or capacity to read, write, modify, or transmit information, or otherwise make use of any system resource

Restricted Information: Describes any confidential or personal information that is protected by law or policy and that requires the highest level of access control and security protection, whether in storage or in transit. This includes PHI (Protected Health Information)/ePHI (electronic protected health information) and other Medical Staff and Allied Health Professionals (AHPs) communication as defined in this section.

Protected Health Information (PHI)*:* individually identifiable health information that is transmitted or maintained in any form or medium, including electronic PHI.

Electronic Protected Health Information* or *ePHI: Is PHI that is transmitted by electronic media or is maintained in electronic media. For example, ePHI includes all data that may be transmitted over the Internet, or stored on a computer, a CD, a disk, magnetic tape, jump drive, or other media.

***Remote Access*:** the ability to access the NIHD network systems from a remote location; this includes home office users, non-NIHD facilities/premises, and business associates's locations

Workforce: Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or who have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care, treatment and services to NIHD's patients/customers.

POLICY:

1. Remote access privilege is granted to NIHD credentialed physicians, NIHD contracted offsite workforce members, NIHD pharmacists that serve call, NIHD Board of Directors and NIHD Exempt workforce members based on their work role.

Title: Remote Access Policy	
Scope: District Wide	Department: Information Technology Services
Source: Director of Information Technology Services	Effective Date:

2. Any remote access requests for workforce members not classified above must be a written request to the IT Service Desk approved by the workforce member's Executive. Under no circumstances shall an NIHD employee work "off the clock" using a remote access without prior written approval of a member of NIHD's Executive Leadership.
3. The use of remote proxy software—such as PC Anywhere, GotoMyPC, LogMeIn—utilized to enable personal remote access to a local desktop from outside the NIHD network is not permitted on user devices without the express written permission of Information Technology Leadership
4. Remote access usage is subject to random and for cause audits for compliance with any NIHD policy
    a. Policy breach may result in corrective action (up to an including termination from employment) which can also include immediate revocation of remote access privileges. Under various laws applicable to NIHD, the user may also be subject themselves to legal action.
    b. Executive approval shall be required for the restoration of revoked privileges
5. Remote access privileges may include the ability to download or print documents or files that contain PHI or confidential business information. It is expected that users permitted this access shall manage documents and files in accordance with NIHD policies and practices for retention and destruction of confidential and/or PHI information. Remote access by users shall be audited for any suspicious system activity and/or security/device failures; cooperation of remote access users or sponsoring organization is required during an investigation in accordance with applicable laws and NIHD policies.
6. Remote access will automatically be inactivated if there has been no log in activity for 45 calendar days.
7. NIHD shall not provide support for non-NIHD-owned technology—such as hardware, software, Internet connectivity. NIHD will provide support for any problems with the operation and installation of the Web Interface.
8. Initial training and set up walk through will be done with remote users. Remote users may bring their mobile device to the ITS department for the technical staff to assist them in initial Web Interface set up.

REFERENCES:

1. HIPAA Administrative Security 164.308(a)(4)(ii)(B) – Access Authorization
2. NIST SP 800-53 Rev. 4 – Access Control
3. Fair Labor Standard Act

Approval	**Date**
Compliance Committee	
IT Council	
Executive Team	
Board of Directors	

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Remote Access Policy	
Scope: District Wide	Department: Information Technology Services
Source: Director of Information Technology Services	Effective Date:

Developed:
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
CODE OF BUSINESS ETHICS AND CONDUCT

Introduction

This code affirms the importance of high standards of business conduct at Northern Inyo Healthcare District. Adherence to this Code of Business Ethics and Conduct by all workforce members is the only sure way we can earn the confidence and support of the public.

This code has been prepared as a working guide and not as a technical legal document. Thus, emphasis is on being easy to read and understand, rather than on providing an all-inclusive answer to specific questions. For example, the term *employee* is used in its broadest sense and refers to every workforce member in the organization and its subsidiaries. The word *law* refers to laws, regulations, orders, and so forth. “Workforce” means persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD’s patients. In observance of this code, as in other business conduct, there is no substitute for common sense. Each employee should apply this code with common sense and the attitude of seeking full compliance with the letter and spirit of the rules presented.

It is your responsibility, as a member of the workforce of Northern Inyo Healthcare District, to perform satisfactorily and to follow our policies and comply with our rules as they are issued or modified from time to time.

These policies and rules are necessary to effectively manage the business and meet the ever-changing needs of the organization. Good performance and compliance with business rules lead to success. Both are crucial since our ability to provide you with career opportunities depend totally on our success in the marketplace. Nonetheless, changes in our economy, our markets, and our technology are inevitable. Indeed, career opportunities will vary between the individual companies. For these reasons, we cannot contract or even imply that your employment will continue for any particular period of time. You may terminate your employment at any time, with or without cause, and we reserve the same right. This relationship may not be modified, except in writing, signed by an appropriate representative of Northern Inyo Healthcare District.

This Code of Business Ethics and Conduct is a general guide to acceptable and appropriate behavior at Northern Inyo Healthcare District, and you are expected to comply with its contents; however, it does not contain all of the detailed information you will need during the course of your employment. Nothing contained in this code or in other communications creates or implies an employment contract or term of employment.

Additionally, we are committed to reviewing our policies continually. This code might be modified or revised from time to time.

You should familiarize yourself with this code so that you might readily identify any proposal or act that would constitute a violation. Each employee is responsible for his or her actions. Violations can result in disciplinary action, including dismissal and criminal prosecution. However, no reprisal will be

made against an employee who in good faith reports a violation or suspected violation.

The absence of a specific guideline practice or instruction covering a particular situation does not relieve an employee from exercising the highest ethical standards applicable to the circumstances.

If any employee has doubts regarding a questionable situation that might arise, he or she should immediately consult his or her immediate supervisor or member of the leadership team.

Competition and Antitrust

Fair Competition

Northern Inyo Healthcare District supports competition based on quality, service, and pride. We will conduct our affairs honestly, directly, and fairly. To comply with the antitrust laws and our policy of fair competition, employees:

- Must never discuss with competitors any matter directly involved in competition between ourselves and the competitor (e.g., sales price, marketing strategies, market shares, and sales policies)
- Must never agree with a competitor to restrict competition by fixing prices or allocating markets, or by other means
- Must not arbitrarily refuse to deal with or purchase goods and services from others simply because they are competitors in other respects
- Must not require others to buy from us before we will buy from them
- Must not require customers to take from us a service they don't want before permitting them to get one they do want
- Must never engage in industrial espionage or commercial bribery
- Must be accurate and truthful in all dealings with customers, and must be careful to accurately represent the quality, features, and availability of company products and services

Compliance with Laws and Regulatory Orders

The applicable laws and regulatory orders of every jurisdiction in which the District operates must be followed. Each employee is charged with the responsibility of acquiring sufficient knowledge of the laws and orders relating to his or her duties in order to recognize potential dangers and to know when to seek advice.

In particular, when dealing with public officials, employees must adhere to the highest ethical standards of business conduct. When we seek the resolution of regulatory or political issues affecting Northern Inyo Healthcare District's interests, we must do so solely on the basis of the merits and pursuant to proper procedures in dealing with such officials.
Employees may not offer, provide, or solicit, directly or indirectly, any special treatment or favor in return for anything of economic value or for the promise or expectation of future value or gain. In addition, there shall be no entertaining of employees in the U.S. government.

NORTHERN INYO HEALTHCARE DISTRICT
CODE OF BUSINESS ETHICS AND CONDUCT

Conflicts of Interest

Several situations could give rise to a conflict of interest. The most common are accepting gifts from suppliers, employment by another company, ownership of a significant part of another company or business, close or family relationships with outside suppliers, and communications with competitors. A potential conflict of interest exists for employees who make decisions in their jobs that would allow them to give preference or favor to a customer in exchange for anything of personal benefit to themselves or their friends and families. Such situations could interfere with an employee's ability to make judgments solely in Northern Inyo Healthcare District's best interest.

Gifts and Entertainment

Definition of Gifts

Gifts are items and services of value that are given to any outside parties, excluding the following:

- Normal business entertainment items such as meals and beverages
- Items of minimal value, given in connection with sales campaigns and promotions, employee services, or safety or retirement awards
- Items or services with a total nominal value as defined by Northern Inyo Healthcare District policy, "Acceptance of Tips, Gratuities, Rewards, Promotional Gifts or Incentives".

Definition of Supplier

Supplier includes not only vendors providing services and material to Northern Inyo Healthcare District, but also consultants, financial institutions, advisors, and any person or institution who does business with Northern Inyo Healthcare District.

Gifts

No employee or member of his immediate family shall solicit or accept from an actual or prospective customer or supplier any compensation, advance loans, (except from established financial institutions on the same basis as other customers), gifts, entertainment, or other favors that are of more than token value or that the employee would not normally be in a position to reciprocate under normal expense account procedures.

Under no circumstances may a gift or entertainment be accepted that would influence the employee's judgment. In particular, employees must avoid any interest in or benefit from any supplier that could reasonably cause them to favor that supplier over others. It is a violation of the code for an employee to solicit or encourage a supplier to give any item or service to the employee, regardless of its value. Our suppliers will retain their confidence in the objectivity and integrity of our company only if each employee strictly observes this guideline.

Reporting Gifts

Any employee who receives an unsolicited gift from an actual or prospective customer or supplier (items other than food or flowers) should report it to his or her supervisor. Unsolicited gifts shall be turned in to the Administrator's office for disposition.

Food and flowers received as departmental gifts must be shared amongst the Northern Inyo

Healthcare District staff. At no time shall an employee keep gifts of food or flowers for themselves.

Discounts
An employee might accept discounts on a personal purchase of the supplier's or customer's products only if such discounts do not affect Northern Inyo Healthcare District's purchase price and are generally offered to others having a similar business relationship with the supplier or customer.

Business Meetings
Entertainment and services offered by a supplier or customer might be accepted by an employee when they are associated with a business meeting and the supplier or customer provides them to others as a normal part of its business. Examples of such entertainment and services are transportation to and from the supplier's or customer's place of business, hospitality suites, lodging at the supplier's or customer's place of business, and business meals for business visitors. The services should generally be of the type normally used by Northern Inyo Healthcare District's employees and allowable under the applicable District expense account.

Outside Employment
Employees must not be employed outside of Northern Inyo Healthcare District in any business that competes with or provides services to Northern Inyo Healthcare District if it is:

1. In a manner that would affect their objectivity in carrying out their Northern Inyo Healthcare District responsibilities;
2. Where the outside employment would conflict with scheduled hours, including overtime, or the performance of Northern Inyo Healthcare District assignments.

Employees must not use Northern Inyo Healthcare District time, materials, information, or other assets in connection with outside employment.

Relationships with Suppliers and Customers
Business transactions must be entered into solely for the best interests of Northern Inyo Healthcare District. No employee can, directly or indirectly, benefit from his or her position as an employee or from any sale, purchase, or other activity of the District. Employees should avoid situations involving a conflict or the *appearance* of conflict between duty to the company and self-interest.

No employee who deals with individuals or organizations doing or seeking to do business with Northern Inyo Healthcare District, or who makes recommendations with respect to such dealings, should:

- Serve as an officer, director, employee, or consultant
- Own a substantial interest in any competitor of the company, or any organization doing or seeking to do business with Northern Inyo Healthcare District (*substantial interest* means an economic interest that might influence or reasonably be thought to influence judgment or action, but shall not include an investment representing less than one percent of a class of outstanding securities of a publicly held corporation.)

In addition, no employee who deals with individuals or organizations doing or seeking to do business

with Northern Inyo Healthcare District, or who makes recommendations with respect to such dealings, may:

1. Have any other direct or indirect personal interest in any business transactions with Northern Inyo Healthcare District (other than customary employee purchases of District products and services as consumers and transactions where the interest arises solely by reason of the employee relationship or that of a holder of securities).
2. Provide telecommunications or information service or equipment, either directly or as a reseller, in a manner that would place the objectivity or integrity of Northern Inyo Healthcare District in question.

Our policy is that employees will not do business on behalf of Northern Inyo Healthcare District with a close personal friend or relative; however, recognizing that these transactions may occur, such transactions must be reported on the Conflict of Interest Questionnaire.

Employment of Relatives or Family Members

A relative or family member is defined as including any one of the following: any person who is related by blood or marriage, or whose relationship with the Workforce is similar to that of persons who are related by blood or marriage, including a domestic partner, and any person residing in the Workforce's household.

> *Examples of relationships by blood or marriage may include, but are not limited to any of the following: Parent, child, husband, wife, grandparent, grandchild, brother, sister, uncle, aunt, nephew, niece, first cousin, step-parent, step-child, relationships by marriage, or domestic partner/cohabitating couple/significant other.*

For further details, please refer to the Northern Inyo Healthcare District policy "Employment of Relatives".

Relatives of employees will not be employed on a permanent or temporary basis by Northern Inyo Healthcare District in such a way that the relative directly reports to the employee or the employee exercises any direct influence with respect to the relative's hiring, discipline, benefits, placement, promotions, evaluations, or pay. If two relatives/family members report to the same leader, the Business Compliance Team shall review the roles of the individuals and their relationship and make appropriate recommendations.

Confidential Information and Privacy of Communications

Confidential Information

Confidential information includes all information, whether technical, business, financial, or otherwise, concerning Northern Inyo Healthcare District that is treated as confidential or secret or that is not available or is not made available publicly. It also includes any private information of or relating to patient medical records, employee records, other persons or other companies, and national security information that is obtained by virtue of the employee's position.

Northern Inyo Healthcare District policy and state and federal laws protect the integrity of the District's confidential information, which must not be divulged except in strict accordance with established

company policies and procedures. The obligation not to divulge confidential District information is in effect even though material might not be specifically identified as confidential; this obligation exists during and continues after employment with Northern Inyo Healthcare District.

A few examples of prohibited conduct are (1) selling or otherwise using, divulging, or transmitting confidential District information, (2) using confidential District information to knowingly convert a District business opportunity for personal use, (3) using confidential District information to acquire property that the employee knows is of interest to the District, (4) using, divulging, or transmitting confidential District information in the course of outside employment or other relationships or any succeeding employment or other relationship at any time.

Employees shall not seek out, accept, or use any confidential District information of or from a competitor of the District. In particular, should we hire an employee who previously worked for a competitor, we must neither accept nor solicit confidential information concerning that competitor from our employee.

District Assets

Cash and Bank Accounts

All cash and bank account transactions must be handled so as to avoid any question or suspicion of impropriety. All cash transactions must be recorded in the books of account.

All accounts of company funds shall be established and maintained in the name of the hospital or other appropriate District entity and may be opened or closed only by the authorized designees of the District's Board of Directors. All cash received shall be promptly recorded and deposited in a District bank account. No funds shall be maintained in the form of cash, except as authorized and there is to be no anonymous (numbered) account at any bank. Because payments into numbered bank accounts by the District may leave the District open to suspicion of participation in a possibly improper transaction, no disbursements of any nature may be made into numbered bank accounts or other accounts not clearly identified to the District as to their ownership.

No payments except in the case of District designated "Disaster", can be made in cash (currency) other than regular, approved cash payrolls, and normal disbursements from petty cash supported by signed receipts or other appropriate documentation. Further, corporate checks shall not be written to "cash", "bearer," or similar designations.

Northern Inyo Healthcare District Assets and Transactions

Compliance with prescribed accounting procedures is required at all times. Employees having control over District assets and transactions are expected to handle them with the strictest integrity and to ensure that all transactions are executed in accordance with management's authorization. All transactions shall be accurately and fairly recorded in reasonable detail in the District's accounting records.

Employees and volunteers are personally accountable for District funds over which they have control. Employees who spend District funds should ensure that the District receives good value in return and

must maintain accurate records of such expenditures. Employees who approve or certify the correctness of a bill or voucher should know that the purchase and amount are proper and correct. Obtaining or creating “false” invoices or other misleading documentation, or the invention or use of fictitious sales, purchases, services, loan entities, or other financial arrangements, is prohibited.

Expense Reimbursement

Expenses actually incurred by an employee in performing District business must be documented on expense reports in accordance with District procedures. In preparing expense reports, employees should review these procedures for the documentation that must be submitted in order to be reimbursed for business expenses.

Northern Inyo Healthcare District Credit Cards

Northern Inyo Healthcare District Board of Directors permits the use of district credit cards by certain District employees to pay for actual and necessary expenses incurred in the performance of work-related duties for the district and for District required purchases. District credit cards shall be under the control of the Chief Executive Officer of Northern Inyo Healthcare District. No personal expenses should be charged on District credit cards. District credit cards should not be used to avoid preparing documentation for direct payment to vendors. Where allowed by local law, charges on District credit cards for which a properly approved expense report has not been received at the time of an employee’s termination of employment might be deducted from the employee’s last paycheck. The District will pursue repayment by the employee of any amounts it has to pay on the employee’s behalf.

Telephones

The District discourages personal use of telephones except in the case of an emergency. It is important that the District telephone lines be kept available for District business. However, it is recognized that employees sometimes need to make personal local calls from work. All employees are asked to keep these calls to a minimum. Any personal long distance calls should be made by using a personal credit card or by reversing the charges.

Software and Computers

Computerized information and computer software may appear intangible, but they are valuable assets of the District and must be protected from misuse, theft, fraud, loss, and unauthorized use or disposal, just as any other District property.

Use of District computers must be customer service – or job-related. Employees cannot access District records of any kind for their personal use. Misappropriation of computer space, time, or software includes, but is not limited to, using a computer to create or run unauthorized jobs, operating a computer in an unauthorized mode, or intentionally causing any kind of operational failure.

District computers, email, internet access systems, hardware/software, passwords, messages and attachments which are composed, sent or received using the NIHD computer systems are all the property of the District. No communication on any of these devices or systems is private. All such devices or systems are subject to monitoring, access, review and/or disclosure. For additional information please see the NIHD “Internet/Email Usage” policy.

Other Assets

The property of the District is intended to be used in a way that benefits our patients and organization. Supplies and/or equipment belonging to the District will not be used by or loaned to any person, regardless of position, including District employees or Medical Staff for their personal use. Please refer to Northern Inyo Healthcare District policy "Company Property – Hospital Equipment and Supplies for Personal Use" for further details.

Employee Conduct

Conduct while on District Business

Violations of District policy or illegal activity on District premises or while on District business will not be condoned and can result in disciplinary action, including dismissal and criminal prosecution. The following illustrates activities that are against District policy, and that will not be tolerated on District premises, in company vehicles, or while engaged in District business:

1. Consumption and storage of alcoholic beverages, except where legally licensed or authorized by an officer of the District.
2. Use of tobacco/nicotine products (excluding smoking cessation products) of any sort on District premises including in personal vehicles, in company vehicles, or while on District business
3. The use of non-physician prescribed controlled substances, such as drugs or alcohol, as well as the unlawful manufacture, distribution, dispensation, possession, transfer, sale, purchase, or use of a controlled substance
4. Driving vehicles or operating District equipment while under the influence of alcohol or controlled substances
5. Illegal betting or gambling
6. Carrying weapons of any sort on District premises, in District vehicles, or while on District business, regardless of whether an employee possesses the legally required permits or licenses *with the exception of District employed security officers,* unless specifically and expressly authorized by the Chief Executive Officer*.*

The District reserves the right to inspect any property that might be used by employees for the storage of their personal effects. This includes desks, lockers, and vehicles owned by the District. It is a violation of District policy to store any contraband, illegal drugs, toxic materials, or weapons, on District property.

Reporting Violations

All employees are responsible for compliance with these rules, standards and principles. In the area of ethics, legality, and propriety, each employee has an obligation to the District that transcends normal reporting relationships. Employees should be alert to possible violations of the code anywhere in the District and are encouraged to report such violations promptly. Reports should be made to the employee's manager, Compliance Officer, or Human Resources as the circumstances dictate. Employees will also be expected to cooperate in an investigation of violations. In addition, any employee, who has been convicted of a felony, whether related to these rules or not, should also report that fact.

All cases of questionable activity involving the code or other potentially improper actions will be

reviewed for appropriate actions, discipline, or corrective steps. Whenever possible, the company will keep confidential the identity of employees about or against whom allegations of violations are brought, unless or until it has been determined that a violation has occurred. Similarly, whenever possible, the company will keep confidential the identity of anyone reporting a possible violation. Any hospital employees (including Management), who report a violation or suspected violation shall be protected from any and all retaliation or retribution by any hospital employee (including Management). Such protection shall include immediate disciplinary action or sanction of the perpetrator of retaliation or retribution in addition to any remedies available under the law.

All employees are required to notify the District within 5 days of any conviction of any criminal statute violation occurring on the job. In addition, any employee who has been convicted of a felony, whether related to these rules or not, should report that fact.

Discipline

Violation of this code can result in serious consequences for the District and its image, its credibility, and the confidence of its customers, and can include substantial fines and restrictions on future operations as well as the possibility of fines and prison sentences for individual employees. Therefore, it is necessary that the District ensure that no violations occur. Employees should recognize that it is in their best interest – as well as the Districts – to follow this code carefully.

The amount of any money involved in a violation may be immaterial in assessing the seriousness of a violation since in some cases, heavy penalties may be assessed against the District for a violation involving a relatively small amount of money, or no money.

The District shall determine the course of action best suited to the circumstances and may employ progressive discipline procedures as outlined in our District policy. The overall seriousness of the matter will be considered in setting the disciplinary action to be taken against an individual employee. Such action, which might be reviewed with the appropriate human resources organization, might include:

- Verbal Counseling
- Written Counseling
- Probation
- Termination

In addition, individual cases might involve:

- Reimbursement of losses or damages
- Referral for criminal prosecution or civil action
- Both of the above

Disciplinary action might also be taken against managers or executives who condone, permit, or have knowledge of illegal or unethical conduct by those reporting to them and who do not take corrective action. Disciplinary action might also be taken against employees who make false statements in connection with investigations of violations of this code.

NORTHERN INYO HEALTHCARE DISTRICT
CODE OF BUSINESS ETHICS AND CONDUCT

The District's rules and regulations regarding proper employee conduct will not be waived in any respect. Violation is cause for disciplinary action, including dismissal. All employees will be held to the standards of conduct described in this booklet.

The District never has authorized, and never will authorize, any employee to commit an act that violates this code, or to direct a subordinate to do so. Thus no such act is justifiable as having been directed by someone in higher management.

Compliance Letter and Conflict of Interest Questionnaire

All Northern Inyo Healthcare District workforce members will review the Code of Business Ethics and Conduct, sign the Code's Acknowledgement form. Annually, all workforce members shall complete and sign the Conflict of Interest Questionnaire. If the employee's circumstances change at any time, a new Conflict of Interest Questionnaire or letter of explanation must be requested and completed.

Potential conflicts of interest shall be reviewed by the NIHD Business Compliance Team on an individual basis and appropriate action shall be taken.

The Code of Business Ethics and Conduct Acknowledgement form (on the following page) should be signed and given to Human Resources for inclusion in your personnel file.

NORTHERN INYO HEALTHCARE DISTRICT
CODE OF BUSINESS ETHICS AND CONDUCT

Code of Business Ethics and Conduct Acknowledgement Form

I have received and read the Code of Business Ethics and Conduct, and I understand its contents. I agree to comply fully with the standards, policies and procedures contained in the Code and Northern Inyo Healthcare District's related policies and procedures. I understand that I have an obligation to report to my manager, Compliance Officer, Chief Performance Excellence Officer or Human Resources any suspected violations of the Code that I am aware of. I acknowledge that the Code is a statement of policies for ethical business conduct and does not, in any way, constitute an employment contract or an assurance of continued employment.

_____

Printed Name

_____

Signature

_____

Date

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Family Member and Relatives In The Workplace*	
Scope: NIHD	Manual: Compliance
Source: Compliance Officer	Effective Date: 3/1/2018

PURPOSE:
Northern Inyo Healthcare District (NIHD) is a family-friendly workplace committed to maintaining an environment where members of the community can work together to provide great patient care and service to the community. The purpose of this policy is to provide guidelines for family members working at NIHD and relationships in the workplace.

DEFINITIONS:
"Relative" or "Family Member" means any person who is related by blood or marriage, or whose relationship with the Workforce is similar to that of persons who are related by blood or marriage, including a domestic partner, and any person residing in the Workforce's household.

Examples of relationships by blood or marriage may include, but are not limited to any of the following: Parent, child, husband, wife, grandparent, grandchild, brother, sister, uncle, aunt, nephew, niece, first cousin, step-parent, step-child, relationships by marriage, or domestic partner/cohabitating couple/significant other.

"Workforce" means persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Advanced Practice Professionals (APPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

POLICY:
It is the policy of the Northern Inyo Healthcare District to seek the best possible candidates for its staff through appropriate search procedures. There shall be no restrictions to the appointment of individuals who have close relatives in any staff category in the same or different departments so long as the following standard is met:

1. Relatives of employees will not be employed on a permanent or temporary basis by Northern Inyo Healthcare District in such a way that the relative directly reports to the employee or the employee exercises any direct influence with respect to the relative's hiring, discipline, benefits, placement, promotions, evaluations, or pay.
2. If two relatives/family members report to the same leader, the Business Compliance Team shall review the roles of the individuals and their relationship and make appropriate recommendations.

PROCEDURE:

1. When an individual is considered for appointment in a department in which a relative or family member is already assigned, the Conflict of Interest Questionnaire will be reviewed by the Business Compliance Team. The objective of this review shall be to assure equity to all members of the department.
2. When an individual is considered for appointment in a department in which a relative or family member has supervisory responsibility, the appointment shall not be granted.

RESPONSIBILITIES:

- All employees are required to follow this policy.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Family Member and Relatives In The Workplace*	
Scope: NIHD	Manual: Compliance
Source: Compliance Officer	Effective Date: 3/1/2018

- All employees are required to disclose relative/family member relationships in the workplace on the NIHD "Conflict of Interest" Questionnaire at the time of occurrence and annually thereafter.

REFERENCES:

1. NIHD "Code of Business Ethics and Conduct"
2. Political Reform Act of 1974

Approval	**Date**
Compliance Committee	
Administration	
Board of Directors	
Last Board of Directors Review	

Developed:
Revised: 02/06/2018
Reviewed: 9/1/2017
Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT
COMPLIANCE DEPARTMENT
POLICY AND PROCEDURE

Title: **Auditing of Workforce Access to Confidential Information**	
Scope: **District Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date: March 1, 2018

PURPOSE: Establishes requirements for auditing access to confidential information including protected health information in accordance with Northern Inyo Healthcare District (NIHD) policy and state and federal regulations.

Definitions:

Workforce: Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

Confidential Information - protected health information and information related to patients, workforce, providers, financial data, trade secrets, business proprietary information, information protected by law and any other information pertaining to NIHD unless specifically designated as not confidential.

Covered Entity – (for the purpose of this policy) a healthcare provider, a healthplan, or a healthcare clearinghouse who transmits any health information in electronic form.

Minimum Necessary - covered entity must make reasonable efforts to limit the use, disclosure, and/or request for protected health information, and other confidential information to the minimum necessary (lowest amount) to accomplish the intended purpose of the use, disclosure, or request.

Need-to-Know - access to only the data he or she needs to perform a particular function (role based access).

Protected Health Information (PHI) - individually identifiable health information that is transmitted or maintained in any form or medium, including electronic PHI.

Electronic Protected Health Information or ePHI*:* Is PHI that is transmitted by electronic media or is maintained in electronic media. For example, ePHI includes all data that may be transmitted over the Internet, or stored on a computer, a CD, a disk, magnetic tape, jump drive (USB) or other media.

Breach - the unauthorized acquisition, access, use or disclosure of PHI and/or confidential information which compromises the security or privacy of the PHI or other confidential information.

NORTHERN INYO HEALTHCARE DISTRICT
COMPLIANCE DEPARTMENT
POLICY AND PROCEDURE

Title: **Auditing of Workforce Access to Confidential Information**	
Scope: **District Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date: March 1, 2018

POLICY:
Access to information systems is granted on a need-to-know basis and is based on one's role with NIHD.

Audits will be performed which evaluate whether information accessed was based on "minimum necessary" and "need-to-know" principles and standards and appropriate corrective action is taken as applicable.

AUDIT TYPES:

1. **Routine Audits** – Routine audits can include but are not limited to:

Audit	Description
Same Last Name	Workforce who access the record of a patient with the same last name
Same Department	Workforce who access the record of a co-worker who works in the same department
Workforce Hospital Admission	When a Northern Inyo Healthcare District employee is admitted to the hospital as a patient
Confidential Document	Workforce who access "confidential" documents
New Workforce Member	All access made by new workforce members are audited prior to the end of their 90 day introductory period
High Profile Individual	The patient is a newsworthy individual

2. **Audits for Specific Cause –** A request to audit for cause may come from various sources including but not limited to:
    a. Administration
    b. Human Resources
    c. Department Director/Manager
    d. Board of Directors
    e. Quality Assurance/Performance Improvement (QAPI) professionals
    f. Security Officer
    g. Patient or representative
    h. Community member

Audits for specific cause are conducted in all systems applicable to services provided at NIHD.

Title: **Auditing of Workforce Access to Confidential Information**	
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Causes or reasons for specific audits include but are not limited to:

Audit	Description
Internal Concern	Concern is expressed by a co-worker, Administration, Department Manager, Security Officer or other user
Patient Complaint	Patients request an audit of access to their medical record
Employee Family Member Admission	When an workforce member's family member is admitted as a patient
Restricted Information Patients	Users who access a patient's record who requests restricted access
Follow-Up	Workforce who have been subject to corrective action(s) for accessing records inappropriately
Disciplined Workforce	Workforce who have been disciplined for accessing records inappropriately

3. **Random Audits –** Random audits may be performed on clinical systems and may be done to determine clean-up of inactive users.

Audits Investigated and Evaluated

1. The Compliance Department will review the audit results for potential breaches of patient privacy based and confidential information on "minimum necessary" and "need-to-know" principles. When questionable access is discovered on the audit report:

    a. A member of the Compliance Department will meet with the workforce member requesting information and an explanation for accessing the patient or other information. For workforce members covered by a Memorandum of Understanding (MOU), any meeting will conform to the MOU's process. If further information is required based on the information received, meetings with additional workforce may occur. Follow up with any findings will be done with relevant workforce member(s).

    b. If the audit findings reveal, as determined by the Compliance/Privacy Officer, activity that appears to constitute a breach of confidentiality, audit and investigation results for disciplinary determination will be reported to, at a minimum, the following:

i. Human Resources and/or the workforce members' department manager/supervisor.
ii. State and/or Federal agencies, in accordance with current law.
iii. For each breach, the department manager/supervisor shall follow up with appropriate corrective action(s) as applicable to each finding and report such actions taken to the Compliance Department.
iv. Department manager/supervisor shall submit copies of all documents for workforce corrective action(s) to the Compliance Department and the Human Resources department.

Audit Record Disposition and Retention

1. Audit reports are confidential documents. Copies of audit reports will be shared internally with Administration and management as necessary, and disclosed as required by law or for other business operations.

2. Audit for specific cause outcomes may be communicated to the requestor via mail or telephone, as determined by the Compliance/Privacy Officer.

3. Audit results will be retained according to state and federal regulations.

Availability and Retention of Documents

1. Audit documents will be made available to appropriate workforce members, as needed for review, discussion, and appropriate corrective action per NIHD policy and any applicable MOU.
2. Audit documents will be made available to state and federal investigators upon request.
3. Audit documentation shall be maintained for no less than three (3) years.
4. Policy documents will be retained for no less than six (6) years from either the creation date or the last effective date, whichever is longer.

REFERENCES:

1. 45 CFR Part 164.308(a)(8) – Administrative Safeguards
2. 45 CFR Part 164.312 (a)(1) – Technical Safeguards
3. 45 CFR Part 164.308(a)(1)(ii)(D) – Administrative Safeguards
4. 45 CFR Part 164.312(b)– Administrative Safeguards
5. 45 CFR Part 164.316 – Policies and procedures and documentation requirements

NORTHERN INYO HEALTHCARE DISTRICT
COMPLIANCE DEPARTMENT
POLICY AND PROCEDURE

Title: **Auditing of Workforce Access to Confidential Information**	
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6. TJC Standard IM.01.01.01
7. TJC Standard IM.02.01.01
8. TJC Standard IM.02.01.03
9. TJC Standard PI.03.01.01

Committee Approval	**Date**
Compliance Committee	1/31/2018
Administration	
Board of Directors	

Developed: 12/10/2013 KH
Revised: 9/1/2017, 1/31/2018PD
Reviewed: 12/16/15
Supersedes:

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

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811
www.nih.org

Compliance Report
February 2018

1. Comprehensive Compliance Program review
    a. As of February 7, 2018, >70% of the District's employee workforce have reviewed the Compliance Program.
    b. The Compliance Department will begin following up individually with employee workforce members who have not read the assigned Compliance Program, since it is mandatory.
    c. We will roll the Compliance Program out to non-employee workforce members this year, too.
2. Breaches
    a. Calendar Year (CY) 2017 – (attachment A)
        i. 60 alleged breaches of PHI (Personal Health Information) potentially affecting 108 patients have been investigated by the Compliance Office
        ii. 27 of the alleged breaches of PHI have been reported to California Department of Public Health (CDPH) and the Office of Civil Rights (OCR)
            1. 8 have had deficiencies assigned. When a deficiency is assigned, civil monetary penalties may be assessed.
            2. 5 cases are still pending CDPH investigation.
    b. Calendar Year (CY) 2018 – (attachment B)
        i. 13 alleged breaches of PHI potentially affecting 13 patients have been investigated by the Compliance Office since January 1, 2018
        ii. 9 of the alleged breaches of PHI have been reported to California Department of Public Health (CDPH) and the Office of Civil Rights (OCR)
            1. 9 cases are still pending CDPH investigation.
    c. Summary of Breaches reported annually (attachment C)
3. Issues and Inquiries
    a. CY 2017 – More than 330 requests for research and input on a wide variety of topics have been made to the Compliance Department
4. Audits
    a. Employee Access Audits (attachment D) - The Compliance Office manually completes audits for access of patient information systems to ensure that employees

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
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access records only on a work-related, "need to know," and "minimum necessary" basis.

i. The HIPAA and HITECH Acts imply that organizations must perform due diligence by actively auditing and monitoring for appropriate use of PHI. These audits are also required by the Joint Commission and are a component of the "Meaningful Use" requirements.
ii. Access audits monitor who is accessing records by audit trails created in the systems. These audits allow us to detect unusual or unauthorized access of patient medical records.
iii. Compliance performs between 300-500 audits monthly.
    1. Each audit ranges from hundreds of lines of data to hundreds of thousands of lines of data.
iv. In negotiations with Protenus to provide auditing software services to NIHD beginning when we go live with Athena and partners.

b. Excluded Individuals and Entities audit – CY 2017
    i. Complete review of entire vendor master (4300 entries) in Paragon
    ii. Complete review of entire caregiver master (3000 entries) in Paragon
    iii. Accounting verifies all new vendors are not on an exclusions list.
    iv. Compliance verifies every non-staff provider added is not on an exclusions list.
    v. Medical Staff Office verifies every staff provider is not on an exclusions list.
c. Business Associates Agreements audit
    i. Contracts are currently under review to ensure all vendors, individuals, and entities providing services that access, disclose, retain, or transmit PHI for NIHD have an up-to-date Business Associates Agreement.
    ii. We currently have around 100 Business Associates Agreements.

5. Conflicts of Interest questionnaires – (attachment E)
    a. Compliance has processed more than 400 Conflict of interest disclosure forms since January 1, 2018.
    b. The Management Plan form is being re-designed by HR/Compliance to simplify the process for our leadership team. (The reason we are at 71% of requested plans.)
    c. We are sending the Conflict of Interest Disclosure form to non-employee workforce this year. We have received them back from 19 non-employee workforce as of Feb

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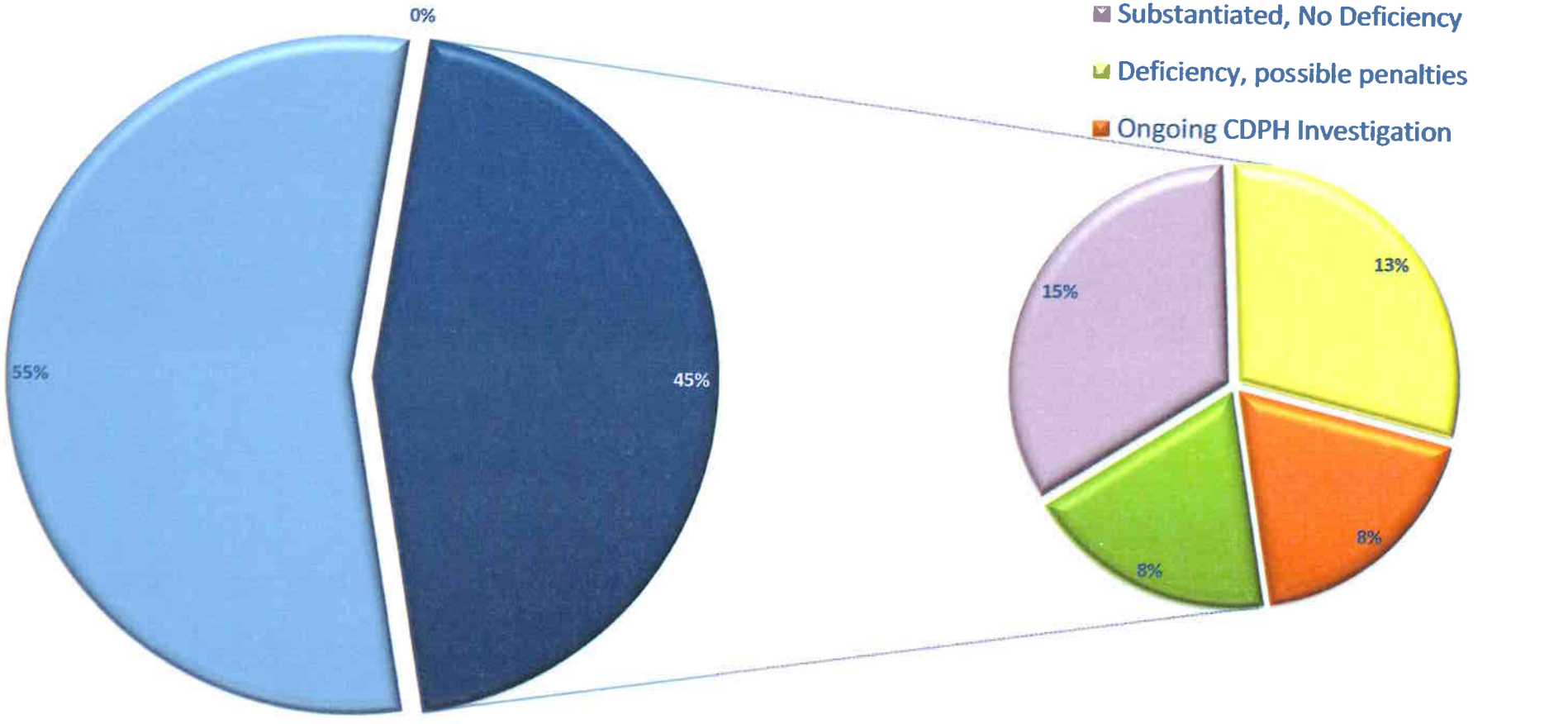
7, 2018. (Non-employee workforce members are typically physicians, members of the Board of Directors, student interns, etc.)

6. CPRA Requests
    a. The Compliance office has prepared documents for 5 CPRA requests in CY 2017.
    b. This is a significant reduction in public records requests from the past several years.

A

2017 Breach Outcomes

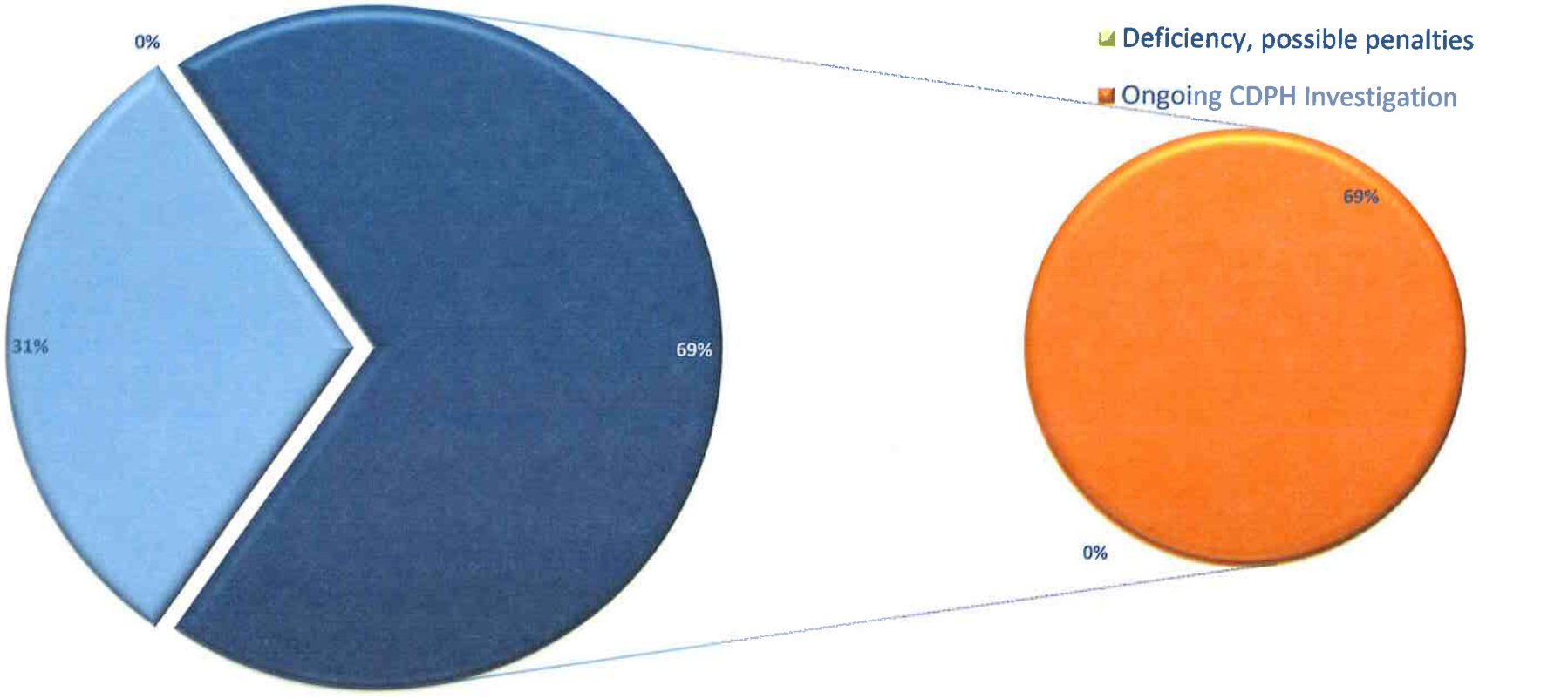
60 Breach investigations potentially affecting 108 patients



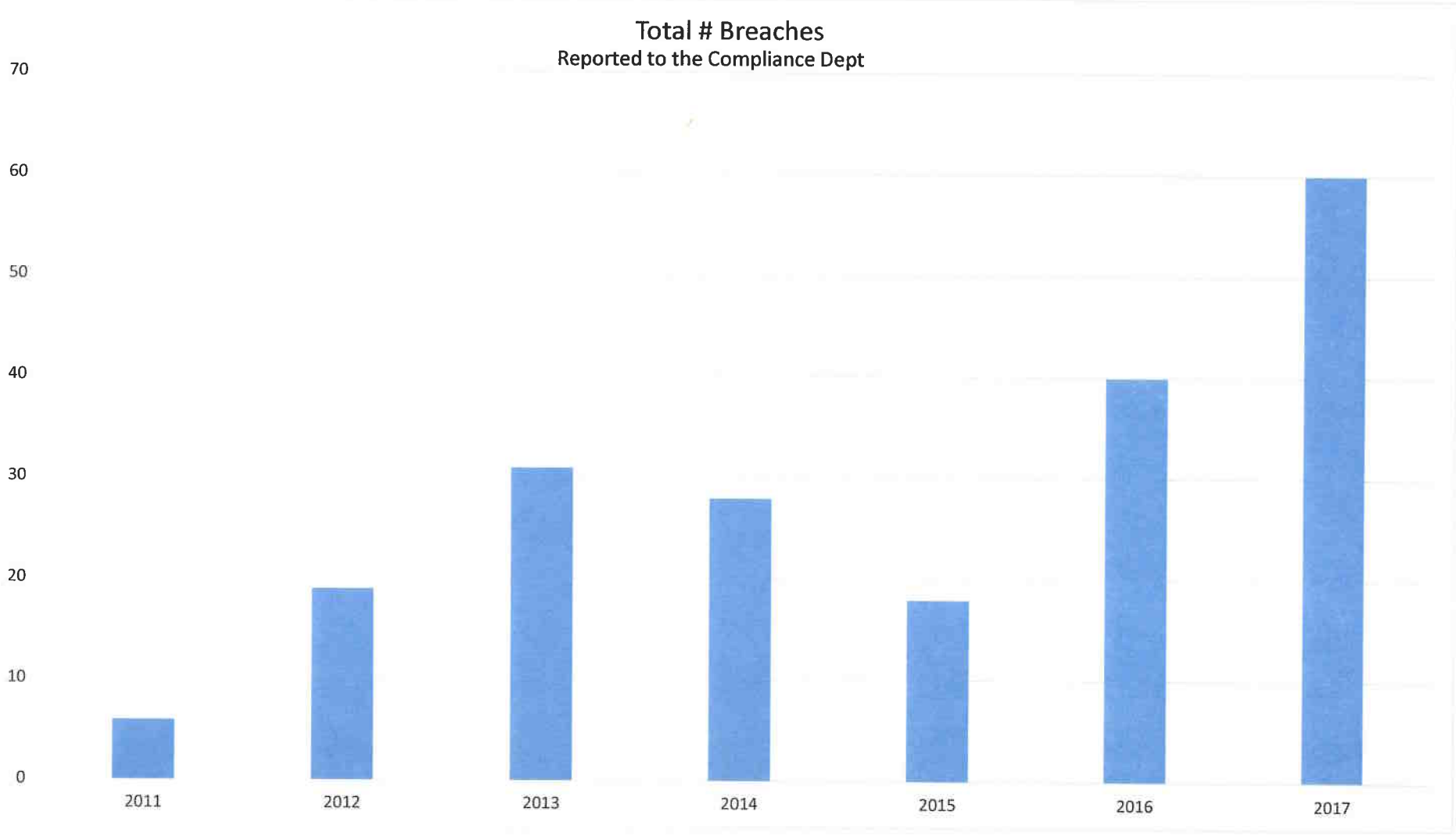
February 1, 2018

2018 Breach Outcomes

13 Breach investigations potentially affecting 13 patients

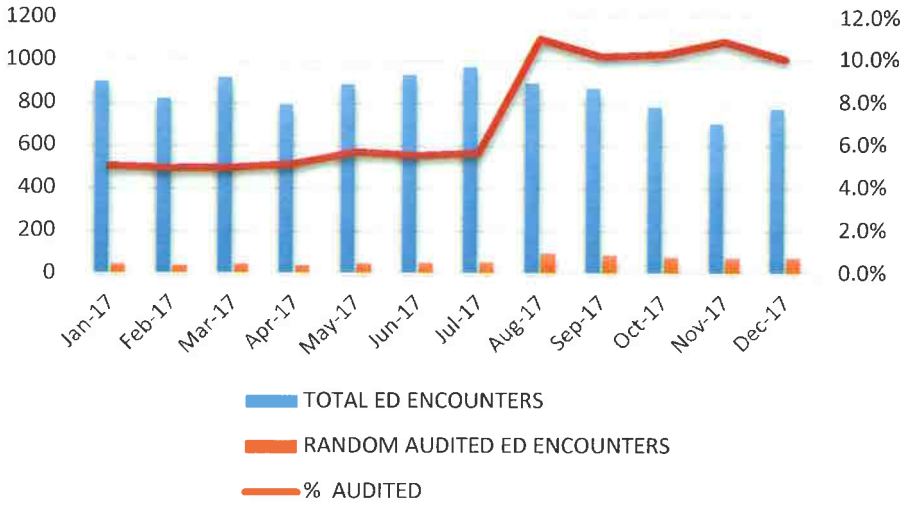


February 1, 2018

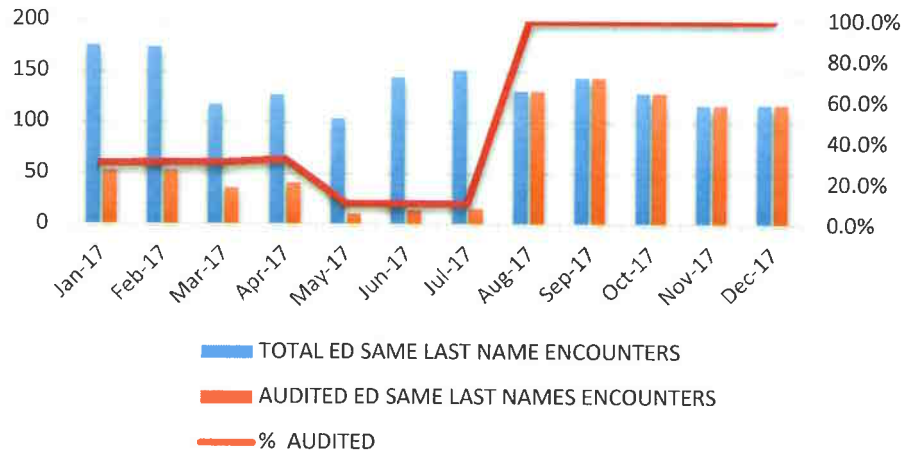

Total # Breaches
Reported to the Compliance Dept
70
60
50
40
30
20
10
0
2011
2012
2013
2014
2015
2016
2017

Emergency Room Encounters

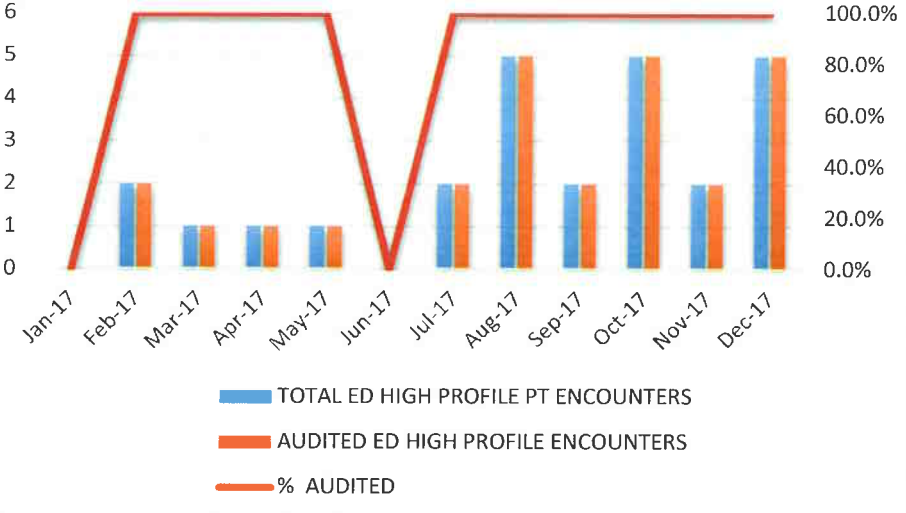
Random ED Encounter Audits



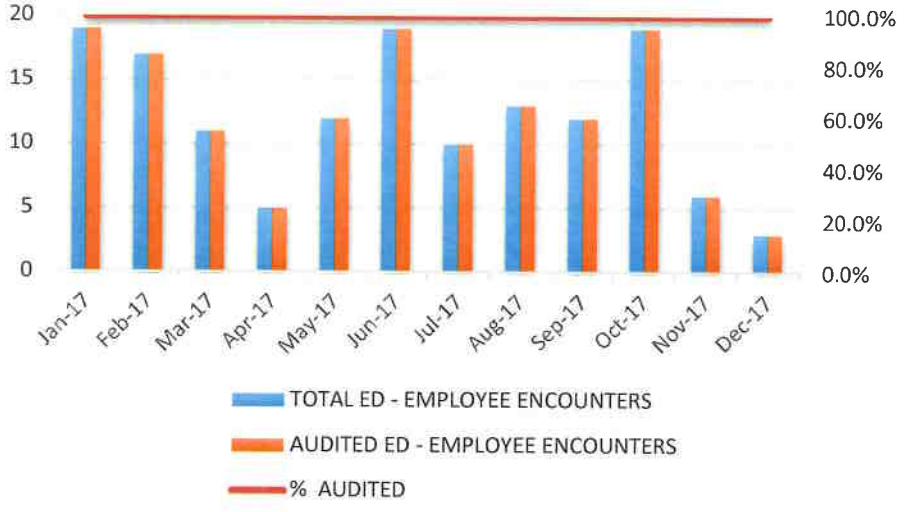
ED Patient with the same last name as an employee



HPP ED Encounters



Employee ED Encounters

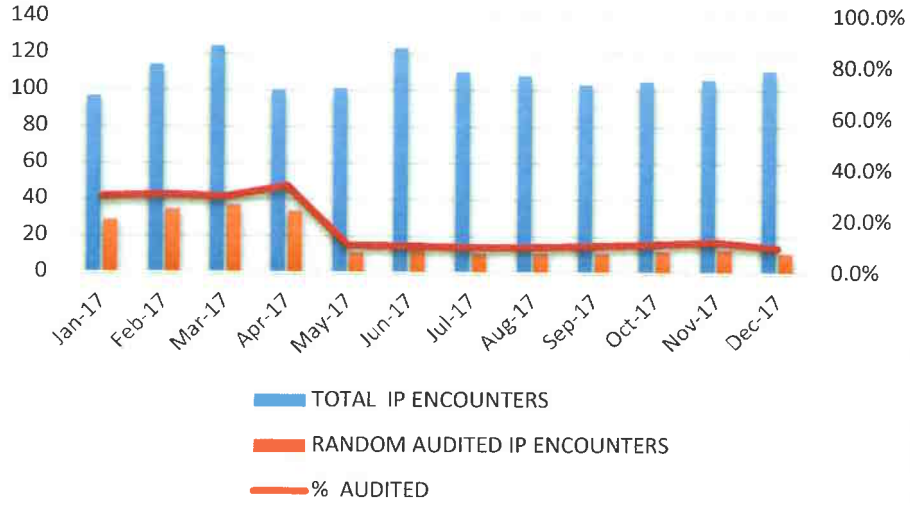


D2

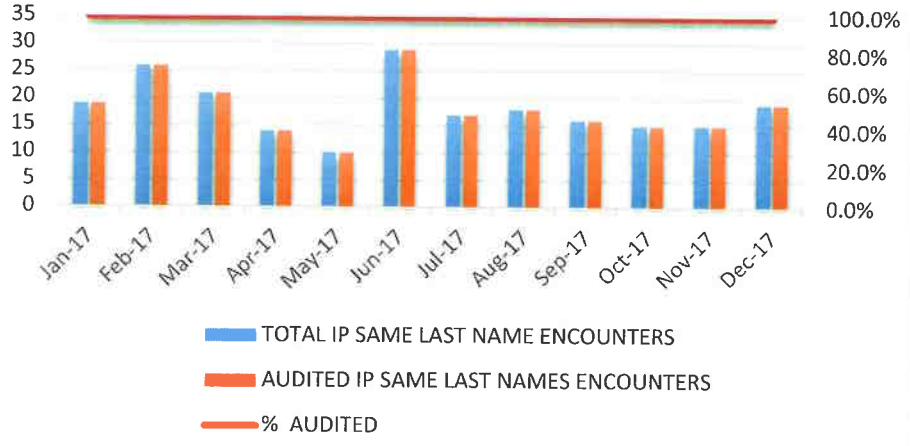
Employee EHR Access Audits

Inpatient Encounters

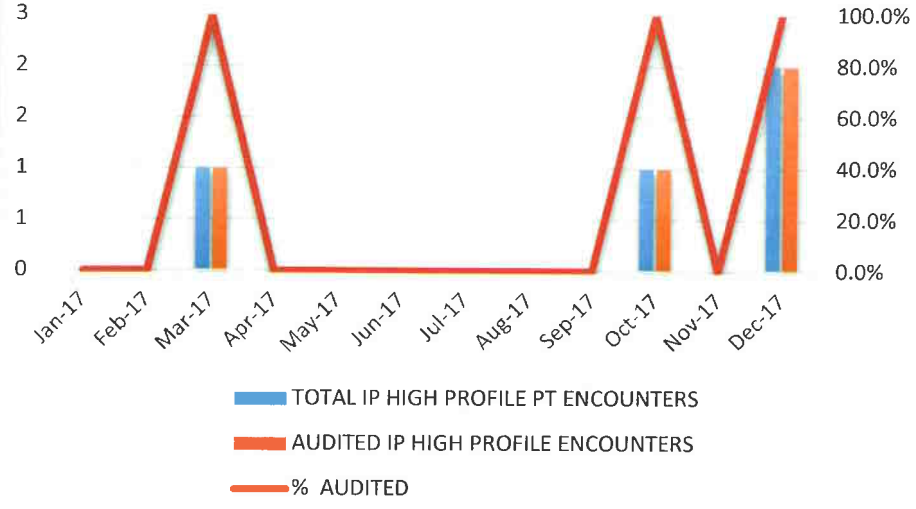
Random IP encounter Audits



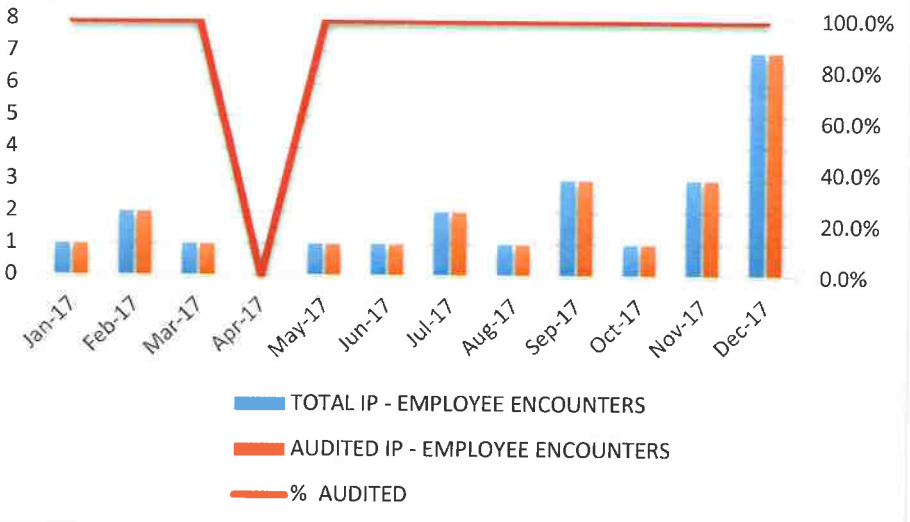
Inpatient with the same last name as an employee



HPP IP Encounters

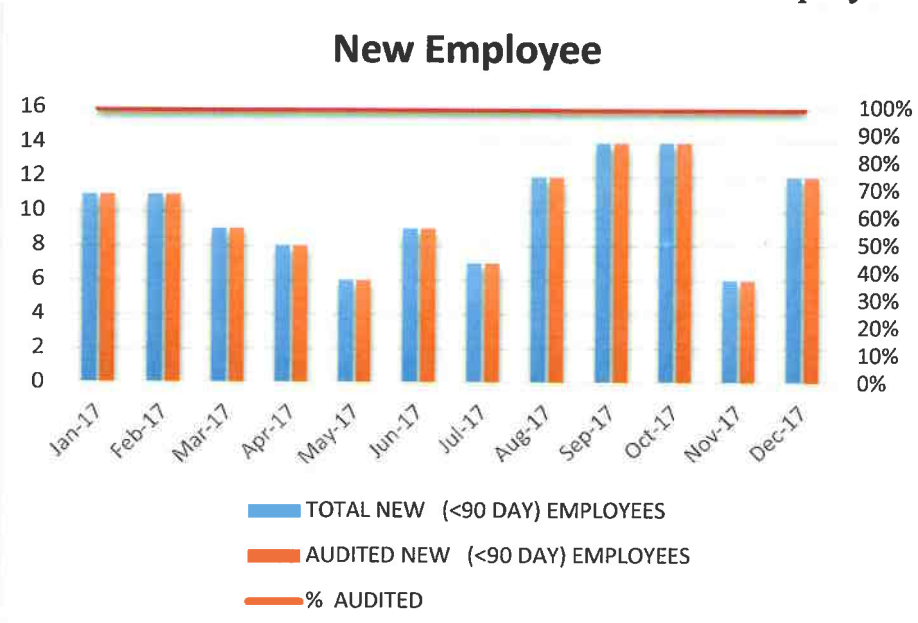


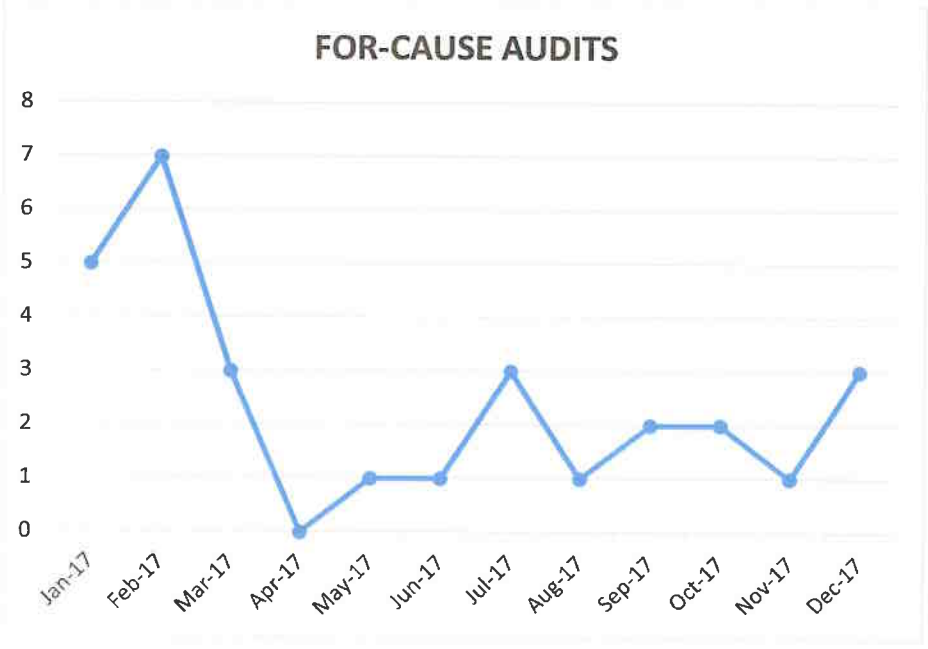
Employee IP Encounters



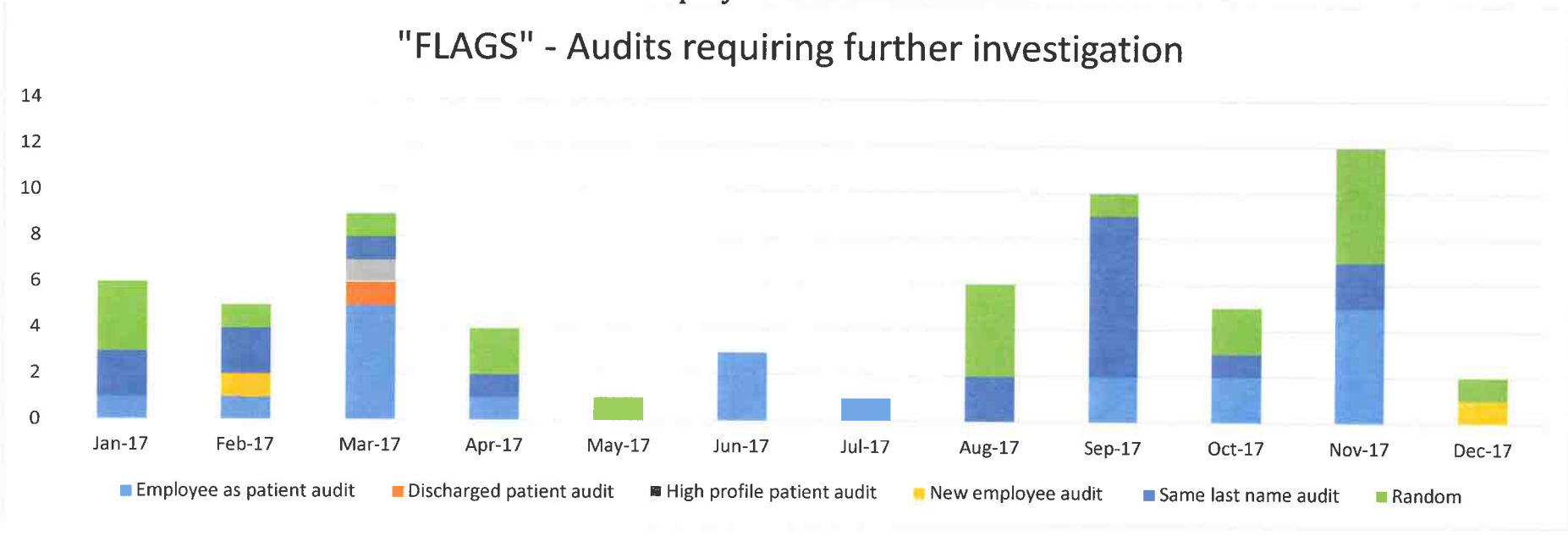
D3

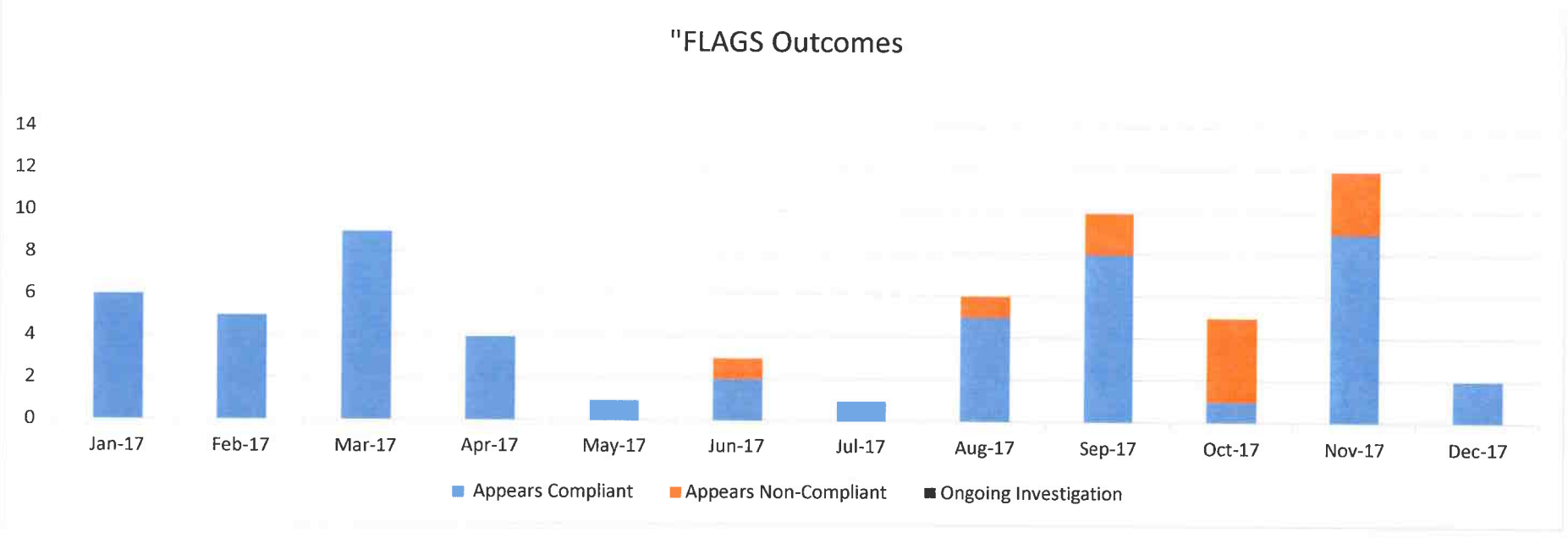
Employee EHR Access Audits





Employee EHR Access Audits





E

Compliance Report - Conflicts of Interest		Target = 100%
		CY 2018
Number of employees/student members of workforce	462	
Conflicts of Interest Forms Received	390	84.4%
Conflicts of Interest Forms Reviewed	390	100.0%
COI with no conflicts	236	
COI with Category A conflict	98	
COI with Category B conflict	56	
COI with Category C conflict	0	
Non-Disclosure Agreements/ Management Plans requested	14	
Non-Disclosure Agreements/ Management Plans received	10	71.4%

Definitions

Category A conflict:	Not significant and generally permissible activities.
Category B conflict:	Potential or perceived conflict of interest. Activities may be permitted after Non-Disclosure Agreement and or Management Plan
Category C conflict:	Actual conflict of interest. Activities which represent actual conflicts of interest which may be permitted to go forward only with appropriate management plan to eliminate the conflict, safeguard against prejudice toward NIHD activities, and provide continuing oversight.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Scope of Service Perinatal	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date:

I. Department Description:

The Perinatal department is a 6-bed unit on the second floor of the hospital. There are 3 locked entrances with badge swipe accessibility by approved staff. The primary entrance has a video intercom system with door lock release available at the nurse's station.
The department has a triage room with 2 gurneys, 4 Labor, Delivery, Recovery, Postpartum (LDRP) rooms, one postpartum room, and a fully equipped general nursery. An outpatient clinic (NEST) is located within the unit.

ADC: We currently deliver an average of 17 patients per month and have approximately 130 outpatient visits per month

II. Scope:

The Perinatal unit provides nursing care for obstetric patients meeting the specialized medical care needs of antepartum, intrapartum and post partum patients, as well as care of normal neonates.
NIH does not electively care for high risk obstetrical patients and we do not electively perform Vaginal Birth After VBAC deliveries. We have a general nursery caring for level 1 type neonates.
We do offer induction of labor after 39 weeks or for medical necessity, caesarian deliveries in the Operating Room, antepartum testing and outpatient newborn follow-up and support.

III. Staffing:

Medical care is provided by OB/GYN MDs, Pediatricians, credentialed Certified Nurse Midwife (CNMWs), or credentialed Family Practice MDs for specified aspects of perinatal care.

Nursing staff include a Nurse Manager, an Assistant Nurse Manager, RNs, and LVN/Clerks.

Patient care is delivered in nurse patient ratios that are determined by patient acuity and in compliance with the state nursing staffing ratios. The core minimum staffing is 2 Labor & Delivery nurses in house for night shift and day shift.

IV. Customers

Perinatal Unit management is a joint function of the Medical Staff and Nursing Department and requires close cooperation with: Respiratory Therapy, Lab, Pharmacy, Dietary, Radiology, other nursing departments and Case Management departments.

V. Ages Serviced:

The Perinatal Unit provides care across the life span
Neonate: Birth to 27 days
Adult: 13 to 65 years

VI. QA/PI:

The Perinatal nurse manager integrates all nursing performance improvement functions on the unit, tracks identified problems, assist the nursing unit in the development and evaluation of effective performance improvement reviews, ensures appropriate follow up occurs, and prepares Pillars of Excellence nursing performance improvement programs for the Nurse Executive

Title: Scope of Service Perinatal	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date:

Council (NEC). The Pillars will be documented in the minutes of the unit staff meetings and will be reported to the QA/PI committee and NEC.

VII. Budgeted Staff:

Refer to Master staffing plan

Committee Approval	Date
NEC	12/6/17
Board	

Developed: 7/2014
Reviewed:
Revised: 12/5/2017
Supersedes:
Index Listings:

Orientation Competency Committee (OCC)

Reports to: CNO

Led by: District Education Coordinator

Membership: ED RN CSE, ICU RN CSE, MS RN CSE, Surgery RN CSE, PACU/Infusion RN CSE, Perinatal RN CSE, Manager of Quality/Informatics and Infection Preventionist

Convenes: Monthly

Purpose:

1. To establish an oversight nursing committee that focuses on verifying and validating the skills and abilities of staff to ensure that staff meet the job description competency performance stamdards
    - Before orientation (initial competency assessment)
    - During orientation (verification and validation)
    - Every year after orientation (annual on-going competency assessment)
2. Oversee Nursing Competency Based Job Descriptions including job specific department based Skills Checklist
3. Oversee Generic Nursing Orientation Agenda
4. Oversee the on-going annual job specific department based competency check-off plan based on:
    - The department educational needs
    - Employee needs
    - New technology
    - High/low volume, problem prone, high risk, high cost activities
5. To review Nursing's Compliance with TJC Education Standards
6. To evaluate preceptor standards, education and competency
7. To provide support and feedback to the AHA Training Center

Dev: 8/2013
Reviewed:
Revised: 10/2017ta
Last Board of Director review: 3/15/17

NORTHERN INYO HEALTHCARE DISTRICT
PRELIMINARY STATEMENT OF OPERATIONS
for period ending November 30, 2017

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	891,451	778,471	112,980	4,544,635	3,970,211	574,424
Ancillary	2,593,775	2,700,381	(106,606)	14,035,119	13,771,932	263,187
Total Inpatient Service Revenue	3,485,226	3,478,852	6,374	18,579,754	17,742,143	837,611
Outpatient Service	8,041,589	7,857,438	184,151	42,368,504	40,072,962	2,295,542
Gross Patient Service Revenue	**11,526,815**	**11,336,290**	**190,525**	**60,948,258**	**57,815,105**	**3,133,153**
Less Deductions from Revenue						
Patient Service Revenue Deductions	465,953	227,153	238,800	1,035,866	1,158,475	(122,609)
Contractual Adjustments	4,178,395	4,348,068	(169,673)	24,593,853	22,175,148	2,418,705
Prior Period Adjustments	(198,741)	(12,967)	(185,774)	(899,809)	(66,134)	(833,675)
Total Deductions from Patient Service Revenue	**4,445,606**	**4,562,254**	**(116,648)**	**24,729,910**	**23,267,489**	**1,462,421**
Net Patient Service Revenue	**7,081,208**	**6,774,036**	**307,172**	**36,218,348**	**34,547,616**	**1,670,732**
Other revenue	40,943	74,342	(33,399)	246,107	379,141	(133,034)
Total Other Revenue	**40,943**	**74,342**	**(33,399)**	**246,107**	**379,141**	**(133,034)**
Expenses:						
Salaries and Wages	1,995,928	2,253,618	(257,690)	10,601,236	11,493,453	(892,217)
Employee Benefits	1,592,286	1,538,619	53,667	7,676,626	7,846,962	(170,336)
Professional Fees	957,263	701,142	256,121	5,082,300	3,575,811	1,506,489
Supplies	728,813	627,567	101,246	3,638,997	3,200,598	438,399
Purchased Services	283,908	348,470	(64,562)	1,417,632	1,777,198	(359,566)
Depreciation	409,460	428,731	(19,271)	2,041,772	2,186,531	(144,759)
Bad Debts	308,631	234,952	73,679	1,298,500	1,198,256	100,244
Other Expense	413,020	341,327	71,693	2,023,246	1,740,754	282,492
Total Expenses	**6,689,310**	**6,474,426**	**214,884**	**33,780,309**	**33,019,563**	**760,746**
Operating Income (Loss)	**432,842**	**373,952**	**58,890**	**2,684,146**	**1,907,194**	**776,952**
Other Income:						
District Tax Receipts	43,955	47,513	(3,558)	219,775	242,314	(22,539)
Tax Revenue for Debt	128,647	160,148	(31,501)	643,234	816,757	(173,523)
Partnership Investment Income	-	-	-	-	-	-
***Grants and Other Contributions**	42,766	41,096	1,670	78,800	209,590	(130,790)
Interest Income	25,623	16,302	9,321	151,461	83,139	68,322
Interest Expense	(290,712)	(252,142)	(38,570)	(1,266,797)	(1,285,925)	19,128
Other Non-Operating Income	4,963	2,344	2,619	24,884	11,954	12,930
Net Medical Office	(309,539)	(383,901)	74,362	(1,696,463)	(1,957,890)	261,427
340B Net Activity	-	16,439	(16,439)	932	83,839	(82,907)
Non-Operating Income/Loss	**(354,297)**	**(352,201)**	**(2,096)**	**(1,844,174)**	**(1,796,222)**	**(47,952)**
Net Income/Loss	**78,545**	**21,751**	**56,794**	**839,972**	**110,972**	**729,000**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary BUDGET VARIANCE ANALYSIS

Nov-17 *Fiscal Year Ending June 30, 2018*

Year to date for the month ending November 30, 2017

	-24	or	-2%	less IP days than in the prior fiscal year
$	837,611	or	4.72%	over budget in Total IP Revenue and
$	2,295,542	or	5.7%	over budget in OP Revenue resulting in
$	3,133,153	or	5.4%	over budget in gross patient revenue &
$	1,670,732	or	4.8%	over budget in net patient revenue

Year-to-date Net Revenue was			$	36,218,348
Total Operating Expenses were:			$	33,780,309
				for the fiscal Year To Date
$	760,746	or	2.3%	over budget. Salaries and Wages were
$	(892,217)	or	-7.8%	under budget and Employee Benefits
$	(170,336)	or	-2.2%	under budget
			72%	Employee Benefits as Percentage of Wages

The following expense areas were also over budget for the year for reasons listed:

$	1,506,489	or	42.1%	Professional Fees are over budget due to contract labor budgeted as employees
$	282,492	or	16.2%	Other Expenses are over budget due to timing difference on Annual Directors & Officers Liability

Other Information:

$	2,684,146				Operating Income, less
$	(1,844,174)				loss in non-operating activities resulted in a Net
$	839,972	or	$	729,000	over budget.
			40.58%		Actual Contractual Percentages for Year versus
			40.24%		Budgeted Contractual Percentages including
$	899,809	in prior year cost report favorable settlement activity for Medicare & Medi-Cal			

Non-Operating activities included:

$	(1,696,463)	loss	$	261,427	favorable to budget in Medical Office Activities
$	78,800		$	(130,790)	unfavorable to budget in Grants and Other

Northern Inyo Healthcare District

Preliminary Financial Indicators as of November 30, 2017

	Target	Nov-17	Oct-17	Sep-17	Aug-17	Jul-17	Jun-17	May-17	Apr-17	Mar-17	Feb-17	Jan-17	Dec-16	Nov-16	Oct-16
Current Ratio	>1.5-2.0	2.18	2.26	2.45	2.42	2.49	3.39	3.83	3.51	3.41	3.45	3.53	3.69	2.85	2.95
Quick Ratio	>1.33-1.5	1.83	1.84	1.82	1.81	2.05	2.84	3.23	2.96	2.88	2.90	2.93	2.92	2.46	2.41
Days Cash on Hand prior method	>75	169.35	165.31	140.47	142.06	160.31	154.70	160.60	159.55	160.80	157.10	151.40	140.37	160.86	145.43
Days Cash on Hand Short Term	>75	87.18	81.28	53.95	59.26	79.93	79.37	75.71	76.12	77.66	79.99	71.85	62.90	85.97	67.02
Debt Service Coverage	>1.5-2.0	2.74	2.78	2.79	2.87	2.34	1.81	1.96	1.91	2.07	2.23	2.17	2.13	2.46	2.30
Operating Margin		7.32	7.64	7.49	8.45	6.67	4.71	6.18	6.06	6.01	6.83	6.30	5.59	7.48	6.43
Outpatient Revenue % of Total		69.52	69.46	69.13	69.83	66.58	69.86	69.96	69.76	69.43	69.11	69.10	69.28	68.11	67.48
Cash flow (CF) margin (EBIDA to revenue)		4.30	4.69	4.82	5.62	3.68	2.48	2.84	2.59	3.41	4.27	3.94	3.71	5.43	4.53
Days in Patient Accounts Receivable	<60 Days	81.80	81.40	82.10	81.40	74.10	78.90	89.00	86.00	85.10	76.70	80.80	77.70	75.60	75.00

Debt Service Coverage as outlined in 2010 and 2013 Revenue Bonds require that the district has a debt service coverage ratio of 1.50 to 1 (can be 1:25 to 1 with 75 days cash on hand)

Debt Service Coverage is calculated as Net Income (Profit/Loss) from the Income Statement PLUS Depreciation & Interest Expense added back divided by the Current Interest & Principle for TOTAL DEBT from the Debt Information divided by number of closed fiscal periods

Current Ratio Equals (from Balance Sheet) Current Assets divided by Current Liabilities

Quick Ratio Equals (from Balance Sheet) Current Assets;Cash and Equivalents through Net Patient Accounts Receivlable Only divided by Current Liabilities

Updated Days Cash on hand Short Term = current cash & short term investments / by total operating expenses year-to-date / by days in fiscal year

Operating Margin Equals (from Income Statement) Year-to-date Operating Income /(Year-to-date Net Patient Service Revenue+Other Operating Revenue+District Tax Receipts) *100

Outpatient Revenue % of Total Revenue Equal (from Income Statement) Gross Outpatient/Total Gross Patient Revenue

Cash Flow (CF) margin (EBIDA to revenue) Equals (from Income Statement) [Net Income+Interest+Depreciation+Amoritization(if any)/Total Revenue] x 100

Accounts Receivable Days are pulled from the AR Aging report

NORTHERN INYO HEALTHCARE DISTRICT

Restricted and Specific Purpose Fund Balances
for period ending November 30, 2017

	Current Month	Prior Month	Change
Board Designated Funds:	November		
Tobacco Fund Savings Account	$ 1,098,501	$ 1,098,455	46
Equipment Fund Savings Account	$ 26,725	$ 26,725	-
Total Board Designated Funds:	**$ 1,125,226**	**$ 1,125,180**	**$ 46**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 320,336	$ 320,336	$ -
Nursing Scholarship Savings Account	$ 33,038	$ 33,038	$ -
Medical Education Savings Account	$ 75	$ 75	$ -
Joint NIHD/Physician Group Savings Account	$ 100,041	$ 100,041	$ -
Total Specific Purpose Funds:	**$ 453,491**	**$ 453,491**	**$ -**
Grand Total Restricted and Specific Purposes Funds:	**$ 1,578,716**	**$ 1,578,671**	**$ 46**

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending November 30, 2017

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	10,044,132	8,608,982	1,435,150
Short-Term Investments	9,203,023	9,291,018	(87,995)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	-	-	-
Other Investments	1,094,029	1,094,029	-
Patient Receivable	61,578,618	62,414,744	(836,126)
Less: Allowances	(46,262,941)	(46,595,223)	332,282
Other Receivables	1,208,039	2,306,911	(1,098,872)
Inventories	3,943,466	4,030,899	(87,433)
Prepaid Expenses	1,734,261	1,593,840	140,421
Total Current Assets	**42,542,626**	**42,745,199**	**(202,573)**
Internally Designated for Capital Acquisitions	1,125,226	1,125,180	46
Special Purpose Assets	453,491	453,491	-
Limited Use Asset; Defined Contribution Pension	907,810	819,815	87,995
Limited Use Assets Defined Benefit Plan	13,365,385	13,365,385	-
Limited Use Asset Defined Benefit Plan 003	7,485	7,119	367
Revenue Bonds Held by a Trustee	3,544,280	3,363,754	180,525
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**19,403,677**	**19,134,744**	**268,932**
Long Term Investments	1,750,000	1,750,000	-
Property & equipment, net of Accumulated Depreciation	78,262,993	78,576,296	(313,303)
Unamortized Bond Costs	-	-	-
Total Assets	**141,959,296**	**142,206,239**	**(246,943)**

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending November 30, 2017

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	2,076,026	1,946,222	129,805
Accounts Payable	2,634,741	2,417,128	217,613
Accrued Salaries, Wages & Benefits	5,734,890	5,459,493	275,397
Accrued Interest and Sales Tax	522,234	681,605	(159,370)
Deferred Income	2,945,032	2,712,404	232,628
Due to 3rd Party Payors	1,089,914	1,203,233	(113,319)
Due to Specific Purpose Funds	44	-	44
Other Deferred Credits; Pension	4,514,301	4,513,935	367
Total Current Liabilities	**19,517,182**	**18,934,018**	**583,164**
Long Term Debt, Net of Current Maturities	42,919,947	43,931,947	(1,012,000)
Bond Premium	585,220	592,467	(7,247)
Accreted Interest	11,419,838	11,309,289	110,549
Other Non-Current Liabilities; Pension	30,487,532	30,487,532	-
Total Long Term Debt	**85,412,537**	**86,321,235**	**(908,698)**
Net Assets			
Unrestricted Net Assets less Income	36,576,085	36,497,496	78,590
Temporarily Restricted	453,491	453,491	-
Net Income (Income Clearing)	(761,670)	(761,432)	(238)
Total Net Assets	**37,029,576**	**36,950,986**	**78,590**
Total Liabilities and Net Assets	**141,959,296**	**142,206,239**	**(246,943)**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary OPERATING STATISTICS

for period ending November 30, 2017

		FYE 2018	FYE 2017		Variance %
	Month to Date	Year-to-Date	Year-to-Date	Variance from PY	
Licensed Beds	25	25	25		
Total Patient Days with NB	290	1,526	1,550	(24)	-2%
Total Patient Days without NB	255	1,368	1,396	(28)	-2%
Swing Bed Days	30	150	242	(92)	-38%
Discharges without NB	91	449	461	(12)	-3%
Swing Discharges	5	20	34	(14)	-41%
Days in Month	31	31	31		
Occupancy without NB	8.23	44.13	45.03	(0.9)	-2%
Average Stay (days) without NB	2.80	3.05	3.03	0.0	1%
Average LOS without NB/Swing	2.62	2.84	2.70	0.1	5%
Hours of Observation	698	4,916	3,497	1,419	41%
Observation Adj Days	29	205	146	59	41%
ER Visits All Visits	717	4,315	4,109	206	5%
RHC Visits	2,176	13,776	10,216	3,560	35%
Outpatient Visits	3,967	19,758	17,549	2,209	13%
IP Surgeries	17	111	121	(10)	-8%
OP Surgery	117	534	474	60	13%
Worked FTE's	319.99	338.92	319.92	19	6%
Paid FTE's	393.73	391.57	364.23	27	8%
Hours Worked to Hours Paid%	81.3%	86.6%	87.8%	-1.3%	-1%
Payor %					
Medicare		41%	41%	1%	
Medi-Cal		20%	23%	-3%	
Insurance, HMO & PPO		36%	33%	3%	
Indigent (Charity Care)		0.9%	1.2%	-0.3%	
All Other		2%	2%	0%	
Total		100%	100%		

NORTHERN INYO HEALTHCARE DISTRICT

Investments as of November 30, 2017

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate	Principal Invested
2	30-Nov-17	01-Dec-17	Local Agency Investment Fund	Northern Inyo Hospital	1.17%	8,953,022.88
3	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%	250,000.00
				Short Term Investments		9,203,022.88
4	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%	150,000.00
5	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%	250,000.00
6	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%	250,000.00
7	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%	100,000.00
8	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%	250,000.00
9	02-Sep-16	28-Sep-21	Capital One Bank	Multi-Bank Service	1.70%	250,000.00
10	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%	250,000.00
11	28-Sep-16	28-Sep-21	Wells Fargo Bank NA	Multi-Bank Service	1.70%	250,000.00
				Long Term Investments		$ 1,750,000.00
				Total Investments		$ 10,953,022.88
1	11/30/2017	12/1/2017	LAIF Defined Cont Plan	Northern Inyo Hospital	1.17%	$ 907,810.11
				LAIF PENSION INVESTMENTS		$ 907,810.11

NORTHERN INYO HEALTHCARE DISTRICT
PRELIMINARY STATEMENT OF OPERATIONS
for period ending December 31, 2017

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	1,012,918	804,423	208,495	5,557,554	4,774,634	782,920
Ancillary	2,806,230	2,790,390	15,840	16,841,349	16,562,322	279,027
Total Inpatient Service Revenue	3,819,148	3,594,813	224,335	22,398,902	21,336,956	1,061,946
Outpatient Service	8,085,352	8,119,362	(34,010)	50,453,855	48,192,324	2,261,531
Gross Patient Service Revenue	**11,904,500**	**11,714,175**	**190,325**	**72,852,758**	**69,529,280**	**3,323,478**
Less Deductions from Revenue						
Patient Service Revenue Deductions	314,075	234,723	79,352	1,349,941	1,393,198	(43,257)
Contractual Adjustments	4,621,468	4,493,004	128,464	29,215,321	26,668,152	2,547,169
Prior Period Adjustments	(25,597)	(13,400)	(12,197)	(925,406)	(79,534)	(845,872)
Total Deductions from Patient Service Revenue	**4,909,946**	**4,714,327**	**195,619**	**29,639,856**	**27,981,816**	**1,658,040**
Net Patient Service Revenue	**6,994,554**	**6,999,848**	**(5,294)**	**43,212,902**	**41,547,464**	**1,665,438**
Other revenue	48,101	76,819	(28,718)	294,208	455,960	(161,752)
Total Other Revenue	**48,101**	**76,819**	**(28,718)**	**294,208**	**455,960**	**(161,752)**
Expenses:						
Salaries and Wages	2,187,573	2,328,739	(141,166)	12,788,809	13,822,192	(1,033,383)
Employee Benefits	1,887,199	1,589,908	297,291	9,563,825	9,436,870	126,955
Professional Fees	1,065,427	724,509	340,918	6,147,727	4,300,320	1,847,407
Supplies	677,162	648,488	28,674	4,316,158	3,849,086	467,072
Purchased Services	350,324	360,086	(9,762)	1,767,956	2,137,284	(369,328)
Depreciation	409,460	443,023	(33,563)	2,451,232	2,629,554	(178,322)
Bad Debts	211,661	242,784	(31,123)	1,510,161	1,441,040	69,121
Other Expense	405,399	352,700	52,699	2,428,644	2,093,454	335,190
Total Expenses	**7,194,205**	**6,690,237**	**503,968**	**40,974,514**	**39,709,800**	**1,264,714**
Operating Income (Loss)	**(151,550)**	**386,430**	**(537,980)**	**2,532,596**	**2,293,624**	**238,972**
Other Income:						
District Tax Receipts	43,955	49,096	(5,141)	263,730	291,410	(27,680)
Tax Revenue for Debt	128,647	165,487	(36,840)	771,881	982,244	(210,364)
Partnership Investment Income	-	-	-	-	-	-
***Grants and Other Contributions**	583,587	42,466	541,121	662,387	252,056	410,331
Interest Income	27,736	16,845	10,891	179,197	99,984	79,213
Interest Expense	(241,020)	(260,547)	19,527	(1,507,816)	(1,546,472)	38,656
Other Non-Operating Income	2,151	2,422	(271)	27,035	14,376	12,659
Net Medical Office	(333,577)	(396,696)	63,119	(2,030,040)	(2,354,586)	324,546
340B Net Activity	(4,183)	16,987	(21,170)	(3,251)	100,826	(104,077)
Non-Operating Income/Loss	**207,296**	**(363,940)**	**571,236**	**(1,636,878)**	**(2,160,162)**	**523,284**
Net Income/Loss	**55,746**	**22,490**	**33,256**	**895,718**	**133,462**	**762,256**

Northern Inyo Healthcare District

Preliminary Financial Indicators as of December 31, 2017

	Target	Dec-17	Nov-17	Oct-17	Sep-17	Aug-17	Jul-17	Jun-17	May-17	Apr-17	Mar-17	Feb-17	Jan-17	Dec-16
Current Ratio	>1.5-2.0	2.41	2.18	2.26	2.45	2.42	2.49	3.39	3.83	3.51	3.41	3.45	3.53	3.69
Quick Ratio	>1.33-1.5	1.99	1.83	1.84	1.82	1.81	2.05	2.84	3.23	2.96	2.88	2.90	2.93	2.92
Days Cash on Hand prior method	>75	165.72	169.35	165.31	140.47	142.06	160.31	154.70	160.60	159.55	160.80	157.10	151.40	140.37
Days Cash on Hand Short Term	>75	83.05	87.18	81.28	53.95	59.26	79.93	79.37	75.71	76.12	77.66	79.99	71.85	62.90
Debt Service Coverage	>1.5-2.0	2.67	2.74	2.78	2.79	2.87	2.34	1.81	1.96	1.91	2.07	2.23	2.17	2.13
Operating Margin		5.79	7.32	7.64	7.49	8.45	6.67	4.71	6.18	6.06	6.01	6.83	6.30	5.59
Outpatient Revenue % of Total		69.25	69.52	69.46	69.13	69.83	66.58	69.86	69.96	69.76	69.43	69.11	69.10	69.28
Cash flow (CF) margin (EBIDA to revenue)		4.05	4.30	4.69	4.82	5.62	3.68	2.48	2.84	2.59	3.41	4.27	3.94	3.71
Days in Patient Accounts Receivable	<60 Days	82.80	81.80	81.40	82.10	81.40	74.10	78.90	89.00	86.00	85.10	76.70	80.80	77.70

Debt Service Coverage as outlined in 2010 and 2013 Revenue Bonds require that the district has a debt service coverage ratio of 1.50 to 1 (can be 1:25 to 1 with 75 days cash on hand)

Debt Service Coverage is calculated as Net Income (Profit/Loss) from the Income Statement PLUS Depreciation & Interest Expense added back divided by the Current Interest & Principle for TOTAL DEBT from the Debt Information divided by number of closed fiscal periods

Current Ratio Equals (from Balance Sheet) Current Assets divided by Current Liabilities

Quick Ratio Equals (from Balance Sheet) Current Assets;Cash and Equivalents through Net Patient Accounts Receivlable Only divided by Current Liabilities

Updated Days Cash on hand Short Term = current cash & short term investments / by total operating expenses year-to-date / by days in fiscal year

Operating Margin Equals (from Income Statement) Year-to-date Operating Income /(Year-to-date Net Patient Service Revenue+Other Operating Revenue+District Tax Receipts) *100

Outpatient Revenue % of Total Revenue Equal (from Income Statement) Gross Outpatient/Total Gross Patient Revenue

Cash Flow (CF) margin (EBIDA to revenue) Equals (from Income Statement) [Net Income+Interest+Depreciation+Amoritization(if any)/Total Revenue] x 100

Accounts Receivable Days are pulled from the AR Aging report

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary BUDGET VARIANCE ANALYSIS

Dec-17 *Fiscal Year Ending June 30, 2018*

Year to date for the month ending December 31, 2017

77	or	4%	more IP days than in the prior fiscal year
$ 1,061,946	or	4.98%	over budget in Total IP Revenue and
$ 2,261,531	or	4.7%	over budget in OP Revenue resulting in
$ 3,323,478	or	4.8%	over budget in gross patient revenue &
$ 1,665,438	or	4.0%	over budget in net patient revenue

Year-to-date Net Revenue was			$	43,212,902
Total Operating Expenses were:			$	40,974,514
				for the fiscal Year To Date
$ 1,264,714	or	3.2%		over budget. Salaries and Wages were
$ (1,033,383)	or	-7.5%		under budget and Employee Benefits
$ 126,955	or	1.3%		over budget
		75%		Employee Benefits as Percentage of Wages

The following expense areas were also over budget for the year for reasons listed:

$ 1,847,407	or	43.0%	Professional Fees are over budget due to contract labor budgeted as employees
$ 335,190	or	16.0%	Other Expenses are over budget due to timing difference on Liability Insurance, Surgery Lease, Plant Utilities as well as Chemistry and Pharmacy spending

Other Information:

$ 2,532,596			Operating Income, less
$ (1,636,878)			loss in non-operating activities resulted in a Net
$ 895,718	or	$ 762,256	over budget.
		40.68%	Actual Contractual Percentages for Year versus
		40.24%	Budgeted Contractual Percentages including
$ 925,406	in prior year cost report favorable settlement activity for Medicare & Medi-Cal		

Non-Operating activities included:

$ (2,030,040)	loss	$ 324,546	favorable to budget in Medical Office Activities
$ 662,387		$ 410,331	favorable to budget in Grants and Other Contributions

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending December 31, 2017

Assets:	Current Month	Prior Month	Change
Current Assets			
Cash and Equivalents	9,366,854	10,044,132	(677,278)
Short-Term Investments	9,126,389	9,203,023	(76,634)
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	-	-	-
Other Investments	1,094,029	1,094,029	-
Patient Receivable	61,690,891	61,578,618	112,273
Less: Allowances	(46,157,627)	(46,262,941)	105,314
Other Receivables	1,647,710	1,208,039	439,671
Inventories	3,986,524	3,943,466	43,059
Prepaid Expenses	1,782,862	1,734,261	48,601
Total Current Assets	**42,537,632**	**42,542,626**	**(4,994)**
Internally Designated for Capital Acquisitions	1,125,271	1,125,226	45
Special Purpose Assets	430,923	453,491	(22,568)
Limited Use Asset; Defined Contribution Pension	984,444	907,810	76,634
Limited Use Assets Defined Benefit Plan	13,365,385	13,365,385	-
Limited Use Asset Defined Benefit Plan 003	8,585	7,485	1,099
Revenue Bonds Held by a Trustee	2,205,232	3,544,280	(1,339,048)
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**18,119,839**	**19,403,677**	**(1,283,837)**
Long Term Investments	1,750,000	1,750,000	-
Property & equipment, net of Accumulated Depreciation	77,977,520	78,262,993	(285,473)
Unamortized Bond Costs	-	-	-
Total Assets	**140,384,992**	**141,959,296**	**(1,574,304)**

Northern Inyo Healthcare District
Preliminary Balance Sheet
Period Ending December 31, 2017

Liabilities and Net Assets	Current Month	Prior Month	Change
Current Liabilities:			
Current Maturities of Long-Term Debt	2,125,815	2,076,026	49,789
Accounts Payable	2,517,743	2,634,741	(116,998)
Accrued Salaries, Wages & Benefits	5,072,512	5,734,890	(662,378)
Accrued Interest and Sales Tax	179,911	522,234	(342,324)
Deferred Income	2,203,660	2,945,032	(741,372)
Due to 3rd Party Payors	1,029,914	1,089,914	(60,000)
Due to Specific Purpose Funds	44	44	-
Other Deferred Credits; Pension	4,515,401	4,514,301	1,099
Total Current Liabilities	**17,645,000**	**19,517,182**	**(1,872,182)**
Long Term Debt, Net of Current Maturities	41,839,947	42,919,947	(1,080,000)
Bond Premium	577,974	585,220	(7,247)
Accreted Interest	11,530,387	11,419,838	110,549
Other Non-Current Liabilities; Pension	30,487,532	30,487,532	-
Total Long Term Debt	**84,435,839**	**85,412,537**	**(976,698)**
Net Assets			
Unrestricted Net Assets less Income	37,873,229	36,576,085	1,297,144
Temporarily Restricted	430,923	453,491	(22,568)
Net Income (Income Clearing)	(761,670)	(761,670)	-
Total Net Assets	**38,304,152**	**37,029,576**	**1,274,576**
Total Liabilities and Net Assets	**140,384,992**	**141,959,296**	**(1,574,304)**

NORTHERN INYO HEALTHCARE DISTRICT

Preliminary OPERATING STATISTICS

for period ending December 31, 2017

	Month to Date	FYE 2018 Year-to-Date	FYE 2017 Year-to-Date	Variance from PY	Variance %
Licensed Beds	25	25	25		
Total Patient Days with NB	318	1,844	1,767	77	4%
Total Patient Days without NB	291	1,659	1,589	70	4%
Swing Bed Days	28	178	270	(92)	-34%
Discharges without NB	92	541	536	5	1%
Swing Discharges	5	25	39	(14)	-36%
Days in Month	31	31	31		
Occupancy without NB	9.39	53.52	51.26	2.3	4%
Average Stay (days) without NB	3.16	3.07	2.96	0.1	3%
Average LOS without NB/Swing	3.02	2.87	2.65	0.2	8%
Hours of Observation	877	5,793	4,328	1,465	34%
Observation Adj Days	37	241	180	61	34%
ER Visits All Visits	622	4,937	4,873	64	1%
RHC Visits	2,234	16,010	12,230	3,780	31%
Outpatient Visits	3,830	23,588	21,079	2,509	12%
IP Surgeries	21	132	142	(10)	-7%
OP Surgery	122	656	600	56	9%
Worked FTE's	351.96	341.11	323.75	17	5%
Paid FTE's	377.73	389.24	364.97	24	7%
Hours Worked to Hours Paid%	93.2%	87.6%	88.7%	-1.1%	-1%
Payor %					
Medicare		42%	41%	1%	
Medi-Cal		20%	23%	-3%	
Insurance, HMO & PPO		35%	33%	2%	
Indigent (Charity Care)		0.9%	1.2%	-0.2%	
All Other		2%	2%	0%	
Total		100%	100%		

NORTHERN INYO HEALTHCARE DISTRICT

Investments as of December 31, 2017

ID	Purchase Date	Maturity Dat	Institution	Broker	Rate		Principal Invested
2	31-Dec-17	01-Jan-18	Local Agency Investment Fund	Northern Inyo Hospital	1.24%		8,876,388.88
3	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%		250,000.00
				Short Term Investments			9,126,388.88
4	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%		150,000.00
5	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%		250,000.00
6	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%		250,000.00
7	20-May-15	20-May-20	American Express Centurion Bank	Financial Northeaster Corp.	2.05%		100,000.00
8	26-Sep-16	27-Sep-21	Comenity Capital Bank	Multi-Bank Service	1.70%		250,000.00
9	02-Sep-16	28-Sep-21	Capital One Bank	Multi-Bank Service	1.70%		250,000.00
10	28-Sep-16	28-Sep-21	Capital One National Assn	Multi-Bank Service	1.70%		250,000.00
11	28-Sep-16	28-Sep-21	Wells Fargo Bank NA	Multi-Bank Service	1.70%		250,000.00
				Long Term Investments		$	1,750,000.00
				Total Investments		$	10,876,388.88
1	31-Dec-17	01-Jan-18	LAIF Defined Cont Plan	Northern Inyo Hospital	1.24%	$	984,444.11
				LAIF PENSION INVESTMENTS		$	984,444.11

NORTHERN INYO HEALTHCARE DISTRICT

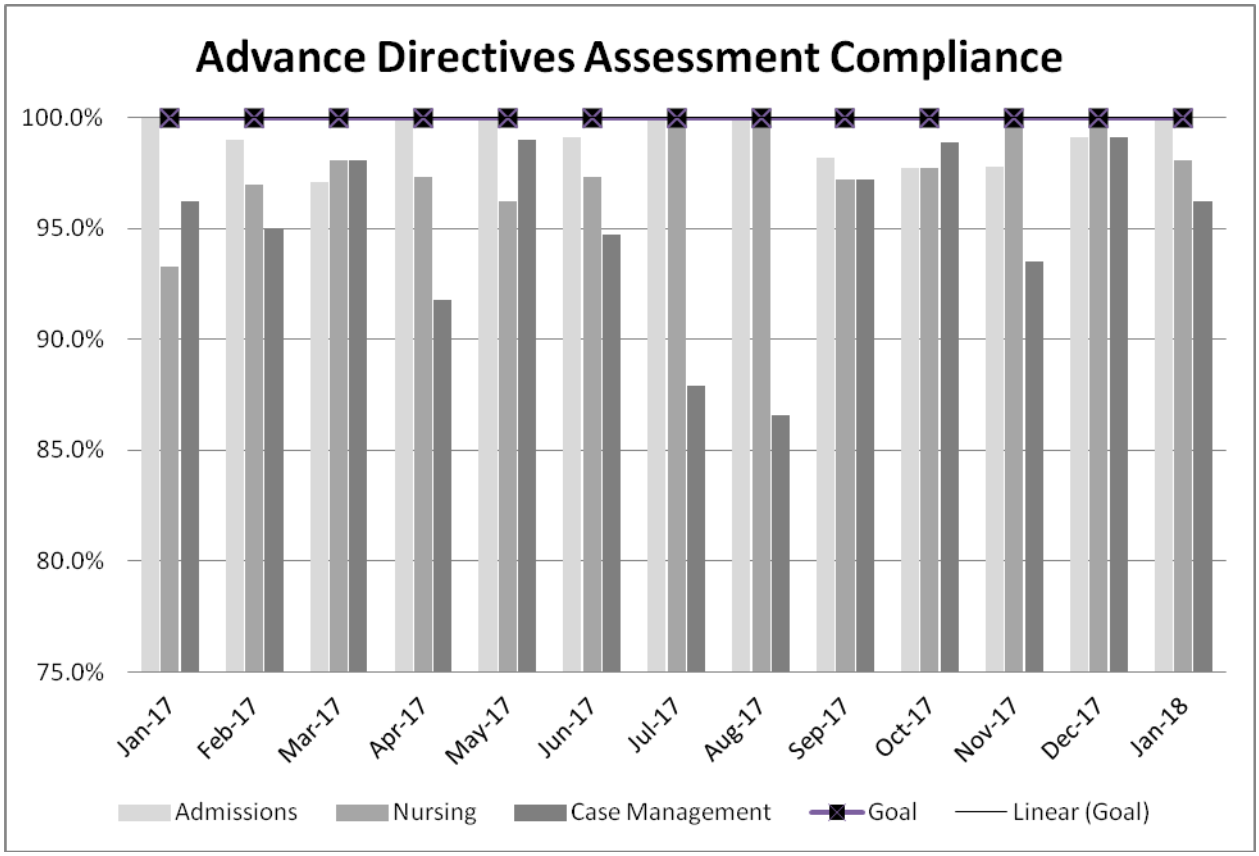
Restricted and Specific Purpose Fund Balances
for period ending December 31, 2017

	Current Month	Prior Month	Change
Board Designated Funds:	December		
Tobacco Fund Savings Account	$ 1,098,545	$ 1,098,501	44
Equipment Fund Savings Account	$ 26,726	$ 26,725	1
Total Board Designated Funds:	**$ 1,125,271**	**$ 1,125,226**	**$ 45**
Specific Purpose Funds:			
* Bond and Interest Savings Account	$ 320,346	$ 320,336	$ 10
Nursing Scholarship Savings Account	$ 10,448	$ 33,038	$ (22,590)
Medical Education Savings Account	$ 75	$ 75	$ -
Joint NIHD/Physician Group Savings Account	$ 100,053	$ 100,041	$ 12
Total Specific Purpose Funds:	**$ 430,923**	**$ 453,491**	**$ (22,568)**
Grand Total Restricted and Specific Purposes Funds:	**$ 1,556,194**	**$ 1,578,716**	**$ (22,522)**

2013 CMS Validation Survey Monitoring-February 2018

1. QAPI continues to receive and monitor data related to the previous CMS Validation Survey, including but not limited to, restraints, dietary process measures, case management, pain re-assessment, as follows:

    a. Advance Directives Monitoring.

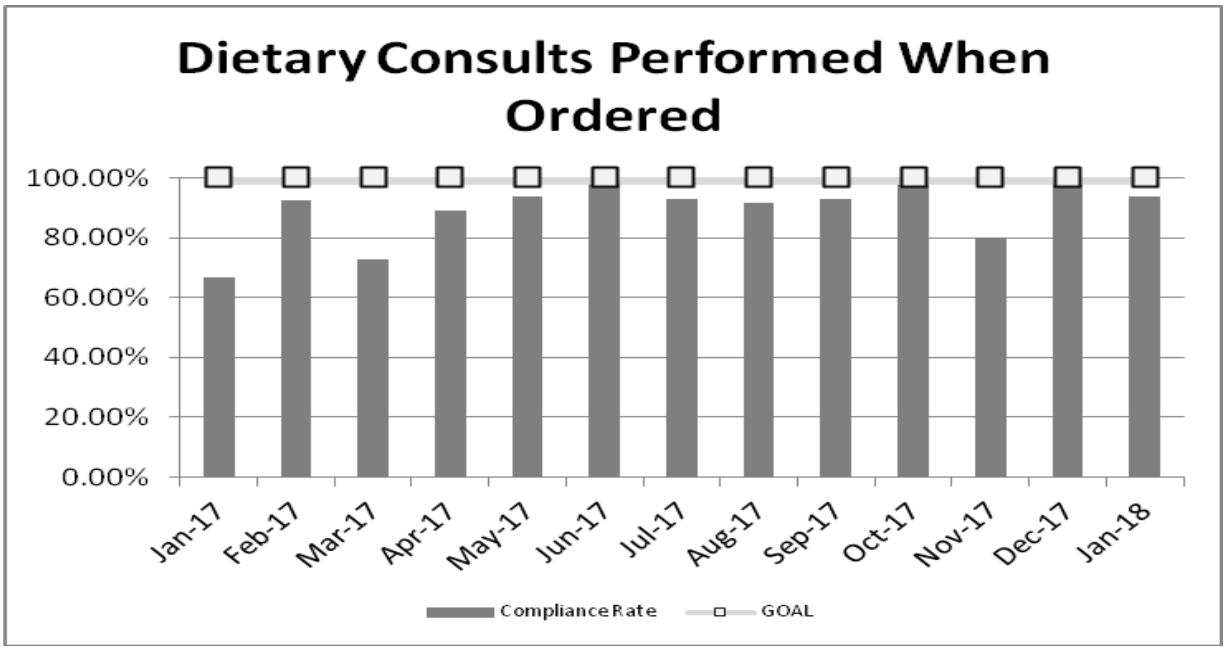


    b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

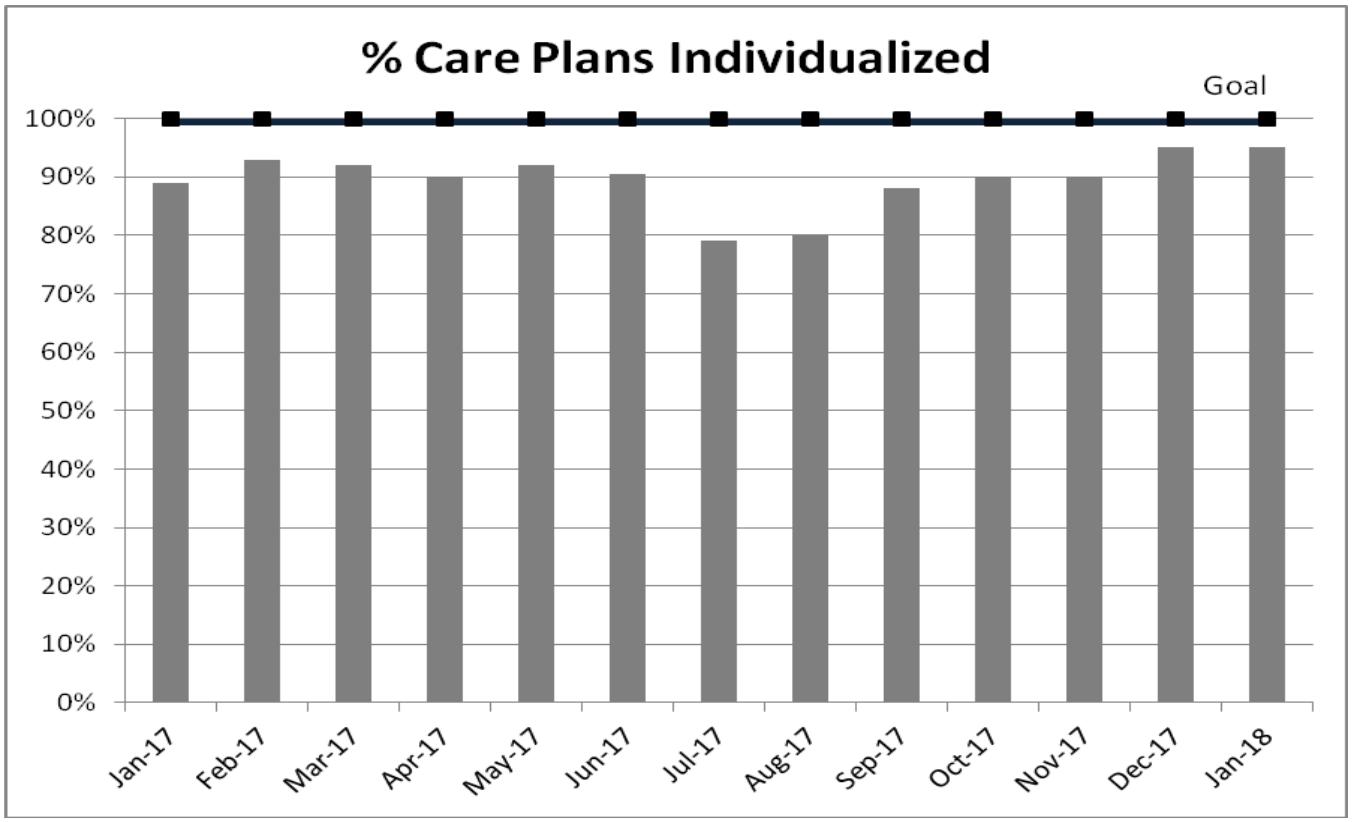
    c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

    d. Dietary hand washing logs have been reported and are at 100% compliance since May 6, 2013.

e. QAPI continues to monitor dietary referrals and the number of consults completed within 24 hours.

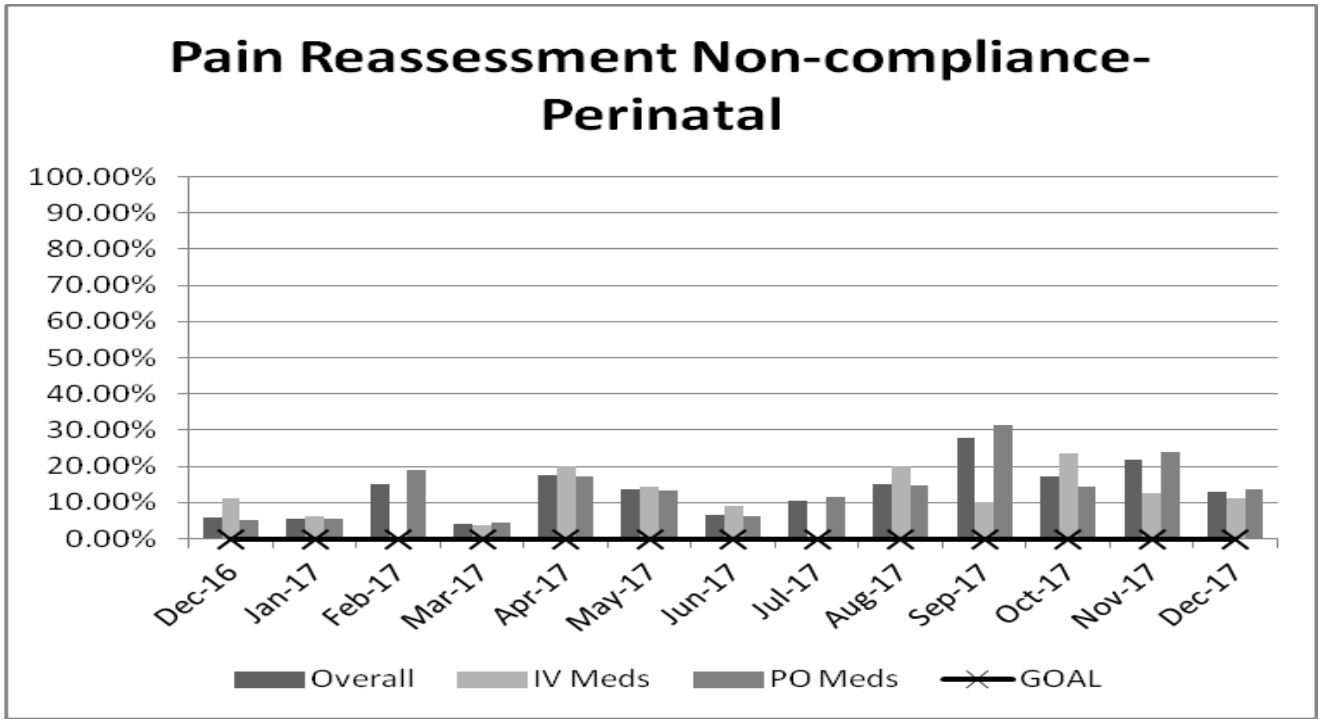


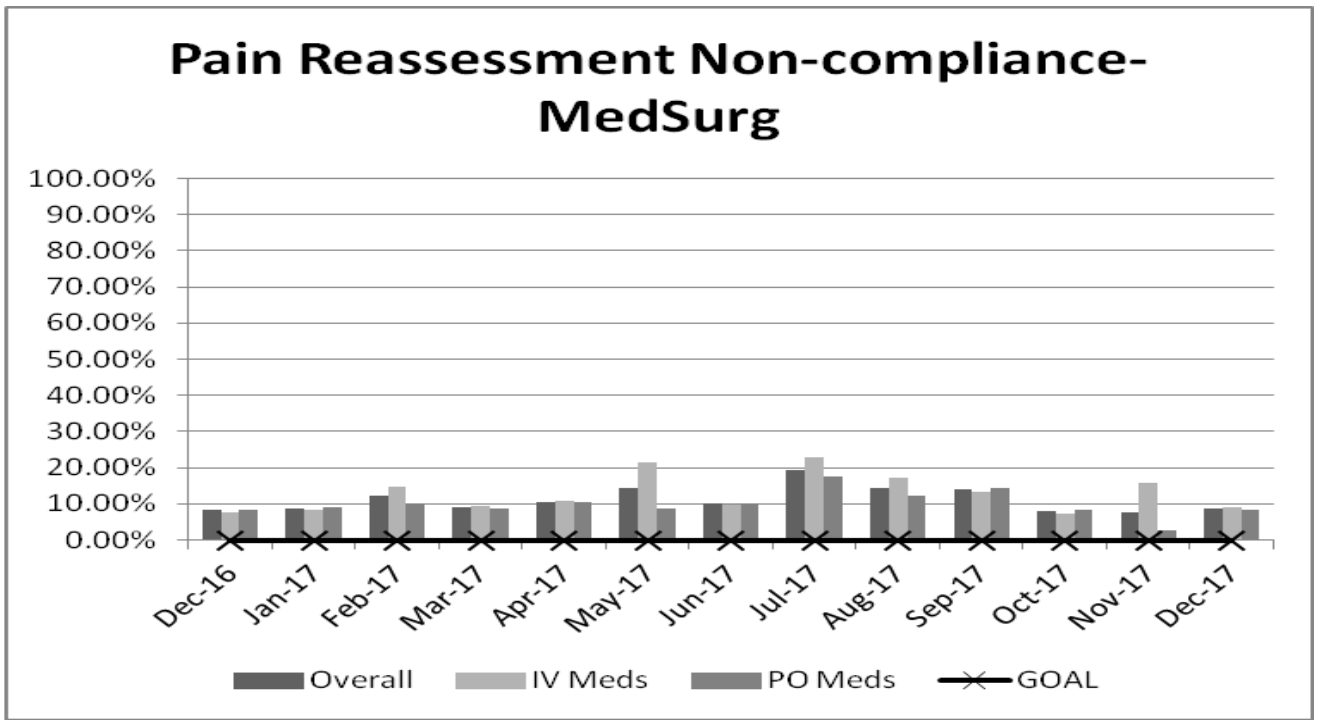
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

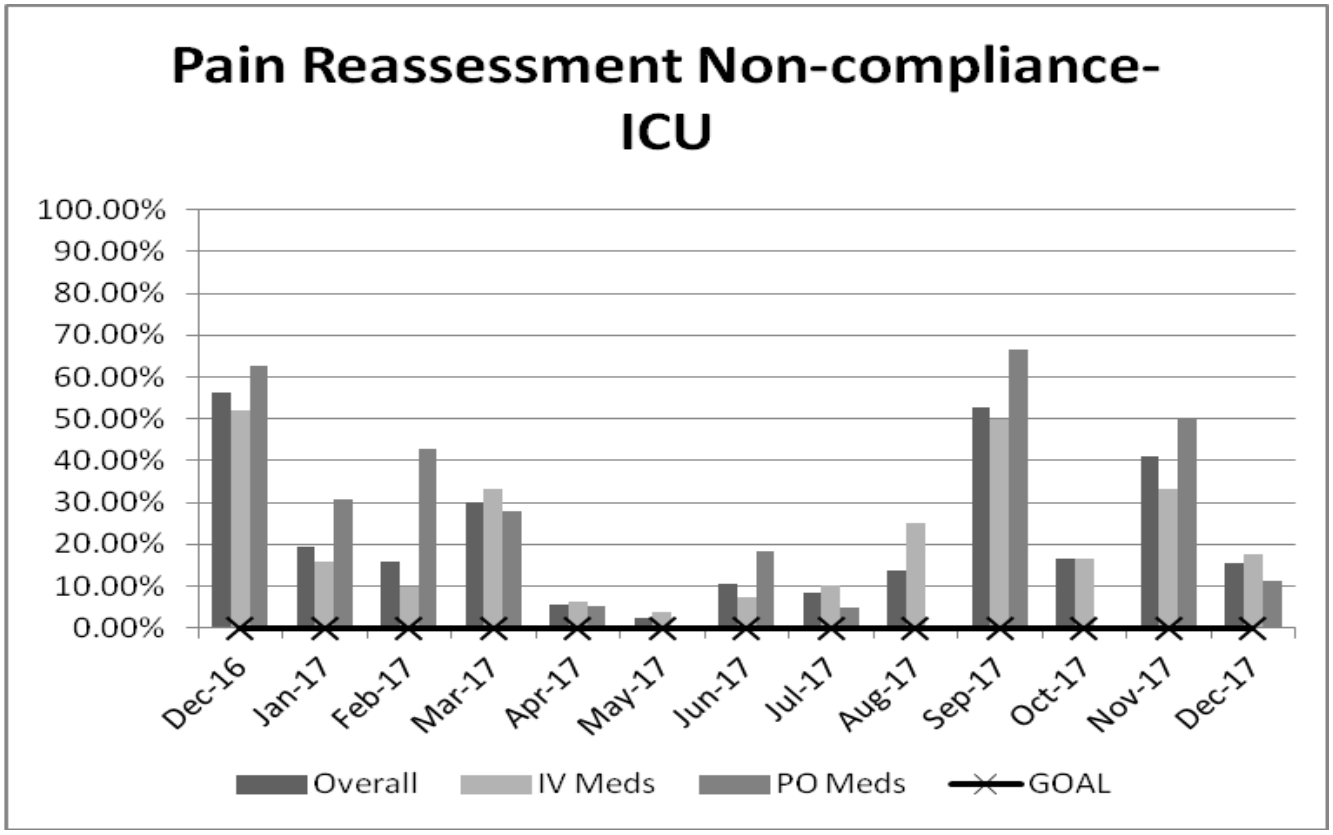


g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been approved. All fire drills were complete and compliant from May 6, through present.

h. Pain Re-Assessment. NIH conducts pain re-assessment after administering pain medications and uses a 1-10 scale.







Note: Due to small sample sizes in the ICU, results should be interpreted with caution for this unit.

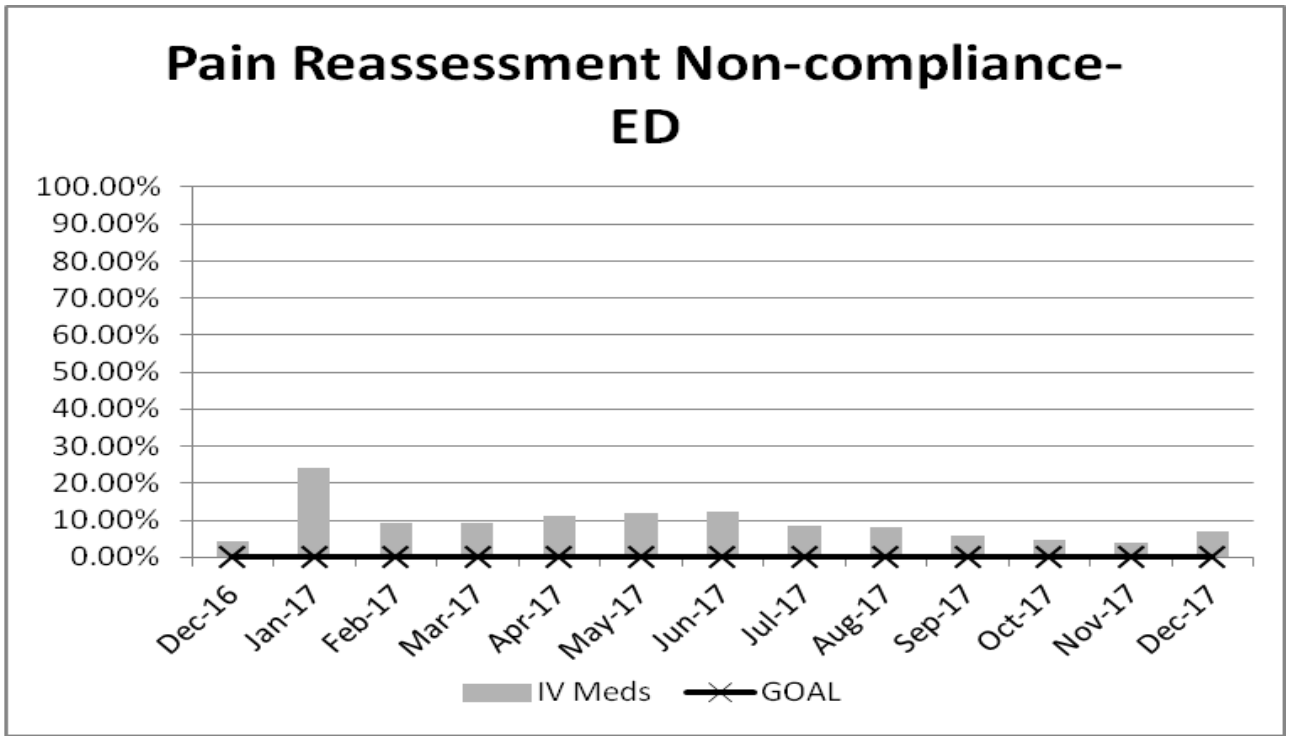


Table 6. Restraint chart monitoring for legal orders.

	June 2017	***July 2017***	***Aug 2017***	***Sept 2017***	***Oct 2017***	***Nov 2017***	***Dec 2017***	***Jan 2018***	***Goal***
Restraint verbal/written order obtained within 1 hour of restraints	2/2 (100%)	3/3 (100%)	3/3 (100%)	2/2 (100%)	3/3 (100%)	1/1 (100%)	3/3 (100%)	1/1 (100%)	100%
Physician signed order within 24 hours	2/2 (100%)	3/3 (100%)	2/3 (66%)	1/2 (50%)	2/3 (66%)	1/1 (100%)	2/3 (66%)	0/1 (0%)	100%
Physician Initial Order Completed (all areas completed and form/time/date noted/signed by MD and RN)	1/2 (50%)	3/3 (100%)	1/3 (33%)	0/2 (0%)	2/3 (66%)	1/1 (100%)	1/3 (33%)	0/1 (0%)	100%
Physician Re-Order Completed (all areas completed and form time/date/noted/signed by MD and RN)	3/3 (100%)	2/5 (40%)	2/8 (25%)	0/2 (0%)	1/2 (50%)	N/A	2/6 (33%)	N/A	100%
Orders are for 24 hours	5/5 (100%)	8/8 (100%)	11/11 (100%)	4/4 (100%)	5/5 (100%)	1/1 (100%)	9/9 (100%)	1/1 (100%)	100%
Is this a PRN (as needed) Order	0/5 (0%)	0/8 (0%)	0/11 (0%)	0/4 (0%)	0/5 (0%)	0/1 (0%)	0/9 (0%)	0/1 (0%)	0%

CALL TO ORDER	The meeting was called to order at 3:00 pm by John Ungersma, President.
PRESENT	John Ungersma MD, President M.C. Hubbard, Vice President Mary Mae Kilpatrick, Secretary Jean Turner, Treasurer Peter Watercott, Member at Large Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer Tracy Aspel RN, Chief Nursing Officer Evelyn Campos Diaz, Chief Human Resources Officer Sandy Blumberg, Executive Assistant
ABSENT	Richard Meredick, MD, Chief of Staff John Tremble, Chief Financial Officer
OPPORTUNITY FOR PUBLIC COMMENT	Doctor Ungersma stated at this time persons in the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of 3 minutes each. No comments were heard.
EASTERN SIERRA EMERGENCY PHYSICIANS CONTRACT RENEWAL	Chief Executive Officer (CEO) Kevin S. Flanigan MD, MBA called attention to a proposed contract renewal for Emergency Department Services with Eastern Sierra Emergency Physicians group (ESEP). He noted that Northern Inyo Healthcare District (NIHD) has been pleased with the services previously provided by ESEP and proposes a renewal of their current contract with only minor changes. ESEP partner Ann Goshgarian, MD was present to answer questions if necessary, and Doctor Flanigan noted that District legal counsel has reviewed and approved the renewal agreement as presented. Following review of the information provided it was moved by M.C. Hubbard, seconded by Peter Watercott, and unanimously passed to approve the proposed agreement for Emergency Department Services with Eastern Sierra Emergency Physicians as presented.
CHIEF EXECUTIVE OFFICER CONTRACT EXTENSION	Doctor Flanigan also called attention to a proposed extension of the current Chief Executive Officer Agreement (with Kevin S. Flanigan, MD, MBA), asking that the agreement currently in place be extended through March 31 2018 in order to allow legal counsel time to finalize the details for a renewal agreement. It was moved by Mary Mae Kilpatrick, seconded by Jean Turner, and unanimously passed to approve the extension of the Chief Executive Officer Agreement with Kevin S. Flanigan MD, MBA as requested.
REVIEW OF DISTRICT BOARD SELF ASSESSMENT	The Board of Directors used the remainder of the meeting to review the results of the 2017 Governance Self-Assessment survey, a self-assessment tool provided for governing boards by the Association of California

Healthcare Districts (ACHD). Review of the Board's Self-Assessment included the following:

- Summary of Board performance relating to the District Mission, Values, and Vision
- Discussion of NIHD's future Strategic Direction
- Review of current Leadership Structure and Processes
- Overview of District Quality and Patient Safety
- Discussion of Community Relationships with the District
- Assessment of the Board's relationship with the CEO
- Overview of the Board of Trustees relationship with District Medical Staff
- Assessment of Financial Leadership
- Assessment of overall community health
- Discussion of the District's Organizational Ethics
- Future Issues and Priorities

ADJOURNMENT The meeting was adjourned at 5:21 pm.

_____
John Ungersma MD, President

Attest: _____
Mary Mae Kilpatrick, Secretary

CALL TO ORDER	The meeting was called to order at 5:30 pm by John Ungersma MD, President.
PRESENT	John Ungersma MD, President M.C. Hubbard, Vice President Mary Mae Kilpatrick, Secretary Jean Turner, Treasurer Peter Watercott, Member at Large Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Huntsinger, Chief Operating Officer John Tremble, Chief Financial Officer Evelyn Campos Diaz, Chief Human Resources Officer Richard Meredick MD, Chief of Staff Sandy Blumberg, Executive Assistant
ABSENT	Tracy Aspel RN, Chief Nursing Officer
OPPORTUNITY FOR PUBLIC COMMENT	Doctor Ungersma stated at this time persons in the audience may speak on items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers will be limited to a maximum of three minutes each. Doctor Ungersma also thanked Peter Watercott for his service as District Board President during the 2017 calendar year. No other comments were heard.
ADVENTIST HEALTH TELEHEALTH PROGRAM	Chief Executive Officer (CEO) Kevin S. Flanigan MD, MBA introduced representatives from Adventist Health, who will partner with Northern Inyo Healthcare District (NIHD) to provide telehealth services for this community. Adventist Health representatives in attendance were Arby Napapetian MD; Cynthia Scheideman-Miller; James Burke MD; and Rob Marchuk, Vice President of Ancillary Services. Adventist Health will begin providing both telehealth and on-site specialty services for NIHD in the next several months, in addition to providing additional call coverage for the District's orthopedic surgeons.
INTERIM DIRECTOR OF PHARMACY	Chief Operating Officer Kelli Huntsinger reported that Northern Inyo Healthcare District (NIHD) has a new Interim Director of Pharmacy, Nicholas Vu, who brings with him valuable experience in many areas including 340B Pharmacy programs.
RADIOLOGY SERVICES AGREEMENT WITH TAHOE CARSON RADIOLOGY	Doctor Flanigan stated that NIHD's Radiology Services Agreement with Tahoe Carson Radiology is in final review with District Legal Counsel, and it will be placed on a future Board agenda for approval.
NIHD AUXILIARY FUNDRAISING REPORT	NIHD Auxiliary President Judy Fratella presented a fundraising report for the annual Auxiliary Boutique, which takes place as a culmination of an entire year of hard work and effort on the part of Auxiliary members. Ms.

Fratella reported that this year's boutique raised over $31,000 in proceeds and donations, a more than $10,000.00 increase over the prior year's total. Proceeds from the boutique will be used to purchase critically needed equipment for Northern Inyo Hospital.

RENTAL AGREEMENT WITH KERN REGIONAL

Doctor Flanigan reported that NIHD has entered into an agreement with Kern Regional to lease office space at the District's Birch Street Annex. Kern Regional recently encountered environmental issues that forced them out of their previous office space, requiring them to find a new location in which to operate in less than 30 days. NIHD worked quickly to prepare space for Kern Regional in order to prevent disruption of the services they provide for this community.

CMS VALIDATION SURVEY MONITORING

Ms. Huntsinger reviewed the District's 2013 CMS Validation Survey Monitoring report as of January 2018. The report monitors data on specific quality measures including patient restraints; dietary consults; case management; and pain re-assessment. The District's performance in each these areas is strong, with the goal being to achieve 100% compliance in all areas.

MEDICAL STAFF PILLARS OF EXCELLENCE

Doctor Flanigan reviewed quarterly Medical Staff Services Pillars of Excellence as of December 31, 2017. The Pillars of Excellence measure Medical Staff Office performance in the areas of customer satisfaction, staffing, credentialing, and privileging.

FATIGUE MANAGEMENT PROGRAM POLICY AND PROCEDURE

Chief Human Resources Officer Evelyn Campos Diaz called attention to a proposed *Fatigue Management Program Policy and Procedure*, which is intended to address the effects and risks of employee fatigue and mitigate fatigue in the workplace. It was moved by Mary Mae Kilpatrick, seconded by Jean Turner, and unanimously passed to approve the proposed *Fatigue Management Program Policy and Procedure* as presented.

COMPETENCY PLAN PERSONNEL POLICY

Ms. Campos Diaz also called attention to a proposed *Competency Plan* which establishes a District-wide plan to ensure that the competence of all employees is assessed, maintained, improved upon, and appropriately aligned with organizational needs. It was moved by Ms. Turner, seconded by Mr. Watercott, and unanimously passed to approve the proposed *Competency Plan* as presented.

RURAL HEALTH CLINIC GROWTH

Doctor Flanigan provided an update on the expected growth of Same Day Services at the NIHD Rural Health Clinic (RHC). Patient use of the Same Day Services program has increased rapidly and sufficient need exists to add more provider hours and an additional practitioner to expand provision of the Service. It was noted that the popularity of the Same Day Service program has not had an impact on NIHD Emergency Department volume, and that the District will still continue to recruit for another practitioner to join the Hathaway and Kamei Internal Medicine practice.

BUDGET PHILOSOPHY 2018	Chief Financial Officer John Tremble presented a potential budget philosophy for the District to follow when preparing the 2018/2019 fiscal year budget. Rather than basing the District's annual budget on prior year performance (as is the historical norm), the new budget process would focus on looking forward to estimate and plan for the District's future needs, keeping in mind that the budget process should confirm and support the District's mission, vision, and strategic goals. Board input on this topic revealed that a top priority moving forward will be to plan to rebuild the NIHD Rural Health Clinic as soon as financially possible. During the budget philosophy discussion it was also determined that the District will go out to bid to select an audit firm to complete the District's 2017/2018 annual audit.
OLD BUSINESS	
BISHOP UNION HIGH SCHOOL CLINIC UPDATE	Doctor Flanigan reported a Memorandum of Understanding to operate a student clinic on the Bishop Union High School campus is expected to be signed later this week. The clinic will be staffed by NIHD employees and is scheduled to open on January 23, 2018.
PIONEER HOME HEALTH (HOSPICE) UPDATE	NIHD continues to partner with Pioneer Home Health to ensure that they are able to continue providing Hospice services for this community. Both Doctor Flanigan and Ms. Kilpatrick are now members of the Pioneer Home Health Advisory Board.
ATHENA IMPLEMENTATION UPDATE	The District's first "go live" software implementation occurred this week when the ReDoc scheduling program went online for the Rehab Services Department. ReDoc implementation is the first of 12 projects relating to implementation of the AthenaHealth Health Information System, which is scheduled to take place on September 25 2018. The next implementation will be a go live of ADP software for the NIHD Payroll and Human Resources Departments.
340B PHARMACY AGREEMENT WITH DWAYNE'S PHARMACY	Ms. Huntsinger reported that the District has re-enrolled in the Federal 340B Pharmacy program, and will partner with Dwayne's Pharmacy to operate a 340B program. She additionally noted the District will implement Macro Helix software for operation of the program.
UROLOGY SERVICES UPDATE	Doctor Flanigan reported the District's first urology services provider will arrive later this week and will begin initial setup of a part-time urology practice for NIHD. The District has contracted with temporary (locums) urologists to establish a practice which will be taken over by Colby Perkins-Souders MD in the future. For the time being, locums urologists will be on site at NIHD for one week at a time, every other month.
PHYSICIAN RECRUITMENT UPDATE	The District continues its recruitment for practitioners to join the Hathaway and Kamei Internal Medicine practice. Additionally, the District is negotiating to bring pediatrician Kristen Irmiter MD on board full time, and is also recruiting Dr. Irmiter's fiancé William Huddleston

MD to join NIHD's general surgery rotation and potentially provide services at Southern Inyo Hospital on a part time basis.

CONSENT AGENDA

Doctor Ungersma called attention to the Consent Agenda for this meeting, which contained the following items:

- *Approval of minutes of the December 13 2017 regular meeting*
- *Policy and Procedure annual approvals*

It was moved by Mr. Watercott, seconded by Ms. Kilpatrick, and unanimously passed to approve both Consent Agenda items as presented.

CHIEF OF STAFF REPORT

Chief of Staff Richard Meredick MD reported following careful review and consideration the Medical Executive Committee recommends Board approval of the following:

A. Telemedicine Services

- *In processing a request for telemedicine privileges, the Medical Staff and Hospital may follow the normal credentialing process described in Section 2 of the Medical Staff Bylaws. Alternatively, the Medical Staff may elect to rely upon the credentialing and privileging decisions made by distant-site hospitals and telemedicine entities when making recommendations on privileges for individual distant-site practitioners, subject to meeting the conditions required by law and those specified in Section 3.6.1 of the Bylaws, including being party to a written agreement with the distant-site (NIHD Medical Staff Bylaws, Section 3.6.1).*

1. The NIHD Medical Staff has voted to accept the provision of the following services offered by Adventist Health via a telemedicine link:
    a. Gastroenterology
    b. Hematology / Oncology
    c. Infectious Disease
    d. Orthopedic Surgery
    e. Pulmonary Disease
    f. Rheumatology
    g. Sleep Medicine
    h. Dermatology
    i. Interventional Cardiology
    j. Neurology – outpatient
    k. Endocrinology
    l. Pediatric Endocrinology
    m. Psychiatry

It was moved by Mr. Watercott, seconded by Ms. Turner, and unanimously passed to approve the Telemedicine Services privileging and credentialing process as presented.

Doctor Meredick also reported following careful review and consideration the Medical Executive Committee recommends approval of the following:

B. *Telemedicine Privileging Request Form* for use with proxy credentialing

It was moved by Ms. Turner, seconded by Ms. Hubbard, and unanimously passed to approve the *Telemedicine Privileging Request Form* for use with proxy credentialing as presented.

Doctor Meredick additionally stated the Medical Executive Committee recommends approval of the following Medical Staff Resignations:

C. The following Medical Staff members' privileges have expired effective January 1, 2018:
   a. Jennifer Scott MD (*emergency medicine*)
   b. A. Douglas Will MD (*neurology*)

It was moved by Mr. Watercott, seconded by Ms. Hubbard, and unanimously passed to approve both Medical Staff resignations as requested.

Doctor Meredick also requested Board approval of the following:

D. The following Temporary privileges practitioner has relinquished clinical privileges effective December 30, 2017:
   - Erica Rotundo, DO (*family practice – locums tenens*)

It was moved by Ms. Hubbard, seconded by Ms. Kilpatrick, and unanimously passed to approve the relinquishing of clinical privileges for Doctor Rotundo as requested.

BOARD MEMBER REPORTS

Doctor Ungersma asked if any members of the Board of Directors wished to comment on any items of interest. Mr. Watercott praised the Sierra Lifeflight Farewell Flyaway event, and Ms. Turner expressed her appreciation of the Healthy Lifestyles Same Day Care talk provided by Jennifer Figueroa, PA. Ms. Kilpatrick also commended the District's recruiting efforts which have resulted in obtaining permanent staff for many positions previously held by temporary workers. No other comments were heard.

CLOSED SESSION

At 7:30 pm Doctor Ungersma reported the meeting would adjourn to closed session to allow the Board of Directors to:

A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).
B. Confer with Legal Counsel regarding pending and threatened litigation, existing litigation, and significant exposure to litigation, 1 matter pending (*pursuant to Government Code Section 54956.9*).
C. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined)(*Health and Safety Code Section 32106*).
D. Discussion of a personnel matter (*pursuant to Government Code Section 54957*).

E. Discussion of employment contract for a public employee, to wit: Administrator/Chief Executive Officer (*Government Code Section 54957*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN — At 8:08 pm the meeting returned to open session. Doctor Ungersma reported that the Board took no reportable action.

ADJOURNMENT — The meeting adjourned at: 8:09 pm.

_____
John Ungersma MD, President

Attest: _____
Mary Mae Kilpatrick, Secretary

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

Medical Staff Office
(760) 873-2136 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Richard Meredick, MD, Chief of Medical Staff
DATE: February 6, 2018
RE: Medical Executive Committee Report

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

A. Policies/Procedures/Protocols/Order Sets (*action items*)

a. Accutest Rapid Mono Test
b. Admission, Care, Discharge and Transfer of the Newborn
c. Admission, Transfer, and Discharge Care of the Obstetrical Patient
d. AIDS/HIV Testing and Orders
e. Anesthesia Clinical Standards and Professional Conduct
f. Cardiac Arrest in the OR
g. Chemotherapeutic Agents in the OR
h. *Code Blue Documentation*
i. Emergency Medical Screening of Patients on Hospital Property
j. Entering and ED Admission
k. HIV Testing Without Consents
l. In-House Transport of Ventilator Dependent Patients
m. Newborn Hearing Screening Program
n. Observation in the Operating Room
o. Organization-Wide Assessment and Reassessment of Patients
p. Patient Visitation Rights
q. Pre and Post Operative Anesthesia Visits
r. Standard of Care – The NEST
s. Standard of Patient Care in the Perinatal Unit

B. Annual Approvals (*action items*)

a. ER Service Critical Indicators
b. Medicine/Intensive Care Service Critical Indicators

C. Complaints and Adverse Events reporting form for Adventist Health telemedicine providers (*action item*)

D. Internal Medicine Core Privilege form – revision (*action item*)

E. Medical Staff Appointments/Privileges (*action items*)

a. Robert Nathan Slotnick, MD (perinatology) – Provisional Consulting Staff

b. Michael H. Abdulian, MD (orthopedic surgery, Adventist Health) – Provisional Consulting Staff

c. Sarkis Kiramijyan, MD (interventional cardiology, Adventist Health) – Provisional Consulting Staff

d. Sun I. Kim, MD (urology) – Provisional Consulting Staff

e. Erik J. Maki, MD (radiology, Tahoe Carson Radiology) – Provisional Consulting Staff

f. John Y. Erogul, MD (radiology, Tahoe Carson Radiology) – Consulting Staff

g. Edmund P. Pillsbury III, MD (radiology, Tahoe Carson Radiology) – Consulting Staff

F. Telemedicine Staff Appointment/Privileges – credentialing by proxy (*action items*)

As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined and allowed by 42CFR 482.22, the Medical Staff have chosen to recommend the following practitioners for Telemedicine privileges relying upon Adventist Health's credentialing and privileging decisions.

a. Talha Khawar, MD (rheumatology, Adventist Health) – telemedicine staff

b. Leon Kujmanian, MD (endocrinology, Adventist Health) – telemedicine staff

G. Medical Staff Resignations (*action item*)

a. Bishop Radiology Group

i. Arash Radparvar, MD – effective 2/12/18
ii. Young Song, MD – effective 2/12/18
iii. William I. Feske, MD – effective 2/12/18
iv. Eric W. Wallace, MD – effective 2/12/18
v. David Y. Kim, MD – effective 3/22/18

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Accutest Rapid Mono Test	
Scope: Outpatient Clinics	Manual: Lab- Point of Care
Source: Lab Coordinator	Effective Date:

I. INTENDED USE

The Accutest Rapid Mono Test is a rapid test for the visual, qualitative detection of heterophile antibodies specific to Infectious Mononucleosis (IM) in human whole blood. The test is categorized as a waived test if capillary finger stick whole blood is used as specimen. The test kit is intended as an aid in the diagnosis of IM in patients with characteristic clinical symptoms, and is intended for professional laboratory use only.

II. PRINCIPLE

The Accutest Rapid Mono Test has been designed to detect IM through visual interpretation of color development in the test device, which is a sandwich solid phase gold conjugate immunoassay. The test device contains a membrane strip, which is pre-coated with heterophile antigens on the test band region and goat anti-mouse antibody on the control band region. The anti-human IgM antibody-colloidal gold conjugate pad is placed at the end of the membrane. A mixture of colloidal gold conjugate together with the sample and developer buffer will move along the membrane chromatographically by capillary action. When the IM heterophile antibodies are present in the patient sample, the mixture will migrate to the test band region and form a visible line as the antibody complexes with the heterophile antigen. When IM heterophile antibodies are absent from the sample, no visible color band will form on the test line region. Therefore, the presence of a colored band on the test line region indicates a positive result. A colored band will always appear at the control region. This control band serves as a procedural indicator for the proper performance of the test and the device.

III. MATERIALS, EQUIPMENT, AND REAGENTS

A. Reagents and materials provided

- Individually wrapped test devices with transfer pipettes
- Developer buffer
- Mono Negative control
- Mono Positive control

B. Materials required but not provided

- Gloves
- Skin cleansing product e.g. alcohol swab
- Single use sterile lancet
- Sterile gauze or cotton
- Timer

IV. STORAGE AND STABILITY

The test kit should be stored at room temperature (15-30°C) in the sealed pouch for the duration of the shelf-life.
Note: Do not mix reagents from different lots

V. SPECIMEN COLLECTION

A. Acceptable specimens

1. Fresh capillary whole blood sample (finger stick)

B. Collection
1. Finger stick procedure
Select the finger site for puncture (use middle or ring finger not recently punctured)
a. Enhance blood flow to the selected puncture site
- Warming the site
- Instructing the patient to flex and move the arm, wrist, hand and fingers while you are assembling your supplies and preparing the system for testing
- Positioning the intended puncture site below heart level
- Gently massaging in an outward (distal) direction from the palm and the base of the finger to the fingertip

b. Clean the puncture site by means of appropriate cleansing product e.g. alcohol swab
c. Allow the site to air dry completely before puncturing
d. Advise the patient of imminent puncture
e. Squeeze the end of the fingertip and pierce with a sterile lancet
f. Wipe away the first drop of blood with sterile gauze or cotton
g. Hold the sample transfer pipette horizontally and touch the tip of the pipette to the second drop of sample.
h. Collect blood up to the red fill line (25 uL).

Note: The sample transfer pipette has an air vent positioned on the side wall of the pipette to provide automatic air venting and sample volume control. Do NOT squeeze the sample transfer pipette while filling. Avoid air bubbles.

VI. PROCEDURE

A. Test procedure
1. Gloves should be worn when handling patient specimens
2. Remove the test device from its protective pouch. Label the device with patient or control identification
Note: Do NOT open pouches until ready to perform the assay
3. Add specimen to sample well
- Align the tip of the pipette over the upper area of the sample well (S) of the test device
- Slowly squeeze the bulb until a hanging drop forms and touch this drop to the sample pad

4. Immediately add 3-4 drops of developer buffer into the lower end of the sample well (S).
5. Read results at 8 minutes.
Note: Do NOT read the result after 15 minutes

B. Internal QC procedure
1. Internal procedural control
A procedural control is included in the test. A colored band appearing in the control region (C) is considered an internal procedural control, indicating proper performance and reactive reagents.
2. Internal negative control
A clear background in the result window is considered an internal negative control. The test is invalid if the background fails to clear and obscures the reading of the test result.

C. External QC procedure
External QC should be run once for each untrained operator and once for each new shipment/new lot of kits and every 30 days thereafter.

1. Positive control
   - Follow the steps in A.1-A.2
   - Fill transfer pipette to the black fill line (10 uL)
   - Add the positive control into the sample well using the provided transfer pipette by holding the pipette in a vertical position
   - Immediately add 3-4 drops of developer buffer
   - A positive signal is indicated by the development of two pink-red bands in the test region (T) and the control region (C)
2. Negative Control
   - Follow the steps in A.1-A.2
   - Add the negative control into the sample well using the provided transfer pipette by holding the pipette in a vertical position
   - Immediately add 3-4 drops of developer buffer
   - A negative signal is indicated by the development of only one pink-red band in the control region (C)

VII. RESULT INTERPRETATION

A. **Positive result**: Two pink-red colored bands appear, one in the control region (C) and one in the test region (T).
Note: When testing with strong positive samples, the intensity of the control band may be lighter than expected. Comparison of the line intensity is not recommended

B. **Negative result**: Only one pink-red colored band appears in the control line region (C). No apparent faint pink or red colored band on the test line region (T).

C. **Invalid result**: A total absence of pink colored bands in both regions is an indication of procedural error or that possible test reagent deterioration has occurred.

VIII. LIMITATIONS OF THE PROCEDURE

A. This test kit is to be used for the qualitative detection of IgM antibodies to IM heterophile antigen. A positive result suggests the presence of IgM to heterophile antigen.
B. It should only be used for symptomatic individuals suspected of having IM. Diagnosis of IM should be made by confirmation with other clinical findings.
C. A negative result does not rule out the possibility of IM because the antibodies to heterophile antigen may be absent or may not be present in sufficient quantity to be detected. Approximately 50% of children under the age of 4 who have IM may test as IM heterophile antibody negative.
D. False positive results can occur in 2-3% of patients due to persistent levels of heterophile antibodies long after primary illness.

E. IM heterophile antibodies have been associated with disease states other than IM, such as leukemia and rheumatoid arthritis.

IX. REFERENCES

1. Accutest Rapid Mono Test package insert P-5211-A

Approval	**Date**
Medical Director of the Laboratory	12/18/2017
CCOC	1/22/18
Medical Services Committee	1/25/18
Medical Executive Committee	2/6/18
Board of Directors	
Last Board of Directors Review	

Developed: 12/17
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Admission Procedure and Care of Newborn*	
Scope: Perinatal	Manual: Discharge, Perinatal - Admission, Transfer Documentation (ADT)
Source: Manager of Perinatal Department	Effective Date: 12/98

PURPOSE:
To ensure a safe transition after delivery, and to maintain optimal patient safety while admitting, caring for, and discharging a newborn. To provide guidelines during the transfer of a newborn to another facility.

POLICY:
A qualified Perinatal Unit RN shall oversee the initial or ongoing stabilization of the newborn. A qualified RN or LVN with current NRP certification may care for a neonate at delivery. A qualified Perinatal Unit RN or LVN, cross trained, or float trained RN or LVN may take a neonatal patient assignment, including admission and discharge. A qualified Perinatal RN will care for any neonate needed transfer to a higher level of care.

Perinatal nurses will use the nursing process in the care of patients including: assessment, interpretation and diagnosis, interventions, and evaluation. Licensed and unlicensed assistive personnel may assist in the nursing process by collecting assessment data, and orienting the patient and her family to the hospital/unit environment.

All discharge plans will be coordinated with the provider's plan of care and any concerns will be discussed with the provider in a timely manner. The Patient's needs and discharge planning shall be addressed throughout stay.

PROCEDURE:
1. Admission upon vaginal birth:
    a. Perform Hand Hygiene. Gloves should be worn when handling infant before the first bath, when changing diapers, or during procedures.
    b. Upon vaginal birth, place infant skin-to-skin on mother's chest. Dry and stimulate infant, following NRP guidelines. If additional resuscitation required per NRP, infant may be placed on infant warmer. When/if infant is stable, infant should be returned to mother's chest for skin to skin contact. If mother is unavailable for skin to skin contact due to medical necessity, skin to skin may be performed with mother's partner or other caregiver. If alternate caregiver unavailable, infant may remain on warmer on in bassinette.
    c. An initial assessment will be performed upon birth; the admission assessment will be performed upon 2 hours of birth, or when infant's stabilization is complete.
    d. Assign APGAR scores at 1 and 5 minutes. If the five-minute APGAR score is less than 7, additional scores should be assigned every 5 minutes for up to 20 minutes or until APGAR score is 8 or above.
    e. Observe infant for signs of hypoglycemia or screen for indications for blood glucose monitoring. Follow *Blood Glucose Monitoring* Policy.
    f. Vital signs (temperature, respirations and pulse) shall be taken per MD orders, after initial heart rate assessments and NRP resuscitation if needed. Temperatures shall be taken via axillary method. Spot checking of infant condition may be performed more frequently at RN's discretion and is encouraged.
    g. Prophylactic eye treatment and Vitamin K injection will be administered as ordered by the MD.
    h. If the infant's temperature is less than 97.7 degrees F, assure infant is skin to skin (if available. If unavailable, place under radiant warmer), dry, and cover with a warm blanket, and reassess. If infant's temperature remains less than 97.7 in 15 minutes, consider further warming measures, including placing infant on infant warmer, for further assessment and monitoring.
    i. Infant measurements and weight shall be delayed until initial skin to skin bonding is complete after a minimum of one hour, unless such information is needed promptly for medical needs.

j. Upon completion of initial skin to skin contact, infant shall be weighed on an infant scale. All infant weights shall be taken naked, without a diaper, and recorded in grams in the electronic medical record.
k. Measure the infant's length from the crown of the head to the sole of the feet using a paper measuring tape. Record the length in inches in the electronic medical record.
l. Measure the head and the chest circumferences. Record in inches in the electronic medical record.
m. Fill out crib card with all information complete, and affix to infant bassinette.
n. Infant baths shall be delayed for at least 24 hours. Parents will be educated about the benefits of a delayed bath. Earlier or later baths may be done if medically indicated or per mother's request.
o. Mothers and caregivers will be encouraged to keep infant skin to skin as much as possible. If infant is not skin to skin, the infant shall be appropriately swaddled to maintain temperature WNL.
p. Leave umbilical area and clamped cord stump clean, dry and uncovered. Clamp may be removed once cord is dry, and before discharge home.
q. Attach infant security band, and infant/mother bands. Follow *Infant Security* Policy and Procedure.

2. Special consideration for cesarean birth:
    a. Newborn care upon birth via cesarean section shall follow the same process as for vaginal delivery with the following additions:
        i. Cesarean births shall be attended by a minimum of one Perinatal RN and one RT certified in NRP to care for infant.
        ii. Upon cesarean birth, place infant on warmer via sterile technique, and follow NRP guidelines until infant stable. Assign APGAR scores at 1 and 5 minutes. If the five-minute APGAR score is less than 7, additional scores should be assigned every 5 minutes for up to 20 minutes or until APGAR score is 8 or above.
        iii. If Perinatal unit staffing allows, and if infant is stable, mother's condition is stable per anesthesia provider, and if mother will tolerate it, place the infant skin to skin on mother's chest in the OR. Perinatal RN or LVN shall remain present during skin to skin contact in the OR. Infant shall remain skin to skin until mother is ready to go to PACU or per mother's request and condition. When mother is ready to move to recovery, the RN shall accompany infant and support person (if available) to PACU to await mother. Infant may be placed skin to skin with support person in PACU until mother arrives and is stable and ready for infant to return to her chest. Infant may remain skin to skin as long as mother desires and condition remains stable until mother ready to return to Perinatal unit.
        iv. Continue to care for infant as per vaginal delivery (see 1, above).

3. Admission of infant after initial discharge:
    a. Infants up to and including 27 days shall be readmitted to the Perinatal unit. Infant older than 27 days shall be readmitted to the Pediatric unit. Exceptions may be made on individual bases per diagnosis.

Title: Admission Procedure and Care of Newborn*	
Scope: Perinatal	Manual: Discharge, Perinatal - Admission, Transfer Documentation (ADT)
Source: Manager of Perinatal Department	Effective Date: 12/98

b. Upon admission a qualified Perinatal, float trained, or cross-trained RN shall perform a head to toe assessment of the infant, including naked weight, temperature, pulse and respirations. After initial assessment a qualified LVN may assume patient care.
c. Attach infant security band, and infant/mother bands. Follow *Infant Security* Policy and Procedure.
d. All reasonable efforts will be made to accommodate the infant's mother or caregiver to room-in with the infant. Include parents in the care of the child, being considerate in approach. Parents are to be encouraged to become involved in the child's care. Explain all treatments and procedures the parent and patient should anticipate.
e. Refer to physician orders for frequency of vital signs and weights.
f. Refer to *Breastfeeding and Supplementation* Policy and Procedure for infants readmitted due to weight loss and as needed.

4. Transfer to a higher level of care:
    a. Complete all paperwork as specified on the *Neonatal Transfer Checklist*.
    b. Care of the neonate shall be performed by a NIHD Perinatal RN until the transport team arrives and assumes care of the patient.
    c. Documentation should include a physician order and accepting provider and facility. The house supervisor should be involved to assist in coordination of the transfer.
    d. If the newborn Hearing Screen, Newborn Screen, or bili check were not completed prior to transfer, documentation must be made in the EHR and on official forms as needed (refer to Neonatal Transfer Checklist in Lippincott *Transfer to acute care facility* procedure).

REFERENCES:

1. http://pediatrics.aappublications.org/content/138/3/e20161889
2. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2994120/

CROSS REFERENCE P&P:

1. Admission, Discharge, Transfer of Patients: Continuum of Care
2. Breastfeeding and Supplementation
3. Infant Security Policy and Procedure
4. Blood Glucose Monitoring
5. Transfer to acute care facility (Lippincott procedure)

Approval	**Date**
Peri-Peds	12-15-17
CCOC	12/18/17
MEC	2/6/18
Board	

Developed: 12/98
Reviewed:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Admission Procedure and Care of Newborn*	
Scope: Perinatal	Manual: Discharge, Perinatal - Admission, Transfer Documentation (ADT)
Source: Manager of Perinatal Department	Effective Date: 12/98

Revised: 12/98; 2/2001; 12/2003jk; 01/08jk, 6/11jk, 9/12jk; 11/2015 jb
Supersedes:
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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Admission, Transfer, and Discharge care of the Obstetrical Patient	
Scope: Perinatal	Manual: Perinatal
Source: Manager of Perinatal Department	Effective Date: 12/17/15

PURPOSE: To maintain optimal patient safety while observing, monitoring, admitting, and discharging obstetrical patients in the Perinatal unit. To provide guidelines for care during their transition of care within the LDRP Perinatal unit.

POLICY
A qualified Perinatal Unit RN will assess and monitor all obstetrical patients presenting to the hospital for possible admission and/or treatment. Perinatal nurses will use the nursing process in the care of patients including: assessment, interpretation and diagnosis, interventions, and evaluation. Licensed and unlicensed assistive personnel may assist in the nursing process by collecting assessment data, and orienting the patient and her family to the hospital/unit environment. The Perinatal nurse collects and interprets all fetal monitoring data.

A qualified Perinatal Unit RN* will initiate and manage the care of all outpatients and labor patients following established hospital procedures coordinate with physician or CNM orders. A qualified Perinatal Unit LVN may assist the patients in labor.

A qualified RN or LVN** may care for postpartum patients. All discharge plans will be coordinated with the provider's plan of care and any concerns will be discussed with the provider in a timely manner. The Perinatal Unit staff nurse will begin evaluating needs and initiating the patient's discharge plan on admission.

*A qualified Perinatal Unit RN who has successfully completed unit orientation, intermediate or advanced fetal monitoring class and who is able to independently care for intrapartum patients after evaluation completed by Perinatal Unit Manager or Assistant Manager.
**A qualified RN or LVN who has successfully completed the designated unit orientation, and required certifications stated on their job descriptions.

PROCEDURE FOR OBSTETRICAL ADMISSION:

Each patient will be seen by a Perinatal Unit Nurse within 15 minutes of the patient's arrival in the unit. At this time at least a minimal assessment including maternal vital signs and Fetal Heart Tones (FHT) will be taken and recorded

A. On arrival to the unit, follow physician orders. If patient appears to be in active labor, complete OB assessment first.
B. Complete the obstetrical assessment, as follows:
    1. Apply the EFM to obtain baseline fetal monitor strip. If the patient refuses the application of the fetal monitor, auscultate FHR with Doppler and then perform vaginal exam to assess status, unless contraindicated.
    2. Obtain a complete set of the patient's vital signs and document.
    3. Evaluate membrane status. Spontaneous rupture of membranes may be verified by a sterile speculum exam, laboratory test, or fern test, per orders. Perform a sterile vaginal exam to determine dilatation, effacement, station, and presenting part, according to provider's orders, and document.
    4. Obtain a 20-minute baseline fetal monitor strip. Evaluate strip or palpate uterus for frequency, strength and duration of contractions. Evaluate fetal status including FHR baseline, presence of variability and periodic changes.
    5. Notify MD or CNM of patient's status.

6. Review all available prenatal data, gather a complete history, and perform an initial assessment within 1 hour.
7. Review laboratory data and collect any ordered laboratory specimens.
8. Document ongoing nursing assessments and care provided.
9. Document a personalized nursing care plan, and update as needed, directed by patient's status.

C. If the physician or the C.N.M. discharges the patient, discharge patient in the HIS (computerized hospital information system). Instruct the patient to return to the hospital if any of the following occur:
   1. Membranes rupture;
   2. Contractions increase in strength or in frequency;
   3. Vaginal bleeding occurs (bright red or heavier than normal menses);
   4. Any decrease in fetal movements.

D. If the patient remains in the hospital as a labor patient, complete all required forms and consents when appropriate to the patient's condition.

E. A Perinatal Staff R.N. will be assigned to monitor a actively laboring patient. The patient's vital signs, FHR and labor progress will be assessed at regular intervals according to orders and patient condition.

PROCEDURE FOR OBSTETRICAL TRANSFER:

If a patient needs to be transferred to the ICU or Medical/Surgical Unit based on medical necessity, communication with the provider and house supervisor needs to be initiated for correct unit placement based on the patient's status. Physician order needs to be on the EMR, and report given to the accepting unit's nurse.

If a patient needs to be transferred to a facility for a higher level of care, refer to the transfer checklist to complete the transfer. Documentation should include a physician order and accepting provider and facility. The house supervisor should be involved to assist in coordination of the transfer.

PROCEDURE FOR OBSTETRICAL DISCHARGE:

A. Have the patient complete the postpartum self-assessment sheet to prepare for discharge.
B. Arrange the time and the method of discharge with the patient, and discuss all necessary follow-up care, including the follow-up NEST visit for postpartum discharge.
C. Check the doctor's order sheet for the discharge order and for special follow-up or prescription orders; fax prescriptions to the pharmacy of the patient's choice.
D. For postpartum patients: review the patient's completed postpartum self-assessment checklist and complete postpartum and infant care teaching with the patient.
E. Complete and send high risk referral if needed; arrange for any special home discharge care/community referrals (i.e. home health, WIC etc.) as needed; involve the social worker in the patient's admission and discharge, as appropriate, as soon as possible after the need is identified.
F. Assist the patient in dressing and in packing her belongings. Make sure to check all closets, all drawers and the bedside table. Return all valuables, when applicable.
G. Complete the care plan in the EMR, and actions taken for follow up on any remaining problems.

H. Discharge the patient in the computer, complete infant discharge form, and notify admitting. Before the patient leaves clear with admitting when possible to make sure that all the forms are signed.
I. When everything is in order, the patient may ambulate to her car. However, if the patient requests, she may be transported in a wheelchair. If the mother is in a wheel chair she may hold the infant but otherwise all infants will be carried out by hospital nursing staff. Have a parent place the infant in the infant car seat and help the mother into the vehicle as needed. Document the condition of the patient, mode of transportation for discharge, time of discharge and who accompanied the patient at discharge.
J. Disassemble the completed chart and place in the Medical Records basket.

DOCUMENTATION:
As outlined above under Procedures.

Resources:
American Academy of Pediatrics and American College of Obsetricians and Gynecologists. (2009). *Guidelines for perinatal care* (6th ed.). Elk Grove Village, IL: Authors

Association of Women's Health, Obstetric and Neonatal Nurses. (2009). *The role of unlicensed assistive personnel (nursing assistive personnel) in the care of women and newborns* (AWHONN Position Statement). *JOGGN, 38,* 745-747.

CROSS-REFERENCES HOSPITAL POLICIES:
1. Admission, Discharge, Transfer of Patients: Continuum of Care
2. Standard of Care – Perinatal
3. Lippincott procedure: "Obstetric triage of patients"
4. Lippincott procedure: "Labor, care during"
5. Lippincott procedure: "Sterile Vaginal Examination"
6. Lippincott procedure: "Transfer to acute care facility"
7. Lippincott procedure: "Non-Stress Test"
8. Quick Check policy

Approval	**Date**
Peri-Peds	12/15/17
CCOC	12/18/17
MEC	2/6/18
Board of Directors	
Last Board of Director review	2/15/17

Developed: 8/97
Reviewed:
Revised: 01/01; 01/03; 1/2004, 6/11jk, 7/15jb; 11/2015 jb; 12/2017sg

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: AIDS/HIV Testing and Orders	
Scope: NIHD	**Department:** CPM-Infection Control –Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist Manager	**Effective Date:** July 2017

PURPOSE:

To provide guidance for employees and medical staff on the legal requirements and responsibilities for Human immunodeficiency virus (HIV) consent and testing~~testing is essential for improving the health of people living with HIV and reducing new HIV infections: once diagnosed, persons with HIV can be linked to care and learn how to prevent transmission to others. This policy also outlines the procedure for obtaining HIV test consent and disclosing test results to a patient.~~

POLICY:

1. Per California law, NIHD does not require written consent for HIV testing.
2. Patients must be verbally informed of the intent to test and given the opportunity to consent or refuse testing.
3. No one may be forced to have an HIV test.
   a. Exception: Law enforcement officers may obtain a court order for HIV testing without consent; HIV testing may be performed on blood already collected from the patient in cases of healthcare worker's exposure events.
4. If a person is incompetent, written consent for the test, as well as disclosure of the results, may be given by the patient's parents, guardian, conservator, or other person lawfully authorized to make health care decisions for the patient.
   a. A minor, twelve years or younger, is considered incompetent for the purpose of consenting to HIV testing.
5. HIV results for the patient may be known to healthcare workers involved in the care and treatment (those who "need to know") of HIV tested patients.

PROCEUDRE:

~~1. Written consent is **NOT** required for HIV testing.~~
~~2. Per California Health and Safety code 125085, pertaining to the pregnant patient reference: HIV Prevention Program Perinatal Policy.~~
~~3.~~1. ~~Per~~ California Health and Safety (H&S) Code ~~Section~~ section 120990 (a), a medical care provider must:
   ~~a)~~ Inform the patient that an HIV test is planned;
   a.
   b. ~~b)~~ Provide information about the test;
   c. ~~c)~~ Inform the patient of the many treatment options available to people who test HIV positive;
   ~~d)~~d. Inform the patient that a person who tests HIV negative should continue to be routinely tested for HIV; and
   ~~e)~~e. Inform the patient he or she has the right to decline the test. The refusal must be documented in the patient's medical record.

California Health and Safety Code (H&S) section 125090 states HIV testing for pregnant women is routine prenatal care. See NIHD HIV Prevention Program, Perinatal Policy.

2.
3. ~~4.~~ Per California Health and Safety (H&S) 125090 for pregnant women the medical provider shall ensure the woman is informed:
   a. ~~a)~~ Of the intent to perform a HIV test;~~.~~
   b. ~~b)~~ The routine nature of the test;
   c. ~~c)~~ The purpose of the testing;

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d. ~~d)~~ The risks and benefits of the test;
e. ~~e)~~ The risk of perinatal transmission of HIV;
f. ~~f)~~ The approved treatments are known to decrease the risk of perinatal transmission of HIV;~~N~~
g. ~~g)~~ That the patient has the right to decline the testing.

(An information sheet with all of the required information is available at the California Department of Public Health (CDPH) Web site at: www.cdph.ca.gov/pubsforms/forms/Pages/AIDS.aspx).

~~5. No one can be forced to have an HIV test. **(Exception: law enforcement officers may obtain a court order for HIV testing without consent; and HIV testing can be performed on blood already collected from the patient in case of a healthcare worker exposure event).**~~

~~6. If a person is incompetent, written consent for the test, as well as disclosure of results, may be given by the patient's parents, guardian, conservator, or other person lawfully authorized to make health care decisions for the patient. A minor, twelve years or younger, is considered incompetent for the purpose of consenting.~~

~~7. HIV results (of patients) may be known to healthcare workers involved in the care and treatment of those patients.~~

~~8.~~ Written authorization from the patient is not required to disclose HIV results to healthcare workers providing direct patient care.

4.

5. ~~9.~~ Written authorization from the patient is required to release HIV results to other individuals or insurance companies. *See HIV Test Results – Consent for Permission to Reveal* (NIHD policy and procedure).

HIV orders do not need to be on a separate order page, separated from other electronic orders, or in the confidential area of the patient chart.~~10. An HIV order may be written as any other order; it does not need to be on a separate order sheet or in the confidential packet.~~

6.

7. ~~11.~~ All information pertaining to HIV results will be kept in a packet marked "confidential" in back of the patient's chart or in the confidential area of the patient's electronic record.
   a. ~~(~~*This serves as a flag to the Medical Records Department, so that the HIV results are not provided to payors without the written consent of the patient – still required in the law.*~~).~~
   ~~8. Stamp the envelope with patient's name.~~

~~12.~~ The HIV packet (~~with the results of the test~~if there are paper results) is kept with the patient's medical record at all times. Electronically, the result is located in the confidential portion of the electronic record.

9. If there has been a potential exposure to a healthcare worker, please see *NIHD Policy Initial Evaluation of Exposure Incident.*

~~**GENERAL INFORMATION**:~~

~~1. Acquired Immune Deficiency Syndrome (AIDS) is a contagious disease complex caused by infection with the Human Immunodeficiency Virus (HIV).~~
~~2. HIV infection is characterized by dramatic disruption of the body's normal immune response.~~
~~3. Standard Precautions practiced with **all patients** will protect the Healthcare Worker (HCW) and not place her/him at increased risk for acquiring AIDS or other blood borne diseases.~~
~~4. Accurate knowledge regarding AIDS/HIV is essential for optimum safety of both HCW and patient.~~

~~**II. TRANSMISSION:**~~

~~1. Transmission of AIDS/HIV is known to occur in three ways:~~
~~a. Sexual contact~~

b. By infected blood entering another person through non-intact skin, mucous membrane, or parenterally.
c. Perinatal

2. Fluids that have been linked to the transmission of HIV (and HBV) are:

blood	cerebrospinal fluid	pericardial fluid
blood products	synovial fluid	amniotic fluid
semen	pleural fluid	peritoneal fluid
vaginal secretions	saliva -only if it contains blood	breast milk - transmission to babies only
Exudative or other tissue fluid form burns or skin lesions		

Note: HIV has been isolated from urine, tears and saliva and is likely to be isolated from other body fluids, excretions and secretions. These fluids have not been found to transmit HIV because they contain very minute levels of the virus.

III STANDARD PRECAUTIONS:

Many HIV infected persons are sometimes unknown/undiagnosed for long periods of time; it is imperative to practice Standard Precautions on **all** patients at **all** times.

IV VIROLOGY:

a. The presence of HIV antibody indicates infection with HIV virus.
b. Appearance of HIV antibody may not occur for 3-6 months post infection.
c. HIV tests will be negative until antibodies develop; infection may be transmitted during this time.
d. Outside the body, the AIDS virus is very weak and does not survive well. It is easily killed by many disinfectants.

V. SYMPTOMS:

1. Seroconversion - development of HIV antibodies in the blood; usually occurs between 3 - 6 months after infection has occurred. At this time, mild flu like symptoms may develop.
2. Symptoms of AIDS disease may not develop for many years, but the virus may still be transmitted to others during this time.

VI. THE LAW: AIDS and HIV+

2. Governor Arnold Schwarzenegger has signed into law Senate Bill 699 (Soto), which requires health care providers and laboratories to report cases of HIV infection by name to local health departments. The law also requires local health departments to report unduplicated HIV cases using patient name to the California Department of Health Services. The new reporting requirements became effective immediately upon the Governor's signature on April 17, 2006.
3. Disclosure of HIV test results still requires a written authorization from the patient (as do all medical records disclosures), BUT inclusion of a person's HIV test result in his/her medical record is not considered a disclosure under Health and Safety Code Section 120980. Health and Safety Code Section

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120985 permits a physician who orders an HIV test to record the results in the patient's medical record, or otherwise disclose it without written authorization to the patient's health care providers for the purpose of diagnosis, care, or treatment of the patient.

4. Health and Safety Code Section 121010 also allows disclosures of an individual's HIV test results without prior authorization in several other instances, such as to an agency **designated officer** of an emergency response employee (EMS, Law Enforcement, etc.) who has had a possible exposure incident and from that designated officer to the employee. (It will be expeditious in these cases to identify, on the lab requisition, the designated officer who should receive a copy of the results)
5. If the patient is actually diagnosed or ill with AIDS (not just HIV+) this information may now legally be a part of and be mentioned in the medical record.

VII HIV ORDERS AND INFORMATION[RC1]:

1. Written consent is **NOT** required for HIV testing.
2. Per California Health and Safety code 125085, pertaining to the pregnant patient reference: HIV Prevention Program Perinatal Policy.
3. Per California Health and Safety (H&S) Code Section 120990 (a), a medical care provider must:
   a) Inform the patient that an HIV test is planned;
   b) Provide information about the test;
   c) Inform the patient of the many treatment options available to people who test HIV positive;
   d)Inform the patient that a person who tests HIV negative should continue to be routinely tested for HIV; and
   e)e) Inform the patient he or she has the right to decline the test.
   (An information sheet with all of the required information is available at the California Department of Public Health (CDPH) Web site at: www.cdph.ca.gov/pubsforms/forms/Pages/AIDS.aspx).
4. No one can be forced to have an HIV test. *(Exception: law enforcement officers may obtain a court order for HIV testing without consent; and HIV testing can be performed on blood already collected from the patient in case of a healthcare worker exposure event).*
5. If a person is incompetent, written consent for the test, as well as disclosure of results, may be given by the patient's parents, guardian, conservator, or other person lawfully authorized to make health care decisions for the patient. A minor, twelve years or younger, is considered incompetent for the purpose of consenting.
6. HIV results (of patients) may be known to healthcare workers involved in the care and treatment of those patients.
7. Written authorization from the patient is not required to disclose HIV results to healthcare workers providing direct patient care.
8. Written authorization from the patient is required to release HIV results to other individuals or insurance companies.
9. An HIV order may be written as any other order; it does not need to be on a separate order sheet or in the confidential packet.
10. All information pertaining to HIV results will be kept in a packet marked "confidential" in back of the patient's chart (*this serves as a flag to the Medical Records Department, so that the HIV results are not provided to payors without the written consent of the patient – still required in the law*). Stamp the envelope with patient's name.
11. The HIV packet (with the results of the test) is kept with the patient's medical record at all times.

NORTHERN INYO HEALTHCARE DISTRICT
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~~**VIII POST EXPOSURE TESTING OF HEALTHCARE WORKER (HCW) AND SOURCE PATIENT**~~

1. ~~If an exposure to blood/body fluids has occurred, see policy, "Initial Evaluation of Exposure Incident." The following procedure should be followed by E.R. personnel and the Nursing Supervisor.~~
2. ~~To evaluate risk, utilize the Exposure Evaluation form to determine the source patient's infectious disease status and the severity of the exposure to the healthcare worker, and immediately consult the HIV PEPLINE Hotline **(1-888-448-4911)**~~
3. ~~Follow the recommendations of the HIV hotline, and/or refer the exposed healthcare worker to the ED physician for further evaluation and treatment.~~
4. ~~Obtain baseline HIV rapid test and Hepatitis C baseline test, from both the exposed healthcare worker and the source patient, as soon as possible following the exposure.~~
5. ~~Determine HCW's HBV vaccine / immunity status~~
   a. ~~If HCW is immune, no further workup on either patient or HCW is necessary~~
   b. ~~If HCW is not immune, order HB surface antigen on patient; ask lab to run ASAP~~
   c. ~~If HCW HBV status is unknown (i.e.; vaccine series not completed, order:~~
      i. ~~HB_s Antigen on HCW~~
      ii. ~~HB_s Antibody on HCW~~
      iii. ~~HB_s Antigen on source patient~~
   d. ~~If indicated by above HB_s results – follow NIH policy, "Hepatitis Prophylaxis / Needle Stick Policy"~~
6. ~~If both the HCW and the source patient have negative results, generally no further testing is necessary (consider consultation opinion of HIV Hotline)~~
7. ~~If HCW's baseline HIV is negative and source patient result is unknown, repeat titer at 6 weeks, 3 months, 6 months and possibly at 12 months; or per recommendations of HIV Hotline.~~
8. ~~If HCW's and/or source patient baseline HIV is positive, HCW is counseled and referred to personal physician and further treatment or care is based on test results.~~
9. ~~Post exposure testing is at all times the choice of the HCW; Refusal to be tested should be documented and signed by the HCW. Test results are obtained by the Employee Health Nurse or designee ICP. **Positive or equivocal test results must be interpreted and delivered to the HCW by a physician**.~~
10. ~~The HCW will be notified in writing of all findings and recommendations by the Employee Health Nurse, or designee ICP.~~
11. ~~During the follow up period – the HCW must be advised to consider precautions regarding safe sex, blood donations, pregnancy and breast feeding.~~
12. ~~Testing of the source patient should be done ASAP. False positive and negative results must be considered, and the HCW should be appropriately counseled. Special written consent from patient is **NOT** necessary; if patient refuses to have a baseline test, follow policy on "HIV Testing Without Consent."~~
13. ~~If a needlestick is incurred from a baby less than 15 months old, the HIV titer must be done on the mother, not the baby. If the baby has had blood transfusions, test the baby as well.~~
14. ~~The source patient HIV results may be known to the exposed HCW and Employee Health or designee.ICP.~~

~~**IX PATIENT EXPOSURE:**~~

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~~If a patient has an exposure to blood or other body fluid of a HCW or another person, the patient should be informed of the incident, and the same procedure outlined above for management of exposures should be followed for both the source person and the exposed patient.~~

~~X PROPHYLAXIS:~~

~~Post Exposure Prophylaxis (PEP) is individualized therapy based upon the clinical status of the source patient. The physician, together with the pharmacist, will determine the appropriate PEP regimen for the exposed employee. Physicians and pharmacists staffing the HIV Hotline are available for consultation. (See MMWR, September 30, 2005 - Update: Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis after this policy).~~

REFERENCES:

1. California Health and Safety Code Sections 1797.188, 120260-120263
2. MMWR, September 30, 2005 - Update: Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Post exposure Prophylaxis.
3. California Consent Manual, California Hospital Association, 2017
4. ~~"HIV Testing in Health Care Settings;"~~ California Department of Public Health. ~~January 2010.~~ (2017). HIV testing in Health Care Settings-Legal Background. Retrieved from https://www.cdph.ca.gov/programs/aids/Pages/OAHIVTestLegal.aspx ~~http://www.cdph.ca.gov/programs/aids/Documents/RPT2010_01HIVAIDSLaws2009_.pdf~~ https://www.cdph.ca.gov/programs/aids/Documents/CAHealthAndSafetyCode125090.pdf ~~(PDF of the document)~~ https://www.cdph.ca.gov/programs/aids/Documents/CAHealthAndSafetyCode120990.pdf
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~~7.~~

CROSS REFERENCE P&P

1. Initial Evaluation of Exposure Incident
2. Work Related Accidents/Exposures
3. Blood Borne Pathogen Exposure Control Plan
4. Reportable Disease located in Lippincott Procedures
5. HIV Testing without consent
6. HIV Prevention Program Perinatal
7. Infection Control Exposure Hotline

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: AIDS/HIV Testing and Orders	
Scope: NIHD	**Department:** CPM-Infection Control –Patient Care (ICP)
Source: Quality Informatics Nurse/Infection Preventionist Manager	**Effective Date:** July 2017

Approval	**Date**
CCOC	11/20/2017
Infection Control Committee	11/28/2017
Medical/ICU Committee	1/25/2018
Peri/Peds Committee	12/15/2017
ED Services Committee	1/10/2018
Medical Executive Committee	2/6/18
Board of Directors	
Last Board of Directors Review	

Developed: 3/91
Reviewed:10/96, 6/97, 9/99, 7/00, 4/03, 05/05, 08/07, 06/08, 9/12BS,
Revised: 5/2017 RC/PD
Supersedes:
Index Listings: AIDS, HIV, Testing,

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Anesthesia Clinical Standards and Professional Conduct	
Scope: Anesthesia Providers	Manual: Anesthesia, Medical Staff
Source: Chief of Surgery	Effective Date: 01/2001

PURPOSE:
To assure all peri-operative patients receive the same quality of care when undergoing a surgical intervention requiring an anesthetic.

POLICY:
1. The anesthesia provider shall test and calibrate the anesthesia machine and monitoring equipment prior to starting each case. Any fault or leakage is immediately corrected, or equipment is removed from service until appropriately repaired.
2. Patient identification and surgical consents are checked prior to the patient's being admitted to the operating room.
3. Elective procedures on infants, small children and patients with diabetes should be placed first on the operating room schedule and other procedures may be moved to facilitate this process. As soon as the anesthesia provider has completed his pre-operative visit and the surgeon is present the patient may be transported to the operating room. The first patient of the day should be transferred to the operating room by 07:30 am, subsequent procedures will be done on a "to follow" basis.
4. Emergency anesthesia care is provided by 24 hour coverage by anesthesia staff.
5. The anesthesia provider shall constantly attend and monitor the patient during anesthesia. The methods of monitoring used and the data obtained from them shall be recorded on the anesthetic record. Basic monitoring shall include: blood pressure, EKG, temperature, capnographic and oxygen saturation. Safety warning systems and alarms should be used.
6. The anesthesia provider shall review the patient's condition immediately prior to the induction of anesthesia.
7. The surgeon shall be present and available in the hospital prior to the induction of anesthesia and participate in the pre-anesthesia time-out for all non-emergent cases.
8 Patients are transported to the operating room on a gurney with the side rails up, and are not left unattended. Children may be carried to the "Red Line" by their parent with consent of anesthesia provider.
9. Only members of the operating team and authorized observers shall be present in the operating room during the administration of anesthesia and surgical procedure.
10. No flammable anesthetic agents will be used. All electrical equipment shall be properly grounded and attention paid promptly to the audiovisual electrical isolation monitor signals. All anesthetic waste gasses are scavenged through the suction system directly to the external environment.
11. Elective surgical patients who are to receive general or regional anesthesia should be **"NOTHING BY MOUTH"** as determined by the Guidelines for NPO Status. This does not apply to patients considered to be surgical emergencies. Exception to the regulation may be made by the anesthesia provider if, in his/her opinion, such an exception does not create an additional hazard to the patient.
12. Pre-operative medication shall be ordered or reviewed by the anesthesia provider responsible for each case and be specific for each patient.

Title: Anesthesia Clinical Standards and Professional Conduct	
Scope: Anesthesia Providers	Manual: Anesthesia, Medical Staff
Source: Chief of Surgery	Effective Date: 01/2001

13. Patients receiving anesthesia will have appropriate lab work on their chart. EKG, urinalysis and x-ray may be ordered at the discretion of the attending surgeon or anesthesia provider. For elective procedures all women of childbearing potential (from the onset of menses until the woman has not had a menstrual cycle in over a year) with intact tubo/ovarian/uterine anatomy will have an HCG (pregnancy test) unless they refuse. A copy of these records may be an acceptable substitute if the patient had these studies done elsewhere.
14. The postoperative status of the patient is evaluated on admission to and discharge from the post anesthesia recovery area. A verbal report will be given to the PACU RN upon patient arrival by the anesthesia provider providing care for that patient.
15. Anesthesia personnel will familiarize themselves with the methods of air exchange in the operating rooms.

DOCUMENTATION:
Documentation of patient care and monitoring utilized will be recorded on the anesthetic record.

REFERENCES:
TJC: PC 03.01.03, PC.03.01.07, PC.03.01.01
CMS: Operative & Invasive Procedures: §482.23(b)(3) §482.51(a)(1) §482.51(a)(2) §482.51(a)(3) §482.51(b)(3) §482.52(b) §485.639(b)(2),§485.639(b)(1) §485.639(b)(3), §482.51(b)(4) §485.639(d)

CROSS REFERENCE P&P:
NPO Guidelines; Observation in the Operating Room; Pre and Post Operative Anesthesia Visits; Preoperative EPT Testing Protocol; Preoperative Interview, Preoperative Medications; Preoperative Medication Guidelines; Preoperative Preparation and Teaching; Standards of Care in the PACU in the PACU

Approval	**Date**
STTA	1/24/18
MEC	2/6/18
Board of Directors	
Last Board of Directors Review	1/18/17

Developed:
Reviewed:
Revised: 01/01; 12/2011 BS, 10/21/12 PM, 11/17aw
Supersedes:
Index Listings: Standards and Professional Conduct Anesthesia / Conduct of Anesthesia/ Anesthesia Standards

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Cardiac Arrest in the OR	
Scope: Surgery	Manual: Cardiovascular, Circulation (OXC), Oxygen, Surgery - Respiratory
Source: DON Perioperative Services	Effective Date: 12/31/17

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. 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 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.

PROCEDURE:

NURSING RESPONSIBILITIES:

1. All nurses employed in the operating room must have Advanced Cardiac Life Support and Pediatric Advanced Life Support certificates. Nurses must have completed Advanced Life Support class if monitoring a patient without the presence of an anesthesiologist.
2. It is the responsibility of every nurse in the operating room to learn:
   - The location and use of emergency call buttons in each surgical suite.
   - Location and contents of emergency medications and supplies in each surgical suite.
3. Every nurse in the operating room must know location of the crash cart /defibrillator and be familiar with its functions.
4. Every nurse in the operating room must be able to operate defibrillator utilizing paddles/pads.
5. Every nurse in the operating room must be able to:
   - Prepare and provide emergency medications
   - Prepare, provide and apply as appropriate:
     1. IV solutions and administration sets
     2. Syringes, needles, IV catheters, tourniquet, blood collection tubes.
     3. Gloves, antiseptic solutions, dressings.
     4. Procedure trays
     5. Monitoring devices

RESPONSIBILITIES OF THE CIRCULATING NURSE:

It is the responsibility of the Circulating Nurse to
1. Page a Code Blue internall (Perioperative Unit only)
2. Call the House Supervisor to come immediately to Surgery
3. Obtain the Crash Cart/Defibrillator.
2. Assist in repositioning of patient as necessary.
3. Begin CPR as necessary.
4. Delegate the following responsibilities to other team members who respond (these include, but are not limited to):
   - Medication preparation
   - Defibrillator operation

Title: Cardiac Arrest in the OR	
Scope: Surgery	Manual: Cardiovascular, Circulation (OXC), Oxygen, Surgery - Respiratory
Source: DON Perioperative Services	Effective Date: 12/31/17

- Documentation (Resuscitation Record)

5. Control traffic, limiting personnel to those necessary to implement life saving measures.
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.

RESPONSIBILITIES OF SCRUB PERSON:

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. Documentation of cardiac arrest is accomplished on the appropriate form located on the Crash Cart.
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

REFERENCE: AORN: "Medication Safety" Recommendation III, "Positioning the Patient", "Information Management" Recommendation IV TJC: PC 03.01.01, 03.01.05, and NPSG 03.04.01 California Code of Regulations, Title 22 Standards: 70217, 70223 b #3 & e, 70225, 70227, 70233, 70237

Approval	**Date**
CCOC	11/20/17
STTA	1/24/18
MEC	2/6/18
Board of Directors	
Last Board of Directors Review	1/18/17

APPROVAL NOT NEEDED:
INDEX LISTINGS: Cardiac Arrest Operating Room / Arrest in Operating Room
Revised 02/01 BS; 7/2011 BS & TS, 11/17aw
Reviewed:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Chemotherapeutic Agents in the OR	
Scope: Surgery	Manual: Surgery, Medication (MED)
Source: DON Perioperative Services	Effective Date: 10/31/17

PURPOSE:
To provide guidelines for the safe handling and administration of chemotherapeutic agents in the OR

POLICY:
Strict adherence to the procedure will assure the safety of all personnel and patients. Patient injury can occur if the chemotherapy agent is not controlled on the field during administration.

Only the attending physician shall administer the chemotherapeutic agent and the scrub personnel shall ensure that strict compliance with handling is followed

All agents shall be mixed by the pharmacy. The **agent shall be checked by both the circulating RN, an additional RN or physician** and the scrub personnel that are to be in the room during the procedure.
** Chemotherapy agents must be checked with two licensed personnel.

PRECAUTIONS:

Chemotherapeutic agents are toxic compounds. Many antineoplastic agents are known to cause carcinogenic, mutagenic or tetragogenic effects. On direct contact some of these agents may cause irritation to the skin, eyes, mucous membranes, ulceration and necrosis of tissue. The potential hazards involved with handling of antineoplastic agents are associated with inhalation or skin contact with these agents.

All personnel shall wear the required protective equipment such as gloves, barrier gown and face protection when handling a chemotherapeutic agent, instruments, sponges and other accessories contaminated with the chemo agent.

During the procedure when the agent is being applied to the desired area, the scrub personnel must be aware that the agent is harmful to surrounding tissue. The surgeon is responsible for the application and irrigation of the agent.

Use the same precautions during disposal. Discard items contaminated with the agent into a Biohazard container.

PROCEDURE:

Upon scheduling of a case that requires the use of a chemotherapeutic agent, the operating room shall notify pharmacy of the date of surgery and the agent needed. A doctor's order is required.

Use of 5FU during a Trabeculectomy procedure:

5FU 50mg/ml 1ml dose is required where a cellulose sponge soaked with 5FU is held on the bed in the eye.

1. The drug, when arriving in the unit, from pharmacy will be in a vial.
2. It will be checked by the circulating RN and the scrub nurse to assure appropriate drug, dose and strength.

3. The agent will be transferred from the circulating nurse to the scrub nurse, using sterile technique by drawing the prescribed amount from the vial with sterile needle and labeled syringe to be used on the field.
4. The syringe will then be recapped and kept in a separate basin away from all instruments and/or drugs on the field.
5. The sterile syringe will by used by the physician and then put back directly into the basin. Sponges and any instruments or accessories used will also be placed in the basin to keep separate. Gloves will be changed by scrubbed personnel.
6. At the termination of the case all disposable items contaminated with the agent will be disposed of in a Biohazard Container in the room to be burned.
7. Any leftover medication in the vial/syringe will be placed in a plastic bag and returned to pharmacy for disposal.
8. All instruments will be kept separate and the instrument person notified of contaminated instruments.

Use of Mitomycin C (Urology, Bladder Tumor, S/P TURBT)

The drug comes in a plastic 60ml syringe with a stopcock attached and a separate sterile Christmas tree adapter. It has a warning label sticker to alert personnel that the contents are hazardous. It is contained in a leak proof zip-lock baggie.

1. Observe chemo precautions and safe handling and disposal of Mitomycin C (See precautions).
2. Verify drug name, dose, patient's name, route and time with the surgeon and scrub personnel.
3. The sterile Christmas tree adapter (catheter adapter) is opened by the circulator to the sterile field ahead of time.
4. The circulator will hand the prepared chemo agent to the surgeon at the end of the TURBT procedure.
5. This adapter is the hooked up with the stopcock and is then attached into the open end of the Foley catheter by the surgeon.
6. The drug is instilled by the surgeon into the bladder through the Foley catheter.
7. The Foley catheter is clamped in the OR, and remains clamped for 45 minutes with the Foley bag attached.
8. No instruments that come in contact with the agent are usually used to instill the drug but if there were, they should be kept separate in a basin and the scrub personnel should change gloves prior to touching other instruments.
9. Discard syringe, stopcock and Christmas tree into a Biohazard container (See precautions).

<u>In PACU</u>

1. The PACU nurse will observe the 45 minutes clamping time of the Foley catheter.
2. Unclamp the catheter at the end of 45 minutes and empty the bladder contents into the Foley bag observing chemo precautions.
3. Replace the Foley bag with a new bag (See precautions).
4. Discard the contents of the old Foley bag and the bag into a Biohazard container using chemo precautions (See precautions).

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Chemotherapeutic Agents in the OR	
Scope: Surgery	Manual: Surgery, Medication (MED)
Source: DON Perioperative Services	Effective Date: 10/31/17

DOCUMENTATION: Document the chemotherapeutic agent in the Operating Room Record and the PACU charting.

REFERENCES: National Institute for Occupational Safety and Health. (2004). "NIOSH alert: Preventing occupational exposure to antineoplastic and other hazardous drugs in health care settings" [Online]. Accessed July 2017 via the Web at http://www.cdc.gov.niosh/docs/2004-165/pdfs/2004-165.pdf (Level VII); The Joint Commission. (2017). Standard RI.01.03.01. *Comprehensive accreditation manual for hospitals.* Oakbrook Terrace, IL: The Joint Commission. (Level VII); American Society of Health System Pharmacists (ASHP). (2006). ASHP guidelines on handling hazardous drugs. *American Journal of Health System Pharmacists, 63,* 1172–1193. Accessed July 2017 via the Web at https://www.ashp.org/-/media/assets/policy-guidelines/docs/guidelines-handling-hazardous-drugs.ashx (Level VII)

CROSS REFERENCE P&P: Lippincott Procedures: Chemotherapy Administration, Intravesicular (Bladder)

Approval	**Date**
CCOC	10/23/17
STTA	1/24/18
MEC	2/6/18
Board of Directors	
Last Board of Directors Review	1/18/17

Index Listing: Chemotherapy in the Operating Room
Initiated: 8/97
Revised: 7-2011BS
Reviewed: AW 9/17

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Code Blue (Cardiac Arrest) Documentation**	
Scope: Hospital Wide	Department: **Emergency Dept.**
Source: Emergency Department Manager	Effective Date:

PURPOSE:

1. To ensure that Code Blue resuscitation is documented in a consistent manner throughout the hospital.
2. To provide a record of care delivered during resuscitation.
3. To serve as verification for reimbursement.

POLICY:

1. The *Northern Inyo Hospital Resuscitation Record* will be used for documentation during a cardiac, respiratory or other code blue resuscitation for all adults. The *Neonatal Code Blue Sheet* will be used for neonatal resuscitations.
2. Any cardiac arrest in the operating room will follow the Cardiac Arrest in OR Policy and will use either the *Northern Inyo Hospital Resuscitation Record* or the *Neonatal Code Blue Sheet* for documenation, as appropriate.
3. Respiratory Therapy shall record their activity and observations in the patient's electronic health record.
4. The Code IV RN has responsibility for the documentation done during the resuscitation event, and must review with the Code I RN completeness of documentation and co-sign the *Northern Inyo Hospital Resuscitation Record* document.

PROCEDURE:

1. Sticker or write the patient's name on all forms used for documentation.
2. Date all forms.
3. Chart the specific time of the entry or specific time each event took place when documenting on the Resuscitation document.
4. Number ALL pages of the resuscitation record in consecutive order beginning with page one and filling in the TOTAL number of all pages. Include all supporting narrative pages and supportive monitor strips. Example: Page 1 of 6
5. Write on lines provided and draw a line through any unused spaces or pages. Note "N/A" in spaces on the record where information is not applicable.
6. Record and post rhythm strips of all events of resuscitation- initial rhythm, post defibrillation, post resuscitation medication, any change in rhythm and termination of resuscitation.

DOCUMENTATION:

A. Page 1 of document

1. Document time of arrest and place of arrest. (Med-Surg, ICU, private residence, etc.)
2. Document, if appropriate, if brought in by EMS and what type (BLS, ALS) and estimated pre-hospital downtime.
3. Document all other ancillary departments called and arrival time to unit.
4. Document all procedures initiated by EMS on field or initiated by Code Blue team on unit. (e.g. Endotracheal tube ETT, Intraosseous IO, Nasogastric or Orogastric tube NGT/OGT , Foley Catheter, etc.) Include sizes of tubes, site, drainage, etc.
5. Document under *Notes* patient assessment on initiation of Code Blue and other narrative documentation.
6. Obtain signatures of all members of Code Team including responding physicians and ancillary departments.
7. Document, if appropriate, when resuscitation efforts were discontinued and pronouncing physician
8. Document disposition of patient if transferred to other facility or unit.

Title: **Code Blue (Cardiac Arrest) Documentation**	
Scope: Hospital Wide	Department: **Emergency Dept.**
Source: Emergency Department Manager	Effective Date:

B. Page 2 of document

1. Document initial vital signs on arrival of EMS or Code Blue team.
2. Document Initial Assessment according to determined systems.
3. Obtain signatures of staff performing assessments.

C. Page 3 of document

1. Document in appropriate columns: time, MAP/temperature, HR/ rhythm, defibrillation joules, O2/ SpO2, ETCO2, medications administered with dosage and route and initials of staff administering medication, GCS/LOC.
2. Document under *Notes* other documentation for procedures and other assessments.(CPR in progress, CPR stopped, Portable Chest X-ray, bloods drawn, etc.)
3. Obtain signatures of staff administering medications, performing procedures or involved in continuing resuscitation.

D. Page 4 of document.

1. Document repeat assessments according to systems. If no change in patient status " no change" may be written.
2. Document any other narrative documentation.

CROSS REFERENCE P&P:

1. Rapid Response Team
2. Code Blue procedure- Code Blue Team
3. Cardiac Arrest in the Operating Room

Approval	**Date**
CCOC	11/6/17
Emergency Services Committee	1/10/18
Resuscitation Committee	12/6/2017
Medical services/ ICU Committee	1/25/18
Perinatal/Pediatrics Committee	12/15/17
Surgery/Tissue Committee	1/24/18
Medical Executive Committee	2/6/18
Board of Directors	

Developed:
Reviewed:
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Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Code Blue (Cardiac Arrest) Documentation**	
Scope: Hospital Wide	Department: **Emergency Dept.**
Source: Emergency Department Manager	Effective Date:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Emergency Medical Screening of Patients on Hospital Property	
Scope: Hospital Wide	Manual: Emergency Dept
Source: ED Nurse Manager	Effective Date: 12/15/2004

PURPOSE:
To ensure a uniform process for providing a medical screening examination and necessary stabilizing treatment for any individuals situated on campus or within 250 yards of the main hospital building, and who request, or on whose behalf a request is made for emergency medical evaluation and treatment.

DEFINITION:
"250 Yard Perimeter" – an area encompassed within a 250-yard radius of the main hospital building. Sites covered within this area include sidewalks, streets, alleys, parking lots, parks, public areas (hallways, lobbies, etc.) of hospital-owned medical buildings, and non-owned buildings that are rented, leased or operated by the hospital. Sites within the 250 yard radius that are exempt from response include, but are not limited to, private physician's offices, private residences, private businesses and buildings that accommodate any business or services that are not hospital owned or operated.

POLICY:

1. Upon request for an evaluation of what is believed by an individual, or a person requesting such an evaluation on behalf of an individual, to be a possible emergency medical condition, the individual (patient) will receive a medical screening examination (MSE) and any necessary stabilizing treatment that can be provided within the capability of the department, including resources available within the main hospital.
2. If a request is made for evaluation of an individual who is located at a site covered by the 250-yard guidelines noted above, the Emergency Department shall dispatch a licensed staff member, if staff is available, or a call to 911 will be placed to attend the patient and to immediately report preliminary findings back to the Emergency Department physician.
3. The staff member will take a walkie-talkie or cellular phone to facilitate communication with the ED.
4. At the direction of the emergency department physician, a determination will be made as to the appropriate disposition of the patient.
5. If transport of the patient is required back to the emergency department, to conduct the medical screening examination and provide stabilizing treatment, appropriate transport options shall be considered including, but not limited to, calling 911 for assistance.
6. The ED shall notify police promptly if traffic control is needed or there is evidence of a violent or criminal act.
7. Should a patient refuse to consent to examination or stabilizing treatment, a staff member shall further offer the patient a medical examination and stabilizing treatment.
8. The staff member shall contact the emergency department physician who, in turn, shall make a reasonable effort to inform the patient, or patient's representative, of the benefits to the patient of further evaluation or treatment and the reasonably foreseeable risks, if known; to the patient should such evaluation or treatment not be accepted.
9. The staff member shall take all reasonable steps to secure the written informed refusal (Against Medical Advice – AMA) of the individual. If the patient or his/her legal representative fails or refuses to sign the form, the attempts at counseling and efforts to seek the patient's/legal representative's signature shall be documented.
10. Should the patient request transport or transfer to another hospital or care provider, the staff member shall notify the emergency department physician for further direction.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Emergency Medical Screening of Patients on Hospital Property	
Scope: Hospital Wide	Manual: Emergency Dept
Source: ED Nurse Manager	Effective Date: 12/15/2004

Approval	**Date**
CCOC	11/6/17
Emergency Department Committee	1/10/18
Medical Executive Committee	2/6/18
Board of Directors	
Last Board of Director review	6/21/17

Initiated: 3/04
Reviewed: 7/11as, 02/17 kp
Revised: 10/2017
Supersedes:
Index Listing:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Entering an ED Admission (observation, surgery, inpatient status) into Health Information System	
Scope: Admission Services, Emergency Department, House Supervisor	Manual: Admissions Services, Emergency Dept
Source: ED Manager	Effective Date:

PURPOSE:
The patient who has been admitted from the ED as an observation, surgery or inpatient must have a status change from ED outpatient to the correct status per the physician's orders.

POLICY:
1. House Supervisor shall be notified of every potential patient status change to determine bed and staff availability.
2. After an admitting order has been obtained for inpatient, observation or surgery patients, the ED Clerk provides the information to the Admitting Clerk for entry into the HIS.

PROCEDURE:
1. The Medical Staff Practitioner electronically enters admission orders for ED patients as Observation, Surgery, or Inpatient.
2. The electronically entered Orders print to the ED Clerk.
3. The ED Clerk notifies the House Supervisor (HS) of the patient admitting status including.
    a. Patient's name
    b. Diagnosis
    c. Date of birth
    d. Admitting physician
    e. Telemetry requirements
    f. ED admit
    g. Location: Med, ICU, Ped, Ped Neo, OPO Med, OPO ICU, OP Surg, IP Surg, OB Test, Med OB, OB Vaginal, or C-section
    h. Time admit orders written. If the patient's an observation patient, the time the patient arrives to the observation location needs documented for payment purposes.
4. HS assigns bed and notifies ED Clerk.
5. HS notifies receiving department.
6. The ED Clerk writes the assigned bed number on the printed orders and makes two (2) copies.
    a. One copy is given to the ED Admitting Clerk.
    b. One copy goes to the receiving unit or House Supervisor.
    c. The original copy goes to the ED RN taking care of the patient.
        1) This copy goes with patient to the floor.

REFERENCES:
1. California Code of Regulations, Title 22

CROSS REFERENCE P&P/Plans:
1. Admission, Discharge, Transfer of Patients
2. Conditions of Admission

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Entering an ED Admission (observation, surgery, inpatient status) into Health Information System	
Scope: Admission Services, Emergency Department, House Supervisor	Manual: Admissions Services, Emergency Dept
Source: ED Manager	Effective Date:

Approval	**Date**
CCOC	11/6/17
ED Committee	1/10/18
MEC	2/6/18
Board of Directors	
Last Board of Director Review	

Developed: 7/13
Reviewed: 10/2017
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: HIV Testing Without Consent for Occupational Exposures	
Scope: NIHD	**Department:** CPM-Infection Control Patient Care
Source: Quality Informatics Nurse/Infection Preventionist Manager	**Effective Date:**

PURPOSE:
To provide Northern Inyo Healthcare District with the guidelines of the California Hospital Association on occupational exposures for HIV and other communicable diseases if the source patient refuses to consent for testing of blood if a healthcare provider or NIHD workforce personnel experienced a significant exposure. This can only occur if the source patient's blood, tissue or other material was obtained **prior** to the exposure.

DEFINTIONS:

1. "**Attending physician of the source patient**: is any physician who provides health care services to the source patient and includes any of the following:
    a. The private physician of the source patient;
    b. The physician primarily responsible for the patient who is undergoing inpatient treatment in a hospital; or
    c. A registered nurse or licensed nurse practitioner who has been designated by the attending physician of the source patient.
        i. For purposes of follow-up of Healthcare Worker (HCW) exposure incidents, references to "attending physician of the source patient" shall include the Northern Inyo Healthcare District Infection Preventionist, Employee Health Nurse, Emergency Department RN Nursing Staff, Nursing Supervisor, or Nurse Manager; any of whom may be charged with the initial post-exposure evaluation and follow-up of a hospital employee.
2. **Available blood or patient sample**: means blood or other tissue or material that was legally obtained in the course of providing health care provider of the source patient ***prior to*** the exposure incident.
3. **Certifying physician**: means any physician consulted by the exposed individual for the exposure incident. A certifying physician must have demonstrated competency and understanding of the applicable guidelines or standards of the California Division of Occupational Safety and Health (CAL-0OSHA). (**Note:** The law does not specify how this competency may be demonstrated).
4. **Communicable disease:** any disease transferrable thorough the exposure incident, as determined by the certifying physician.
5. **Exposed individual**: includes any individual health care provider, first responder, or any other person (including any employee, volunteer, or contracted agent of any provider) who is exposed, within the scope of his or her employment, to the blood or other potentially infectious materials of a source patient.
6. **Health care provider**: is also broadly defined to include any of the following persons and entities:
    a. licensed and certified health personnel, including physicians, nurses and other health personnel who work in hospitals;
    b. clinics, health dispensaries and health facilities, including hospitals;
    c. employees, volunteers or contracted agents of Northern Inyo Hospital; and
    d. Professional students of any off the above.
7. **First responder**: means police, firefighters, rescue personnel, and any other person who provides emergency response, first aid care, or other medically related assistance, either in the course of the person's occupational duties or as a volunteer.
8. **Other potentially infectious materials**: means those body fluids identified by Cal/OSHA as potentially capable of transmitting a communicable disease. As defined in Cal/OSHA regulations [Title 8, California Code of Regulations Section 5193(b)] these may include: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any other body fluid that is visibly contaminated with blood such as saliva or

Title: HIV Testing Without Consent for Occupational Exposures	
Scope: NIHD	**Department:** CPM-Infection Control Patient Care
Source: Quality Informatics Nurse/Infection Preventionist Manager	**Effective Date:**

vomitus, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids such as emergency response; any unfixed tissue or organ (other than intact skin) from a human (living or dead); and any of the following, if known or reasonably likely to contain or be infected: cell, tissue or organ cultures, from humans or experimental animals; blood, organs, or other tissues from experimental animals; or culture medium or other solutions.

9. **Significant exposure**: means direct contact with the blood or other potentially infectious materials of a patient in a manner that, according to applicable Cal/OSHA guidelines, is capable of transmitting a communicable disease.
10. **Source patient**: means any person receiving health care services whose blood or other potentially infectious material has been the source of a significant exposure to an exposed individual.
11. **Workforce:** Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

POLICY:

A health care provider who has experienced a significant exposure to a patient's blood or other potentially infectious materials, may have a "source patient's" blood, tissue or other material tested for HIV or other communicable diseases even though the patient refuses to be tested – provided the blood, tissue or other material was obtained ***prior*** to the exposure.

PROCEDURE FOR TESTING PATIENT AND RELEASE OF TEST RESULTS:

1. **Request for Evaluation –** A person who has experienced an exposure to potentially infectious materials while rendering occupational or health care related services requests evaluation be a physician to determine if the exposure was significant.
    a. Request must be in writing
    b. Request must be made within 72 hours of the exposure

2. **Evaluation and Certification of Exposure –** A physician must evaluate and certify the significance of the exposure, including its nature and extent.
    a. Certification must be in writing.
    b. Certification must be within 72 hours of the request.
    c. Exposed individuals, including physicians, may not verify their own exposure as significant, but employing physicians may certify the exposure of their employees.

3. Required Counseling – Regardless of the HIV status of the source person, the exposed individual must be given counseling regarding the transmission of HIV, the limitations of HIV testing, the need for follow-up testing, and precautionary procedures to be followed according to hospital policy.

4. Baseline Testing – The exposed individual *may* be tested for HIV.
    a. The exposed individual ***must*** be tested for HIV, Hepatitis C and Hepatitis B if indicated ***and*** the results of that test must be confirmed as negative before testing the source patient for HIV without the source patient's consent (see # 8 below).

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b. The law does not require the exposed individual to be tested if he or she only wishes to discover if the source patient is known to be infected with a communicable disease positive (see # 7 below),

5. Notice to Source Patient's attending Physician

a. Within 72 hours of certifying the exposure as significant, the certifying physician must provide written certification to the attending physician of the source patient that a significant exposure has occurred.

b. The certifying physician must also request information on whether the source patient has tested positive or negative for a communicable disease and the availability of blood or other patient sample.

6. **Response-** the source patient's attending physician must respond to the certifying physician's request for information within three working days.

7. Release of Known Communicable Disease Positive Status – If the source patient is already known to be positive for a communicable disease, the attending physician must attempt to get the source patient's consent to release his or her communicable disease status to the exposed individual.

a. If the source patient refuses or cannot be contacted, an attending physician of the source patient may advise the exposed individual of the source patient's communicable disease status as soon as possible after certification of the exposure as significant.

b. Consent for release is not required where the exposed individual is a treating health care provider or an employee or agent of the treating health care provider who provides direct patient care and treatment

8. **Testing where Source Patient's Communicable Disease Status is Unknown –** If the source patient's communicable disease status is not known and blood or other patient samples are available, and if the exposed individual has tested negative on a baseline test for communicable disease, then the source patient must be given the opportunity to consent to a test for communicable diseases as follows: Within 72 hours after receiving written certification of a significant exposure, an attending physician of the source patient must do all of the following:

A. **Notice to Source Patient**: The attending physician must make a good faith effort to notify the source patient, or the patient's authorized legal representative, of the significant exposure. This effort includes, but is not limited to, an effort to locate the patient by telephone or by certified first class mail. The efforts to contact the source patient, and the results of these efforts, must be documented in the source patient's medical record. If the source patient or the legal representative cannot be contacted after a good faith effort, it may be treated as if the source patient has refused to be tested (see c below) An inability of the source patient to provide informed consent constitutes a refusal of consent if all the following are met:

a. The source patient has no authorized legal representative.
b. The source patient is incapable of giving consent
c. In the opinion of the attending physician, it is likely that the source patient will be unable to grant informed consent within the 72-hour period during which the physician is required to respond to the certifying physician's request for information.

Title: HIV Testing Without Consent for Occupational Exposures	
Scope: NIHD	**Department:** CPM-Infection Control Patient Care
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B. **Attempt to Obtain Consent:** If the source patient or legal representative is contacted, the attending physician must attempt to get the voluntary written informed consent to communicable disease testing of the source patient or on any available blood or tissue of the source patient. The voluntary informed consent must be in writing. The exposed individual is prohibited from directly seeking consent to testing from the source patient. If the source patient is deceased, consent to perform a test for a communicable disease on any blood or other sample of the source patient legally obtained in the course of providing health care services at the time of the exposure is deemed granted.

C. **Consent Refused.** If the source patient or authorized legal representative refuses consent for a communicable disease, *available blood or other patient samples may be tested anyway*.

a. The source patient or legal representative must be informed that an available sample will be tested despite the refusal and that the exposed individual will be informed of the result only if he or she wishes to know this information.
b. Use the form, "Refusal to Consent to Communicable Disease Testing/Refusal to Receive Results of Communicable Disease Testing" located on NIHD intranet> forms>Employee Health, or in exposure packet".

D. **Right Not to Know Communicable Disease Test Results-**If, after being given the option of receiving the test results or not, the source patient refuses to consent to the communicable disease testing and refuses to learn the results of the testing, the patient must sign a form documenting this refusal. Use the "Refusal to Consent to Communicable Disease Testing/Refusal to Receive Results of Communicable Disease Testing" located on NIHD intranet> forms>Employee Health, or in exposure packet."

a. Refusal to sign this form is deemed to be refusal to be informed of the communicable disease test result.
b. Communicable disease test results may be placed in the source patient's medical record ***only*** if the patient has given written consent to be informed of the test results.
c. If the source patient or legal representative refuses to be informed of the test results, the test results may only be provided to the exposed individual in accordance with the current applicable Cal/OSHA regulations.

E. Patient's Identity Encoded – The source patient's identity must be encoded in the communicable disease test result record.

F. Counseling and Referral – The attending physician must provide the source patient with medically appropriate pretest counseling and refer the source patient to appropriate post test counseling and follow-up if necessary. This must be done whether or not the source patient consents to testing.

9. Informing the Exposed Individual – If an exposed individual is informed of the status of a source patient with regard to a communicable disease, by law the exposed individual must be informed that he or she is subject to existing confidentiality protections for any identifying information about the test results. This includes informing the exposed individual about the need to keep the test results and the identity of the source patient confidential and the penalties for violating the law. The law does not permit the identity of the

source patient to be disclosed to the exposed individual. In many, if not most, instances, the exposed individual will already know who the source patient is. However, the health care provider should not reveal or confirm the identity of the source patient

10. **Costs of Testing and Counseling:** The cost for testing, counseling, post exposure evaluation and follow-up and treatment as required by Cal/OSHA of the exposed healthcare provider, NIHD workforce member and the source patient shall be paid for by Northern Inyo Healthcare District.

11. **Immunity from Liability:** No provider who acts in good faith compliance with this law shall be subject to civil or criminal liability or professional disciplinary action for performing a test for HIV or other communicable disease on an available sample or for disclosing the communicable disease status of the source patient to:
    a. The source patient
    b. An attending physician of the source patient
    c. The certifying physician
    d. The exposed individual
    e. Any attending physician of the exposed individual

    Conversely, any provider or exposed individual who willfully performs or allows the performance of an HIV or other communicable disease test on a patient that results in economic, bodily or psychological harm to the patient, without following the procedures set forth in the law, is subject to criminal penalties.

REFERENCES:

1. California Consent Manual, California Hospital Association, 2017
2. California Code of Regulations, Title 8, Section § 5193. Bloodborne Pathogens. Retrieved from https://www.dir.ca.gov/title8/5193.html
3. Occupational Safety and Health Administration.

CROSS REFERENCE P&P:

1. AIDS/HIV Testing and Orders
2. Bloodborne Pathogen Exposure Plan
3. Recommendation for Prophylaxis After Occupational Exposure
4. Initial Evaluation of Exposure Incident
5. Work Related Accidents/Exposures

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: HIV Testing Without Consent for Occupational Exposures	
Scope: NIHD	**Department:** CPM-Infection Control Patient Care
Source: Quality Informatics Nurse/Infection Preventionist Manager	**Effective Date:**

Approval	**Date**
CCOC	11/20/17
Infection Control Committee	11/28/17
Medical/ICU Services Committee	1/25/18
Peri Peds Committee	12/15/17
Emergency Services Committee	1/10/18
MEC	2/6/18
Board of Directors	
Last Board of Directors Review	05/17/2017

Developed: 01/2006
Reviewed: 09/2007, 8/11rc, 9/12 BS
Revised: 11/17rc
Supersedes:
Index Listings: HIV, exposure, HIV test, consent, refusal, communicable disease

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **In-House Transport of Ventilator Dependant Patient**	
Scope: ~~Respiratory Therapists, ICU RN, ED RN~~Multi-Departmental	Department: **Emergency Department, ICU/CCU, Radiology Respiratory Care**
Source: Director of Respiratory Care	Effective Date: 10-15-2012

PURPOSE:

To maintain ventilatory support on all ventilated patients that are being transferred from ICU/ED to X-ray or any other department for diagnostic or therapeutic procedures and from ED to ICU.
~~There are no MRI capable Ventilators at Northern Inyo Hospital. Patients that are on ventilatory support and need to go to MRI will be hand ventilated in the MRI suite. The attending physician needs to approve of this.~~

~~Transportation of mechanically ventilated patients for diagnostic or therapeutic procedures is always associated with a degree of risk. Every attempt should be made to assure that monitoring, ventilation, oxygenation, and patient care remain constant during movement. Patient transport includes preparation, movement to and from and time spent at destination.~~

~~**INDICATIONS:**Transportation of mechanically ventilated patients should only be undertaken following a careful evaluation of the risk-benefit ratio.~~**POLICY:**

Transportation of mechanically ventilated patients will only be undertaken following a careful evaluation of the risk-benefit ratio.
When transporting any patient in house that is on a ventilator, a Respiratory Care Practitioner, and a Registered Nurse must accompany the patient.
~~-~~Patient transport includes preparation, movement to and from and time spent at destination.
Patients that are on ventilatory support and need to go to MRI will be hand ventilated in the MRI suite as there are currently no MRI-capable ventilators. The attending physician needs to approve of this.

Patients will not be transported with mechanical ventilation if any of the following conditions exist:~~**CONTRAINDICATIONS :**~~

1. Inability to provide adequate oxygenation and ventilation during transport either by manual ventilation, portable ventilator or standard ventilator.
2. Inability to maintain acceptable hemodynamic performance during transport.
3. Inability to maintain airway control during transport.
4. Transport ~~should~~ will not be undertaken unless all the necessary members of the transport team are present.

HAZARDS & COMPLICATIONS:

1. Hyperventilation during manual ventilation.
2. Loss of PEEP.
3. Inadvertent disconnection of intravenous access.
4. Movement may cause disconnection from the ventilatory support and respiratory compromise.

Title: **In-House Transport of Ventilator Dependant Patient**	
Scope: ~~Respiratory Therapists, ICU RN, ED RN~~Multi-Departmental	Department: **Emergency Department, ICU/CCU, Radiology Respiratory Care**
Source: Director of Respiratory Care	Effective Date: 10-15-2012

5. Movement may result in accidental extubation.
6. Loss of oxygen supply may lead to hypoxemia.
7. Ventilator-associated pneumonia has been associated with transport.

PROCEDURE:

1. Nursing staff will notify the Respiratory Therapist of the time and location of the transport.

2. The Respiratory Therapist will obtain the necessary equipment for the transport including but not limited to:

    a. VersaMed I Vent
    b. Resuscitation-bag with mask.
    c. Peep adaptor if necessary
    d. Full O2 E cylinder on I Vent
    e. Spo2 monitor
    f. Stethoscope

There are two methods of transporting patients, the preferred way:

1. If the patient is in the ICU on the PB 840 it is acceptable to use the VersaMed I-vent. Use the same settings as the PB 840, or as close as possible on the I-Vent. It is preferable to place the patient on the I-Vent for 5-10 minutes before transporting to monitor the patient on a different ventilator. If the patient is not tolerating the I-Vent and the patient still needs to be transported follow procedure # 2.

2. The I-Vent can be used as a transport ventilator; it has an internal battery that will last approximately 2 hours on a full charge and an E Oxygen Cylinder that will last approximately 2 hours at 100% FiO2.

3. When transporting the patient be aware of the possible pull on the endotracheal tube from the ventilator. If necessary have someone push the ventilator while you are holding the ET tube.

4. When reaching you destination it is preferable to connect to piped in oxygen if available and plug the ventilator in.

Title: **In-House Transport of Ventilator Dependant Patient**	
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Source: Director of Respiratory Care	Effective Date: 10-15-2012

Option # 2 If the patient is not tolerating the I-Vent and the patient still needs to be transported.

1. If two therapists are working one will manually ventilate the patient while the other therapist moves the PB 840 ventilator to desired location.

2. If one therapist is working, the nurse or the therapist can bag the patient while someone else moves the PB 840 ventilator to the desired location.

3. Once at the desired location the patient will be connected to the ventilator on the same settings.

RESPIRATORY DOCUMENTATION

1. The patient should be monitored on a Cardiac and Spo2 monitor during the procedure.

2. Document the transfer, ventilator check and breath sounds after moving the patient and then after the return trip back to ICU/ED.

REFERENCES:

1. AARC Clinical Practice Guideline "In-Hospital Transport of the Mechanically Ventilated Patient"

CROSS REFERENCE P&P:

1. In-House Transport of Ventilator Dependent Patients
2. Initial Ventilator Settings

Committee Approval	**Date**
Clinical Consistency Oversight Committee	11/20/17
Medical Services/ICU Committee	1/25/18
Medical Executive Committee	2/6/18
Board of Directors	
Last Board Review	

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **In-House Transport of Ventilator Dependant Patient**	
Scope: ~~Respiratory Therapists, ICU RN, ED RN~~Multi-Departmental	Department: **Emergency Department, ICU/CCU, Radiology Respiratory Care**
Source: Director of Respiratory Care	Effective Date: 10-15-2012

Developed: 8/2012
Reviewed:
Revised: 10/6/2017
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Newborn Hearing Screening Program	
Scope: Unit Specific	Manual: Perinatal
Source: Perinatal Nurse Manager	Effective Date: 6/11/2010

PURPOSE: To identify those infants at risk for hearing impairment and who require further auditory assessment.

POLICY: Newborn Hearing Screening will be provided to all infants receiving newborn services at Northern Inyo Hospital and a consent will be signed to allow for this screening.

I. PERSONNEL

A. The Newborn Hearing Screening Program (NHSP) Director is the Perinatal Nurse Manager. The manager is responsible for management of the newborn hearing-screening program, including training and oversight of the individuals performing the screening, reporting, staff, parent, and physician education and coordination of services and follow-up. The Director shall report changes in Director of the NHSP to Children's Medical Services (CMS) Branch, or its designee, within one week of the change. The Hearing Screening Coordinator is responsible for training the screener personnel. The Hearing Screening Coordinator will maintain documentation of these competencies in the office of the Perinatal Nurse Manager. (Refer to section VIII. Competency criteria.)
B. A CCS panel audiologist is contracted with NIH and will be overseeing the development, maintenance, equipment, and follow up of the hearing screen program, and ongoing review of the NIH NHSP, at least annually.
C. Screeners - The hearing screenings will be performed by perinatal staff that has completed training in the use of the hearing screen equipment and documented competency according to the Ca. NHSP standards – attachment A. This staff is available to do the screenings 24 hours/day, 7 days/week. The screeners will have individual training, and completed competency annually.
D. Perinatal LVN/Clerk – Provides support for the NIH NHSP. The ward clerk will maintain the NIH Newborn Hearing Screening Log, submit data in a format specified by the DHCS, submit monthly reports, and submit monthly reports to the CA Department of Health Care Services (DHCS) or its designee South Eastern California Hearing Coordination Center (SECHCC) by the 10th day following the end of each month.

II. FACILITY AND EQUIPMENT:

Infant hearing screening services will be performed using FDA-approved equipment that detects a mild (30-40 dB) hearing loss in infants and newborns. Northern Inyo Hospital uses OAE systems. Please refer to One-Source for each equipment brand used on the unit for hearing screens.

A. The OAE equipment performs a self-calibration with each power-on.
   1. Electrical safety checks are performed twice a year by the Bio-Med Department and logged in their department.
B. The hearing screening tests will be done at the mother's bedside or according to where the environment is best conducive to hearing screening, after agreeing to the plan of care discussed with the newborn's family.
C. The Hearing Screening Coordinator is responsible for obtaining loaner equipment as backup within 24 hours following malfunction.

D. The Hearing Screening Coordinator is responsible for ordering supplies.
E. Nurses performing the hearing screen will document a PASS or REFER according to current state requirements.
F. The equipment will be stored in the circumcision room in the nursery.

III. PROCEDURE:

A. Consent:
    A. There is a declination form that needs to be witnessed and signed by a parent upon admission to the hospital, if the parent(s) would like to decline the hearing screen. This will be placed in the newborn's chart to go to medical records.
        1) If the parent refuses newborn hearing screening, the perinatal RN should provide further education to the family. If they choose to waive the screening, a separate waiver form must be signed and will be placed in the newborn chart with a copy given to the parents.
        2) The perinatal nurse will record the declination in the medical record, notify the primary care physician and give it to the LVN/Clerk to input into the system.
B. Select a baby appropriate for screening:
    A. Infant age specific – Newborn to 6 months.
    B. Infants will be screened as close to discharge as possible, preferably at or greater than 24 hours old.
    C. Infants should be medically stable andmedications should be noted on the EMAR.
    D. Hearing screenings are to be done in a quiet environment, and can be done while breastfeeding or skin-to-skin with mom, or the nursery if discussed with parents.
    E. If the infant is missed prior to discharge, parents will be contacted within one week by the LVN/Clerk and receive an out-patient hearing screening appointment at NIH in the NEST, and the primary care provider will be notified.

C. Hearing Screener Procedure
    1. Hearing screener will check chart for admissions hearing screening consent.
    2. Parental education is to be performed by a licensed perinatal nurse who has completed newborn hearing screening training. The perinatal nurse is to give CA DHCS education materials to parents including information about the hearing screenings.
    3. Set up the screener according to the manufacturer's specifications.
    4. Wash hands.
    5. Prepare baby:
        a. Collect supplies:
        b. This includes the scanner with the appropriate size disposable ear tip. The usual for the newborn is the smallest red tip.
        c. The remote probe works best with newborns and will be on the scanner for use.
        d. Inspect the ear canal for excessive cerumen or vernix prior to testing as this may interfere with the test and give invalid or incomplete results.
    6. Run Screening procedure

- Remove the handset from the cradle. The instrument runs on batteries only. They are not rechargeable: placing it on the cradle does not recharge the batteries.
- To turn on the EROSCAN instrument, press the DOWN key located below the instruments display screen. Three small lights (red, yellow, and green) will appear briefly just above the display screen. The green ready light will remain on. A brief display mode will appear and then ←L test R→ screen will appear
- To begin testing, place an ear tip as far down as possible on the probe tip. Select either the right or left key to indicate which ear will be tested. After the test ear is selected the display will show two horizontal bar graphs representing the environmental noise (NOISE) and the ear canal volume (VOLUME).
- If both bars fill the screen then both the environmental noise and the ear canal volume is high. Correct the environmental noise and then make sure that the seal of the ear is complete. You should see a decrease in the bar to the LEFT. Best results are obtained when both are at a minimum. When a seal is obtained testing will begin automatically. The yellow test light will illuminate throughout the test. The red ERROR LED will illuminate if there is noise in the environment. This flashing is normal and will often occur.
- Once the testing is finished, the unit will display "PASS" or "REFER" on the LED screen.
- When testing is completed on both ears, turn the printer on by pressing the green button on top and place the handset on the cradle. The most recent test results for both ears will automatically print.

7. Observe and record results.
    a. For a REFER condition -
    1) The infant will be re-screened immediately after checking equipment and repositioning infant:
        - Check the equipment:
        - Check the environment:
            a. Is there excessive interference (noisy room or nearby electrical sources)?
        - Check the baby:
            a. Is the baby too active to scan?
            b. Is the baby's ear canal compressed or closed?
            c. Does the baby have fluid or debris in its ears?

    2) If REFER condition is obtained after adjustments are made, re-screen infant at a later time as close to discharge as possible.
8. Turn off screener and cleanup
9. Notification of parents of screening results:

a. **PASS** condition - A congratulations form with screen results is given to parents with Pass results and a CA DHCS PASS brochure filled out on the back.
b. **REFER** condition (after second attempt) - The physician will give all REFER results to the parents. The screener will notify the primary care provider, schedule an appointment for an Out-Patient Re-screening Appointment (to be done within 4weeks of discharge), fill out the CA DHCS REFER brochure and place it on the chart, record results and appointment in medical record, and give the information to the Ward Clerk to record in DMS.

10. Documentation
    a. Consent/ waiver in chart
    b. Test results and follow-up information regarding retesting or anomalies will be recorded
        - In the neonates chart
        - In the Newborn Nursery logbook
        - On the Patient Teaching Form
        - In DMS
    c. If REFER condition, make sure appointment brochure is on the chart and is complete and physician has been notified.

IV. EQUIMENT CARE AND MAINTENANCE

1. Never reuse disposable equipment
2. Store the screener in the nursery
3. Clean remote probe with antiseptic wipe

For service and maintenance of the hearing screener refer to the user manual

V. SERVICES AND CARE COORDINATION/REFERRAL

A. Protocol for Repeat Screening after 2 hearing screening REFERS:
If after re-screening, the infant still has a REFER condition, the following is to be done:

1. A referral form and completed CA DHCS REFER brochure will be put on the patient's chart for the physician to review with the parents and provide additional recommendations along with materials and information of community resources.
2. The Perinatal nurse is to notify the primary care physician
3. The primary care provider is required to inform the parents of the REFER condition; give them the CA REFER brochure, and answer questions and concerns. If the PCP does not fill out the REFER brochure, the Perinatal nurse may only after the PCP has spoken with the parents.
4. The Perinatal nurse will have the Ward Clerk fill out the appointment for Out-Patient screening (place, time, date), verify the parents' information and obtain one additional contact person - 1 copy will be placed in the medical record, and also 1 copy given to the Out-Patient Provider. It will be recorded in DMS

5. The screening results and outpatient appointment needs to be put in the nursery logbook. Information is to be given to the parent on how to come back as an outpatient.

B. Written materials for parents:
- The perinatal nurse will give the CA DHCS "Newborn Hearing Screening Program" brochure to all obstetrical patients after admission to the perinatal unit.
- The perinatal nurse or primary care physician will provide the appropriate CA DHCS brochure (WAIVE, PASS, REFER) at the time of the hearing screening.

C. Notification of primary care providers:

Notification of PASS, REFER, or WAIVE of hearing screenings is included in the physician's record of the newborn in which the physician receives a copy at the time of discharge of the infant (The Discharge Summary is placed in the physician's in-house mail box.) Written notification to the PCP from the Hearing Screening Coordinator will be sent within one week on infants who do not pass, including the outpatient appointment date as appropriate.

1. Notification will be sent to all primary care physicians by the Hearing Screening Coordinator of the following:
    a. Missed tests and follow up information
    b. Refer information based on information entered into DMS

D. Medical Record:
1. A copy of the test results shall be placed on the lab report sheet.
2. Any referral letters and appointments for outpatient testing will be a part of the medical record, recorded on the Maternal Teaching form.
3. The perinatal nurse will include patient education in the Postpartum Self Assessment Checklist Form in the section "Nurse's Notes".

E. Missed Screens:
For infants that are discharged before hearing screening can be provided, the Hearing Screening Coordinator will schedule a follow-up appointment within one week of discharge. The outpatient hearing screening appointment will be scheduled with the parents to take place within 4 weeks of discharge.

a. Telephone call
b. Letter written to the family of missed event
c. Letter to the primary care physician about missed event

F. Transferred Infants
All babies transferred out of Northern Inyo Hospital to a hospital with a higher level of care will be given a hearing screening, if stable and a candidate for the test to be done, prior to transfer and entered into DMS. The receiving hospital will be notified that the transferred baby is part of the CA NHSP and must be screened before discharge. Results of the hearing screen, if performed, will be included in the transfer paperwork.

G. Outpatient screenings/Follow-up appointments:
The hearing screener or coordinator will be responsible for scheduling outpatient screening appointments and notification of the date, time, location, and contact number to the parents. Copy 3 of the referral form will be left for the coordinator for confirmation of the appointment. This is to include special needs.

VI. EDUCATION ACTIVITIES

A. Medical and Nursing staff education
   a. Physician information will be disseminated by the Director to the medical staff by committee meetings, and written correspondence. This will be done at least annually and more often when indicated.
   b. Nurse education will be updated in staff meetings and written correspondence. This will be done at least annually and more often when indicated.

B. Parent education
   a. Literature in the primary care provider offices and on admission to the Perinatal Unit.
   b. Informing parents that if they choose not to have the infant's hearing tested, a waiver form must be signed.
   c. RN or MD will inform the parents, in writing, the result, and follow up appointment date/time/location/and contact information if indicated prior to discharge.

C. The Director or coordinator of the hearing screen program will attend and participate in semi-annual meetings with the SECHCC. If the director is unable to attend information from the meeting will be obtained and reviewed.

VII. DATA MANAGEMENT:

The Hearing Screening Coordinator shall report to DHCS, or its designee (the SECHCC), data on all infants receiving neonatal services, into the DMS, specified by DHCS.

A. Qualified licensed perinatal nurses performing hearing screens shall be responsible to:
   a. Enter into the Newborn Nursery log and the DMS, all hearing screening information, which shall contain at a minimum, the following information for every infant:
      - Infant name
      - Date of birth
      - Medical record number
      - Date of screening
      - Screening results
      - Follow-up appointment date, time, and provider (if applicable)
   b. Verify parent contact information (legal guardian) on all infants with a "Refer" result, and obtain one additional contact person, and enter into DMS.

c. Identify the PCP the infant will see upon discharge if different than the attending Pediatrician or physician, for reporting of "Refer" results and follow-up care notification, and enter information into DMS.
d. For infants with atresia:
   - an appointment or a referral will be made to a Diagnostic Evaluation as an outpatient with a CCS-approved Type C Communication Disorder Center as soon as possible following hospital discharge.
   - An Early Start referral form will be completed and faxed to the state designated Early Start number (916-445-4550).
   - Referral to CCS will be made by the RN or the LVN/Clerk.
     - Completed CCS Request for Service form
     - Completed CCS family application
     - Documentation of microtia
e. For infants with microtia:
   - an appointment or a referral will be made to a Diagnostic Evaluation as an outpatient with a CCS-approved Type C Communication Disorder Center as soon as possible following hospital discharge.
   - Referral to CCS will be made by the RN or the LVN/Clerk.
     - Completed CCS Request for Service form
     - Completed CCS family application
     - Documentation of microtia

B. The NHSP Coordinator (AKA Hearing Screening Coordinator) shall be responsible for the following:
   a. Completing the data entry into the DMS on all infants who expired after birth or when screening isn't medically necessary determined by a physician.
   b. Overseeing accuracy and completeness of all DMS data entry.
   c. Verifying that there is a completed DMS entry on all infants
      - Who pass
      - Who refer
      - Who are transferred out to another hospital
      - Who are missed: discharged without a screen
      - Whose parent waives the hearing screen
      - Who expire after birth
      - Or when screening is not medically necessary (i.e. poor prognosis)
   d. Verifying the accuracy of the screening log of newborns/infants admitted to the Well-Baby Nursery. Comparing the OB statistics log with the Nursery Log will do this.
   e. A monthly report shall be sent within ten days after the end of the month to the SECHCC
      a. Number of live births

Title: Newborn Hearing Screening Program	
Scope: Unit Specific	Manual: Perinatal
Source: Perinatal Nurse Manager	Effective Date: 6/11/2010

VIII. COMPETENCY CRITERIA:

Licensed perinatal staff will have individual training in newborn hearing screening, will demonstrate competency through testing, and will be reassessed yearly.

a. The NHSP Coordinator will provide the training.
b. Training of screeners will include watching a hearing screening video, taking an exam, observing a hearing screen and doing a return demonstration successfully in the presence of the instructor. The coordinator will do spot-checking of individuals periodically. Individual refer rates may indicate need for additional training.
c. Annual competency testing will be documented in the employee file.

IX. QUALITY ASSURANCE ACTIVITIES

The coordinator and director will provide quality assurance.

The coordinator and director will monitor quarterly screening rates.

A minimum of 98% of newborns born in the hospital will be provided hearing screening prior to discharge.

The expected REFER rate for the program as a whole and for each individual screener will be <1% or <10% using OAE equipment.

For variances to the above parameters, corrective measures may include:

1. Checking Equipment/Recalibration
2. Observing Screeners by coordinator
3. Checking compliance with policies and procedures.

X. BILLING

a. Inpatient Infant Hearing Screening Providers shall submit claims for reimbursement to DHCS or its fiscal intermediary using only the infant hearing screening codes identified in the NHSP Provider Manual for services provided to Medi-Cal or CCS-eligible beneficiaries, in a format specified by DHCS.
b. All billing for infant hearing screening services shall conform to the requirements specified in the NHSP Provider Manual and in the Medi-Cal Provider Manual.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Newborn Hearing Screening Program	
Scope: Unit Specific	Manual: Perinatal
Source: Perinatal Nurse Manager	Effective Date: 6/11/2010

REFERENCES:

1. Equipment Manufacturer's User Manual
2. CCS Service Manual of Procedures, In-Patient Provider Standards, Infant Hearing Screening Services, 09/16
3. Health and Safety Code, division 106, chapter 3, part 2, section 23 article 6.5 (commencing with section 124115).
4. Procedure for hearing screen at NIH.

Approval	**Date**
CCOC	**12/18/17**
Peri-Peds	**12/15/17**
MEC	**2/6/18**
Board of Directors	
Last Board of Directors Review	**2/15/17**

Developed: 6/11/2010
Revised: 1/03, 3/4/08 jk, 6/11/10 jk, 6/2014jk, 12/17sg
Last Board of Director review: 2/15/17

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Observation in the Operating Room	
Scope: Surgery	Manual: Anesthesia, OB/Gyn, Surgery
Source: Surgery Nurse Manager	Effective Date: 12/31/17

PURPOSE:
To ensure sanitation and safety needs of the operating room are met.

POLICY:
Persons seeking observation privileges in the operating room will be limited to students in the field of medicine, manufacturer representatives (vendors) required due to specific equipment or implant needs for the surgery, and fathers / significant support persons during Cesarean Section Delivery.

Persons with educational purpose will be interviewed by the Operating Room Nurse Manager or Chief of Surgery prior to admission and must meet the criteria stated below.

PROCEDURE:
- Must comply with the health and dress standards of the OR
- Must have knowledge of sterile technique and conduct in the OR
- Must have permission of the patient, surgeon, operating room nurse manager and anesthesia provider.

MEDICAL STUDENTS:
Medical students previously trained in sterile technique, preoperative scrub and operating room procedures, may "scrub in" at the surgeon's request. **Refer to policy Medical Students in the Operating Room.**

If the student has not had his operating room rotation and the surgeon wants the student to "scrub in", the surgeon will be responsible for the student's performance in all areas of surgical aseptic technique.

NURSING STUDENTS:
LVN and RN nursing students may be rotated through the operating room. At the beginning of their rotation, before being allowed to observe in the operating room suites, they are given a basic orientation as to sterile technique.

- Must be aware of their body space and the sterile field.
- Must maintain a two foot distance.
- Must be instructed as to where they can stand to observe.
- Must be reminded that once in the room they are to remain in the room to decrease unnecessary traffic until the procedure is completed.
- Students may assist the circulating nurse with skills such as placing monitors on the patient, under supervision of the circulating nurse in charge.
- The student is at no time left alone in the operating room without a circulating nurse present.
- The student is at no time responsible for the care of the patient.
- The operating room team will make the rotation through the operating room as educational as possible for the student by facilitating observation of the surgical procedure, answering questions and explaining equipment and procedures.

MANUFACTURER REPRESENTATIVES:
Manufacture representatives may observe in the operating room to help facilitate the use of new or updated equipment or in the event of a total joint replacement where their input is an asset.

Title: Observation in the Operating Room	
Scope: Surgery	Manual: Anesthesia, OB/Gyn, Surgery
Source: Surgery Nurse Manager	Effective Date: 12/31/17

- Must have consent of the Surgery Manager and written consent from the surgeon and patient.
- Must adhere to aseptic technique at all times & wear OR attire.
- Must remain in the room, leaving only when necessary to get implants, in order to decrease unnecessary traffic until the procedure is completed.
- Will leave the operating room at the request of operating room personnel including the operating team or anesthesia provider.
- Will adhere to confidentiality standards.
- The name of the representative will be documented in the Operating Room Record.

EXPECTANT FATHER OR SIGNIFICANT OTHER FOR CESAREAN DELIVERY:

An expectant father, or appropriate support person who has the permission of the surgeon and anesthesia provider and who meets all the criteria for observing cesarean birth, may accompany the mother to the operating room and remain with her during the birth of the baby.

The support person will be given clean scrubs and shown to the PACU bathroom to change clothing. They will then wait in the designated area (PACU) until they are escorted to the operating room by the nurse.

He or she must be prepared to accept the directions and decisions of the nursing and medical personnel.

- Must wear appropriate attire for the operating room.
- Must enter the operating room suite after the regional anesthetic has been administered.
- Will not be allowed in the operating room if the patient is receiving a general anesthetic as the sole purpose is to support the patient.
- Must remain at the head of the operating room table and be supportive and encouraging to the mother.
- Must understand that he/she is in the operating room in order to perform the job of supporting the mother and in that capacity, he participates in the delivery of the baby.
- May be allowed to photograph the birth and the baby with consent of the surgical team and the pediatrician.
- Will leave the room if requested and accept the decision of the surgeon, anesthesia provider and pediatrician as final.
- The relationship to the patient will be documented in the operating room record.

DOCUMENTATION:

Any time there is a person observing in the operating room, their name will be noted in the designated area on the operating room record by the circulating nurse.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Observation in the Operating Room	
Scope: Surgery	Manual: Anesthesia, OB/Gyn, Surgery
Source: Surgery Nurse Manager	Effective Date: 12/31/17

REFERENCES: AORN 2016 Standards: Surgical Attire recommendations I-III, Environment of Care Part 2 recommendation II, VII-VIII

CROSS REFERENCE P&P: Medical Students in the OR

Approval	**Date**
CCOC	12/4/17
STTA	1/24/18
MEC	2/6/18
Board of Directors	
Last Board of Directors Review	1/18/17

Developed:
Reviewed:
Revised: 3/01; 03/09; 6/2011BS, 11/17AW
Supersedes:
Index Listings: Observation in the Operating Room; Students in the OR; Cesarean Section Support Person in the OR; Manufacturer Representative in the OR

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Organization-Wide Assessment and Reassessment of Patients*	
Scope: Clinical Departments	Manual: CPM - Admission, Discharge, Transfer Documentation (ADT)
Source: Chief Nursing Officer	Effective Date: 1/1/15

PURPOSE:
To provide the framework for the initial patient assessment upon admission and the ongoing reassessment of patients during the course of care

POLICY:
1. Patients admitted to NIH will receive an assessment by qualified caregivers to allow development and implementation of a plan of care that will best meet the individualized health care needs of the patient.

2. The assessment of the care and/or treatment needs of the patient will be continuous throughout the patient's hospitalization.

3. All disciplines, as directed by the Medical Staff Practitioner order and/or deemed upon initial or ongoing assessment by Nursing Services, will participate in the assessment process in an effort to provide a comprehensive, collaborative approach to care.

4. Timeframes are defined and performed within which each clinical discipline conducts the patient's initial assessment in accordance to professional standards, hospital policy and procedure, law, and regulation.

5. All disciplines will incorporate age and population assessment parameters upon initial assessment and reassessment.

6. All disciplines will prioritize care so that the most immediate problems related to the patient's health and safety is addressed first. Less acute problems may be referred to appropriate outpatient or community resources.

PROCEDURE:
1. Each discipline, at the time of admission, will outline specific timeframes for completion of the initial assessment. Refer to department specific Assessment & Reassessment policy and procedure:
    - Medical Staff Practitioners
    - Nursing Services
    - Diagnostic Imaging
    - Nutritional Services
    - Case Management
    - Rehabilitation Services
    - Respiratory Services
    - Pharmacy Services

2. As appropriately determined by the RN performing the initial assessment and/or as indicated by the initial medical staff practitioner order, other disciplines may be contacted to assess the patient.

3. Upon completion of the collaborative discipline-specific assessments and interdisciplinary plan of care will be developed with patient/family consultation as appropriate and possible.
4. The scope and intensity of any further assessments are determined by the patient's diagnosis, level of care (location), complexity of care, duration of care, and response to care rendered.

Title: Organization-Wide Assessment and Reassessment of Patients*	
Scope: Clinical Departments	Manual: CPM - Admission, Discharge, Transfer Documentation (ADT)
Source: Chief Nursing Officer	Effective Date: 1/1/15

5. Any significant change in the patient's diagnosis and/or condition necessitates an immediate reassessment with changes in the plan of care reflecting the change in diagnosis or condition.

6. Patients are reassessed after treatment and therapy to determine the effectiveness (extent of improvement) of the intervention undertaken by the health care team.
   a. Timeframes for reassessment are dependent upon the type of treatment of therapy provided specified in policy and procedure.

7. Reassessment may also occur if members of the health care team become aware of issues in the patient's social or home environment which may impact his or her condition/treatment/care. Example: the after admission, the patient's daughter arrives and informs the nurse that the patient drinks a fifth of whiskey daily, an issue previously undetected by staff and unmentioned by the patient during the initial assessment. Further assessment and referral would occur.

8. The plan of care will be reviewed regularly in consultation with appropriate members of the health care team and the patient/family. The plan of care will be reviewed as appropriate to the patient's condition and the ongoing assessment process.

9. Discharge planning will be included in the initial assessment and reassessment process and throughout the patient's hospitalization. The patient/family will be involved in the discharge planning process as appropriate.

REFERENCES:

1. The Joint Commission (January 2013) Comprehensive Accreditation Manual for Critical Access Hospitals. Functional Chapter Provision of Care, Treatment and Services. PC 01.02.01, PC 01.02.03, PC 01.02.05.

CROSS REFERENCE P&P:

1. NIH Medical Staff Rules & Regulations
2. Nursing Care Plan
3. Interdisciplinary team – Clinical screens built into the Initial Nursing Assessment
4. Plan for the provision of nursing care
5. Nursing Assessment and Reassessment
6. Pediatric Admission Assessment
7. Admission Assessment of Obstetrical Patient
8. Admission, Documentation, Assessment, Discharge and Transfer of Swing-Bed
9. Quick Check
10. Interdisciplinary Plan of Care
11. Evaluation and Assessment of Patients' Nutritional Needs
12. Functional Risk Assessment Criteria for Therapy Referral
13. Organization-Wide Assessment and Reassessment of Patients*
14. Organization-Wide Assessment and Reassessment of Patients*
15. Documentation of Case Management Services
16. Nursing Care of Outpatient Interventional Radiology Patient
17. Respiratory Assessment and Reassessment

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Organization-Wide Assessment and Reassessment of Patients*	
Scope: Clinical Departments	Manual: CPM - Admission, Discharge, Transfer Documentation (ADT)
Source: Chief Nursing Officer	Effective Date: 1/1/15

Approval:	**Date**
Clinical Consistency Committee	12/18/17
Medical Executive Committee	2/6/18
Board of Directors	
Last Board of Director review	3/15/17

Developed: 3/8/14
Reviewed:
Revised: 12/17

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Patient Visitation Rights	
Scope: District	Manual: CPM-Admission, Discharge, Transfer (ADT)
Source: CNO	Effective Date:

PURPOSE:
To provide guidelines for patient visitation across the Northern Inyo Healthcare District (inpatient and outpatient service areas) in order to provide support systems to the patients and maintain safety for all. The visitation rights at NIHD align with our non-discrimination policy. NIHD promotes and supports a patient and family centered approach to care. We recognize the importance of allowing family members and other individuals to be present with a patient for emotional support during the course of their stay.

DEFINITIONS:
Significant Other/Support Person: This person is generally identified by the patient as their main support person or caretaker. This individual is not considered a visitor and may remain with the patient to provide support under most circumstances.
Perinatal Child Sibling: A child under the age of 14 years who is related to the newborn patient as a sister/brother, half-sister/half-brother or step-sister/step-brother.
Children: A person who is under the age of 14 years.

POLICY:
NIHD has flexible visiting hours based on patients' needs. Children are welcome, but must have adult supervision at all times. Alteration in visitation may be necessary for certain patients. Visitors are encouraged to check at the nurse's station when those situations occur.

1. Each patient or family/caregiver (designated by the patient) will be informed of their visitation rights, including any clinical restrictions or limitation at the time of admission (when possible) or when new conditions that affect visitation arise.
2. Each patient or family/caregiver has the right to receive the visitor whom they designate without discrimination from the staff. The patient also has the right to exclude any visitor they choose. The patient may withdraw or deny such consent at any time for specific visitors.
3. A refusal to allow the patient's choice of family/caregiver or support person with respect to visitation rights must be documented in the patient's medical record and include specific basis for the refusal.
4. When a patient is incapacitated or unable to communicate their wishes and an advanced directive has not been executed, any individual who asserts that they are the support person shall be accepted. NIHD will not require proof of the relationship that makes the support person validate their role. In the case where two individuals are in conflict over the support role, NIHD will ask for documentation relative to the claim to be the patient's support person.
5. NIHD is a non-smoking campus. Visitors are prohibited from smoking in any location within the district.

PROCEDURE:

1. All visitors will be encouraged to complete hand hygiene upon entering and exiting patient visits. Proper hand hygiene is the best way to reduce the spread of infection.
2. Visitors who have a cough will be encouraged to follow cough etiquette. Masks will be provided at critical entrances within the district.

Title: Patient Visitation Rights	
Scope: District	Manual: CPM-Admission, Discharge, Transfer (ADT)
Source: CNO	Effective Date:

3. During Influenza season, Novembrer1st to March 31st, Visitors who have not received a "flu shot" will be encouraged to mask.
4. Patient Visitation Rights education of staff in admission services and all clinical areas shall be completed upon hire or updating of this policy.
5. Visitor Restrictions:
   a. Nursing staff will consult privately with the patient to determine if s/he wishes to have visitors restricted. If the patient desires visitor restriction, a notice will be placed on the door of the patient's room.
   b. If the nurse and patient determine that visitors would be counter-therapeutic to the patient, the nurse will ask the visitors to return at another time. The nurse will place a sign on the patient's door requesting visitors to inquire at the nurses' station before visiting. The nurse will communicate the reasons for restrictions to the visitors.
   c. Family members or significant others will be enlisted to assist with communicating the restrictions to other family members and friends.
   d. Postpartum/newborn patient visitation is restricted during the hours of 2pm to 5pm; this allows for maternal bonding and establishment of breastfeeding. This is referred to as "Mommy- Baby nap time."
   e. Visitors who are ill are restricted from handling newborns and are encouraged to avoid visitation until they are healthy. This restriction is in place to protect the newborn from infection because of their impaired host defense mechanisms and their limited amounts of protective systems at the time of birth.
   f. Only children who are siblings of the newborn may visit in the Perinatal Department. (see e. for justification.)
   g. Visitors are encouraged to stay away if they have any flu symptoms, including a fever over 100 degrees, cough, sore throat, runny nose, rash or diarrhea, or if they have recently been exposed to someone with symptoms.
      i. If they must come as a visitor with any of these symptoms, they will be encouraged to wear a mask and perform frequent hand hygiene in order to reduce the risk of transmission of the infection to patients who are in compromised health during hospitalization.
      ii. Visitors with signs or symptoms of influenza will not be allowed to visit in the Perinatal Department. This is to avoid exposure of newborns that have a susceptible immune system.
   h. Operating Room visitation will be limited to patients needing support during induction of general anesthesia or when the patient is awake with spinal anesthesia. These cases will be at the discretion of surgeon and anesthesia provider. These support persons will be provided with appropriate surgical attire and staff will provide direction. Regulations require OR to be a controlled traffic area. This is important to infection control practices.
   i. Unruly behaviors by any visitor/support person/caretaker will lead to loss of visitation rights. This is in place to protect the staff, patients and other visitors at NIHD.
6. Number of Visitors: The number of visitors may be limited based on the needs of the patient and/or other patients on the unit.
7. Visitors and Patient Care: The patient will determine if s/he will allow the family to assist with her/his care or be present during her/his care.

8. Overnight Visitors:
   a. Family member, Significant Other or Caretaker may stay overnight with a patient. Children may not stay overnight unless an adult who is not the patient is available to provide supervision. Exception may be made for infants requiring breastfeeding from mother's admitted to the hospital.
   b. Overnight visitors are not provided with shower/hygiene facilities at the hospital. They are expected to utilize public restroom facilities outside of the patient room.
9. Visitors may purchase food at the hospital cafeteria or via vending machines.
10. Isolation: Visitors must follow the isolation instructions as posted and are encouraged to ask for assistance when questions or concerns arise. The Infection Preventionist or her designee may provide education on isolation procedures to the visitors.
11. Children: Child visitation is allowed according to individual patient and hospital needs. Children may disturb other patients, so they will be required to stay in the patient's room and limit the visit to a short period of time. They must be directly supervised by a parent/adult at all times. If children are noisy and/or disruptive, the parents may be asked to take their children out of the unit. Children may not be left in the care of a patient.

REFERENCES:

1. Up to Date: Infection control measures to prevent seasonal influenza in healthcare settings, Thorner MD, Hirsch MD, Baron MD. 2017, Sept.
2. CAH State Operations Manual 12/2016, 485.635(f) Patient Visitation Rights.
3. Medline ® Abstract for Reference 6 of 'Treatment and prevention of bacterial sepsis in the preterm infant (<34 weeks gestation)', Polin, Denson, Brady- Pediatrics. 2012 Apr;129(4):e1104-9. Epub 2012 Mar 26
4. TJC CAMCAH Jan 2016 Standard RI.01.01.01-EP 1, 2, 28 and 29.
5. Barriers to skin-to-skin care during the postpartum stay, American Journal of Maternal/Child Nursing Jan/Feb 2014, Volume:39 Number 1, page 56-61.
6. Helping mothers prevent influenza illness in their infants, Pediatrics Volume 126,
7. Title 77: Public Health ch 1:Part 250 Hospital Licensing Requirements section 250.1300 Operating Room.

CROSS REFERENCE P&P:

1. Nondiscrimination Policy
2. Childbirth Photography/Videotaping
3. Smoking Policy
4. Severe Acute Respiratory Syndrome (SARS) Infection Control Recommendations Hospitalized Patients
5. Observation in the Operating Room
6. Principles of Asepsis in the Operating Room
7. Support Person for the Obstetrical Patient in the Birthing and Operating Rooms

Approval	**Date**
CCOC	11/20/17
Infection Control Committee	11/28/17

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Patient Visitation Rights	
Scope: District	Manual: CPM-Admission, Discharge, Transfer (ADT)
Source: CNO	Effective Date:

STTA	1/24/18
Medical Services/ICU	1/25/18
Perinatal/Pediatrics	12/15/17
Medical Executive Committee	2/6/18
Board of Directors	
Last Board of Directors Review	

Developed: 10/6/2017
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Pre and Post Operative Anesthesia Visits	
Scope:	Manual: Anesthesia
Source: DON Perioperative Services	Effective Date: 5/3/2013

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

POLICY:
PRE- ANESTHESIA:

1. The preoperative visit shall be conducted personally, whenever possible, by the anesthesia provider who is scheduled to provide care for the patient.
2. The pre-operative visit shall include a disclosure of risks and options, a formulation of the plan of anesthesia and informed consent given to the patient and or patient representative, if the patient is not competent.
3. A pre-operative note of the findings relating to anesthesia including the plan of anesthesia, and the patient's informed consent shall be placed in the medical record.
4. A history and physical examination will be available in the patient's medical record at the time of the anesthesia provider's visit. This document shall not replace the anesthesia provider's responsibility for personally evaluating the patient.

POST-OPERATIVE:

1. Post-operative visits are recorded on the evaluation form or progress notes.
2. At least one note will describe the presence or absence of anesthesia related complications.
3. The number and timing of post-anesthesia visits will be determined by the status of the patient. It is recommended that a visit be made early in the post-operative period and after complete recovery from anesthesia.
4. Post-anesthesia notes should specify time and date and be completed within 48 hours after surgery.
5. Post-anesthetic assessment by an anesthesia provider shall be performed and entered in the medical records of all patients discharged directly from the PACU.

DOCUMENTATION: Documentation of pertinent patient information as designated above in the medical record
REFERENCES: CMS Conditions of Participation: Anesthesia Services 482.52 (b) 1, 3
CROSS REFERENCE P&P: Anesthesia Clinical Standards and Professional Conduct

Approval	**Date**
STTA	1/24/18
MEC	2/6/18
Board of Directors	
Last Board of Director review	1/18/17

Developed:
Reviewed:
Revised: 01/01; 12/2011 BS TS, 10/21/12 PM, 4/26/13 aw, 12/17aw
Supersedes:
Index Listings: Pre and Post Operative Anesthesia Visits; Anesthesia Visits/ Visits Anesthesia

NORTHERN INYO HOSPITAL

Standards of Care- The NEST	
Scope: Perinatal Services- NEST Program	Manual: Perinatal Services Unit- Standards of Care (S of C)
Source: Perinatal Manager	Effective Date: 9/14/14

POLICY:

NEST (Newborn, Evalution, Support, and Teaching) services are provided using an interdisciplinary team approach based on holistic assessment of patient needs, problems, capabilities, limitations, interventions, and patient response.

1. Patient expectations as defined will be met for each patient.
2. The patient age specific population served is:
    a. Patients of Childbearing Age
    b. Newborn: 0 days through 27 days of life

~~When the patient presents for OB/Maternity/NEST services, the patient and/or support person can expect:~~

PROCEDURE:

A qualified Perinatal Unit RN or LVN, with a minimum of lactation educator up to International Board Certified Lactation Consultant (IBCLC), will assess and care for all patients that present to the NEST. When the patient presents for OB/Maternity/NEST services, the patient and/or support person can expect:~~The NEST patient(s) and/or significant other can~~

1. For all patients:
    a. Perinatal RNs and LVNs will care for all Perinatal NEST patients.
    b. All Perinatal RNs and LVNs will have certifications in BLS and NRP
    c. All Perinatal RNs will have certification in STABLE
    d. All members of the health care team shall perform hand hygiene according to hospital policy
    e. To have a clean environment conducive to patient care
    f. To have interpretation services available 24 hours a day for women with limited English availability
    g. To be treated in a holistic, dignified and caring manner
    h. To be educated on specific topics to meet individual needs
    i. To receive information about patient rights
    j. To have the right to refuse specific procedures and/or treatments
    k. To have two patient identifiers
    l. All mothers in their third trimester will be offered an appointment at the NEST (Pre-Admission visit)
    m. All mother/infant dyads will be seen while postpartum in the hospital for a breastfeeding evaluation by NEST staff, if needed and ordered, in addition to the standard breastfeeding assessment and support provided by shift Perinatal RN
    n. All infants will be seen in the NEST within 24-48 hours of discharge for a RN basic assessment, weight, hyperbilirubinemia assessment (scan and/or blood draw), and breastfeeding evaluation
    o. Mother/infant dyads may return to the NEST PRN for breastfeeding support and assistance and/or hyperbilirubinemia assessment

~~1.~~2. Pre-Admission Visit:

A. Upon arrival the patient and support person will ~~be greeted~~register in the main hospital lobby ~~by NEST staff and assisted in pre-registering f~~followed ~~b~~by an Perinatal unit tour given by Perinatal NEST staff

B. The patient and support person will be escorted to the NEST and oriented to unit and educated on what the NEST will offer after her baby is born.

C. The patient's specific birthing desires will be reviewed and childbirth education discussed and documented

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Comment [l1]: What was currently written… delete and replace with above?

Comment [l2]: What was currently written… delete and replace with above?

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Comment [l3]: Do we need to state that the NEST RN is LE? Sometimes on the weekends the staff isn't

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a. Birthing plan and breastfeeding goals created and attached to patient prenatal record
b. Patient specific education completed
    i. Childbirth Classes available
    ii. Breastfeeding education provided. If applicable, education on bottle feeding
    iii. Baby Friendly Hospital Initiative practices reviewed
c. Patient profile completed
~~a.~~d. Complete all documentation and patient education in the EMR.
e. The patient's choice for pediatric care for her newborn will be discussed and documented. ~~circumcision handout will be given if applicable and a list of MD approved websites will be given~~

D. In Hospital Visit:
a. Lactation specific visit regardless of feeding type
b. Perinatal NEST staff visits mother/infant dyad to evaluate and assist with infant feeding
c. Provide individualized lactation education and assistance
d. Documents feeding session and education in EMR

E. Mother and Newborn Follow-up Appointment:
a. Weigh the infant naked (per Admission and Care of newborn policy) and calculate percentage loss. If weight loss greater than or equal to 10% inform MD
b. Transcutaneous Bilirubin scan on each infant per policy. Calculate risk per "up to date" or "bilitool". If risk is high intermediate or higher, greater than 75% or phototherapy recommended, or greater than 13, order a neonatal-bilirubin level to be drawn by lab or Perinatal NEST staff and call results to MD. Document risk level with bili level.
c. Complete and document vital signs per admission and care of newborn policy with initial follow up visit only, unless needed at subsequent visits or per family request.
d. Complete assessment of infant, upon arrival, within 1 hour, with initial follow up visit only, unless needed at subsequent visits or per family request.
    i. Activity level
    ii. Color/jaundice
    iii. Neuromuscular
    iv. Respiratory
    v. Cardiac
    vi. Umbilicus
    vii. Circumcision if applicable
    viii. Parent interaction
e. Assess and document infant voiding and stooling patterns
f. Review and document the newborn's feeding pattern and technique, providing assistance prn, of breastfeeding for appropriate positioning, latch, coordinated sucking and swallowing, and any concerns regarding clinical problems that can disrupt effective breastfeeding
g. Perinatal NEST staff may introduce tools to assist with breastfeeding as deemed necessary
h. Complete and document maternal breast assessment upon arrival in NEST, within 1 hour.
i. Pre-and post feeding weight prn
j. Reinforce education (including, but not limited to newborn care, feeding practices, safe sleep practices, post partum depression, community resources, New Mom Group, Period of Purple Crying)
k. Perform any necessary screening tests in accordance with state regulation
l. Review parent concerns and questions; provide resources available to parents
m. Handout Prevention Gift Bag to parents and educate on items inside
n. Complete all documentation in EMR

Comment [I4]:

Comment [I5]: We don't do this full assessment beyond the post d/c visit; Dr Helvie is ok not doing VS on f/u visits (I typically chart what I can see visually (e.g. alert, respirations unlabored, etc) How do we capture that here? Perhaps be need a separate section for f/u visits and this would just be for Post d/c visits??

Comment [I6]: Need?

NORTHERN INYO HOSPITAL

Standards of Care- The NEST	
Scope: Perinatal Services- NEST Program	Manual: Perinatal Services Unit- Standards of Care (S of C)
Source: Perinatal Manager	Effective Date: 9/14/14

o. If during business hours, call physician's office to schedule well baby check and inform parents of date, place, and time.
p. At the end of the day, inform MD office of infants coming back for weight or bili checks.

F. Practice procedures for sending infant home without notifying physician
a. Bilirubin: In low intermediate risk zone or less with no clinical risk factors
b. Weight: Less than 7% total, less than 3% weight loss per day, and feeding well infant may leave NEST to follow with physician at day of life 10-14
c. If infant is at 7-10% weight loss or more than 3% weight loss per day may go home and follow up at NEST within 24 hours for a weight check. If infant is coming back for a weight check, must call physician with weight when infant returns the following day.

~~C.~~G. Call and inform infant's MD prior to infant leaving NEST visit if:
a. High risk jaundice level regardless of phototherapy range or not
b. If hyperbilirubinemia policy implemented and neonatal bilirubin drawn, must call physician with serum results when obtained.
c. Greater than or equal to 10% weight loss
d. Any other problems or concerns
e. At the end of each day, NEST will fax the physician a copy of who they saw, weights and bili levels, and who is coming back the next day for further evaluation

H. Breastfeeding support:
a. All care coordinated according to Breastfeeding policy
b. See Late Preterm Infant Feeding policy, if applicable
c. See Medical Need to Supplement, if necessary
d. All breastfeeding mothers will be educated on
i. Signs of hunger/feeding cues
ii. Breastfeeding benefits/risks of not breastfeeding
iii. Proper position and latch
iv. Milk production and maintenance
v. Nutritive sucking and swallowing
vi. Frequency of feeding
vii. Hand expression and pumping
viii. Warning signs and when to contact the physician
e. All infants coming in for additional breastfeeding support will be weighed. May choose to do a naked weight and/or a pre-post weight in clothes, depending on reason for breastfeeding support
f. Review and document the newborn's feeding pattern and technique, including observation and intervention if necessary of breastfeeding for appropriate positioning, latch, coordinated sucking and swallowing, and any concerns regarding clinical problems that can disrupt effective breastfeeding. Assess and document infant's voiding and stooling patterns
g. Perform a comprehensive maternal/infant/feeding assessment in relation to lactation
h. Develop and implement a feeding care plan as indicated
i. Provide evidenced-based information related to medication, alcohol, tobacco, and street drugs and their potential impact on milk production and child safety
j. Integrate all aspects of breastfeeding: Cultural, psychosocial, nutritional, and physical aspects
k. Protect, promote, and support mothers to successfully meet their breastfeeding goals
l. Work collaboratively with all members of the health care team and community partners to coordinate care. Refer patient to Lactation Consultant or MD when necessary

~~a.~~m. Breastfeeding statistics collected on each patient at discharge, 1 month, 3 months, 6 months, and 1 year. All of this information to be documented in NEST data collection tool

Comment [I7]: Need given that we lay out the parameters below??

Comment [I8]: We chart in Centricity when patient's "graduate" from NEST (before their 2 week appt).. do we need either process in here?

Comment [I9]: We likely need a separate policy of some form for IBCLC visits/criteria, right?

Comment [I10]: Where? This isn't in our charting! Necessary here? (we can add it to our charting ☺)

Comment [I11]: Part of BFHI

Comment [I12]: Redundant due to g?

Comment [I13]: Need? Or add in "if indicated" ??

Comment [I14]: Necessary? This is part of the grant, so I would think would be separate from our Standards of Practice

NORTHERN INYO HOSPITAL

Standards of Care- The NEST	
Scope: Perinatal Services- NEST Program	Manual: Perinatal Services Unit- Standards of Care (S of C)
Source: Perinatal Manager	Effective Date: 9/14/14

REFERENCES:

1. 1. https://www.pediatriccareonline.org/pco/ub/view/AAP-Textbook-of-Pediatric-Care/394094/0/Follow_Up_Care_of_the_Healthy_Newborn
2. 2. http://brightfutures.aap.org/tool_and_resource_kit.html
3. http://iblce.org/wp-content/uploads/2013/08/scope-of-practice.pdf

Committee Approval	**Date**
CCOC	**12/18/17**
Peri-Peds Committee	**12/15/17**
Medical Executive Committee	**2/6/18**
Board of Directors	
Last Board of Director Review	

Developed: 5/5/2014nm
Reviewed: 12/17lg
Revised: 12/17lg

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standards of Patient Care in the Perinatal Unit	
Scope: Perinatal Department	Manual: Perinatal Manual
Source: OB Nurse Manager	Effective Date:

Policy Statement:
Perinatal Nursing is provided using an interdisciplinary team approach based on a holistic assessment of patient needs, problems, capabilities, limitations, interventions, and patient response.

1. Patient expectations as defined will be met for each patient.
2. The patient age specific population served is:
   a. Patients of Childbearing Age
   b. Newborn: 0 days through 27 days of life

Procedure:
The Perinatal patient and/or significant other can expect:

1. For all patients:
   a. Perinatal RNs and LVNs will care for all perinatal patients. A float or cross trained RN or LVN may care for postpartum mothers and infants
   b. All Perinatal RNs and LVNs will have certifications in BLS and NRP
   c. All Perinatal RNs will have certification in STABLE
   d. All RNs taking care of intrapartum patients will be current in Intermediate or Advanced Fetal Monitoring, and maintain competencies and certifications per department standards
   e. All members of the health care team shall perform hand hygiene according to hospital policy
   f. To have a clean environment conducive to patient care
   g. To have interpretation services available 24 hours a day for women with limited English availability
   h. To have access to unscheduled or emergency visits on a 24 hour basis
   i. To be treated in a holistic, dignified, and caring manner
   j. To be educated on specific topics to meet individual needs
   k. To receive information about patient rights and advance directives related to healthcare.
   l. To have discharge needs identified
   m. To have the right to refuse specific procedures and/or treatments.
   n. To have two patient identifiers

2. Upon arrival to unit (outpatient):
   a. To be taken care of by a Perinatal Registered Nurse.
   b. To be placed in a triage or labor room according to presenting complaint and condition.
   c. To have his/her admitting or transfer condition assessed (quick check) by an RN within 15 minutes of arrival.
   d. To potentially have a roommate if in the triage area.
   e. To be cared for as soon as possible by a Perinatal RN based upon patient census and triage assessment.
   f. To be informed and updated on plan of care and changes to plan.
   g. To have vital signs including blood pressure, pulse, respirations, temperature, and pain level assessed upon arrival and thereafter depending on provider orders and patient condition. (Simpson & Creehan, 2014 p. 352).
   h. To have RN review prenatal record (if available) and be familiar with the patient's history and condition.
   i. To assess for fetal well being, presence or absence of fetal movement, assessment of vaginal discharge, fluid, or bleeding.
   j. To have assessment of fetal heart tones and uterine activity (Simpson & Creehan, 2014)
   k. When being evaluated for labor, the following may also be assessed: frequency and duration of uterine contractions; fetal heart rate patterns; cervical dilatation and effacement, and fetal presentation and station of the presenting part (unless contraindicated); status of the membranes. (Simpson & Creehan, 2014 p.9)
   l. To potentially have interventions such as referral to appropriate resources, sterile vaginal exam, speculum exam, ultrasound, laboratory screening, medications, IV placement, potential to stay overnight for observation, admission to Perinatal unit, or transfer to a higher level of care facility via ground ambulance

or air service, or preparation for rapid delivery. All of these would be done according to patient and fetal status.

m. To have OB provider informed and aware of patient status, to be updated on changes to patient status, and make a decision on plan of care.
n. To be discharged with instructions, transferred to a higher level of care, or to be admitted to OB unit.

3. On Admission
    a. To be oriented to room and Perinatal unit environment and routine within 2 hours of arrival.
    b. To have admission assessment completed within 2 hours of admission, unless delayed due to medical condition.
    c. To have her health status monitored and full head to toe assessment by an RN on admission, per provider orders, and as the patient's condition warrants.
    d. To receive prompt identification and intervention for potential and actual complications and emergencies.
    e. To have pain assessed and managed in a systematic way, and with the understanding that labor is painful and that full pain relief may not be a patient goal nor objective.
    f. To have skin integrity maintained.
    g. To be supported in activities of daily living as necessary (bathing, peri-care, ambulation, feeding, mouth care, etc.)
    h. To be cared for in an environment that is safe, secure, and private as demonstrated by:
        i. Call light within reach
        ii. Upper side rails up as appropriate
        iii. Privacy curtain pulled as needed
        iv. Bed maintained in low position
        v. Fall risk assessment completed on admission and as needed per policy.
        vi. To have identification bracelet(s) in place.
        vii. To have allergy bracelet if applicable
        viii. To be in a smoke free environment
        ix. To have confidentiality maintained
        x. To have a clean, well maintained, and ventilated patient room
    l. To be supported throughout the admission with information and education as appropriate to maximizing their understanding of their health status, disease processes, treatment options, and expected outcomes of same (i.e. medication, activities of daily living, follow-up care, etc.)
    m. To have continuity of care maintained between caregivers and other departments through appropriate sharing of information and achieved through documentation, report, order entry of patient data and progress.
    n. To receive information about patient rights and advance directives related to healthcare.
    o. To have discharge needs identified throughout hospitalization and have an interdisciplinary plan implemented as indicated to meet identified needs.
    p. To have labs drawn.
    q. To have an IV placed.
    r. To receive IV fluids if indicated and ordered.
    s. To have antibiotics during labor if known to be GBS positive or if GBS status is unknown, or in the presence of suspected infection.
    t. To have an ultrasound if indicated and ordered.
    u. To be educated on infant security practices and policies.
    v. To be educated on signs of imminent delivery and when to call RN to bedside.

4. Throughout stay:
    d. Intrapartum (labor)

a. To have a sterile vaginal examination by RN, MD, or CNM to assess for dilatation, effacement, position, consistency, and station periodically through labor.
b. To be on continuous or intermittent electronic fetal and uterine contraction monitoring according to OB provider orders and fetal well being.
c. To have internal fetal and contraction monitoring if indicated.
d. To have FHT and uterine contractions monitored and documented throughout labor.
e. To have intrauterine resuscitation methods performed if indicated.
f. To be educated on pain relief options available, including pharmaceutical as well as non-pharmaceutical options.
a. To allow patient to manage labor pains through whichever available methods most suits her needs and desires, unless contraindicated.
b. To utilize the labor tub on a first come, first serve basis, unless contraindicated.
c. If requesting an epidural
    i. To be fully informed by anesthesia provider and sign a consent for epidural.
    ii. To be expected to sit up and keep still during epidural procedure.
    iii. To have a Foley catheter placed after epidural placement.
    iv. To be on continuous fetal monitoring after epidural placement.
    v. To receive medications to manage blood pressure, per provider orders.
    vi. To not get out of bed with epidural in place.
    vii. To be assisted in changing positions.
    viii. To have continuous IV fluid infusion.
    ix. To be prepared for emergency measures, including cesarean section if necessary.
    x. To have epidural turned off after delivery or per provider order.
    xi. To have Foley catheter removed prior to pushing or delivery.
    xii. To have epidural catheter removed by RN or MD after delivery.
    xiii. To have leg strength evaluated before attempting to get out of bed after removal of epidural.
    xiv. To get up with assistance the first time out of bed after epidural is out and as frequently as needed.
d. To be encouraged to frequently change positions and empty if patient does not have epidural.
e. To potentially have labor augmented.
f. To be informed from physician, and sign a consent if requiring augmentation or intervention outside of the normal course of labor.
g. To have perineal care and pad changes as needed during labor.
h. To have a minimum of 2 RN's and 1 physician or certified nurse midwife present at each delivery.
i. To have a respiratory therapist, additional RNs, and a pediatrician present at delivery, if indicated.
j. To be educated on pushing technique prior to delivery.
k. To have mirror, birthing ball, or birthing bar available upon patient request.
l. To have an infant warmer in the room for delivery
m. To have a physician or certified nurse midwife deliver the baby.
n. To be prepared for an assisted vaginal birth via forceps or vacuum if medically indicated.
o. To have local pain medication offered for repair if patient has an unmedicated delivery and repair is needed.
p. To have infant placed skin to skin on mother immediately after delivery if both are medically stable, and to have infant remain skin to skin for one hour or until after breastfeeding is established.

5. Unscheduled Cesarean Section:
    a. To sign consent for cesarean section and blood transfusion after receiving information from OB provider.

b. To have one support person attend a cesarean section, unless patient is undergoing general anesthesia, or per OB provider. Support person will wear surgical attire, including scrubs or jumpsuit, hair covering, mask, and booties.
c. To be prepped for surgery per OB and anesthesia provider orders and hospital policy.
d. To be transported to OR via bed or gurney.
e. To have care assumed by an OR RN, while the Perinatal RN will take care of the infant after delivery
f. To have fetal heart tones assessed after placement of spinal anesthesia.
g. To have respiratory therapy and potentially a pediatrician accompany the Perinatal RN at delivery
h. To have a Perinatal RN take infant to warmer for initial stabilization and any further resuscitation measures if needed.
i. To have identification bracelets placed on the mother and infant before the infant leaves the OR.
j. To have newborn medications administered per orders.
k. To be able to see, hold, touch, and complete skin to skin with infant at delivery if infant and mother are stable and staffing levels permit. Skin to skin shall be continued in PACU by Perinatal RN or LVN if patient and infant conditions and if staffing levels permit.
l. Support person may stay with patient or accompany infant and RN back to OB or PACU unit if infant is medically stable if skin to skin contact not maintained.
m. To have infant placed skin to skin with designated support person if mother unable to initiate or continue skin to skin, and infant is stable.
n. To be cared for in PACU after surgery until stable.

6. Scheduled Cesarean Section (additional):
    a. To be assessed in perinatal department upon arrival, including having a NST completed and vital signs taken.
    b. To be accompanied to PACU via ambulation, wheelchair, or gurney per patient's request and condition.
    c. To have PACU staff completes all pre-op nursing care.
7. Newborn Care
    a. To have a Perinatal RN care for infant until stable, after which a qualified RN or LVN may care for infant.
    b. To have all health care providers taking care of infant will be trained and current in neonatal resuscitation (NRP)
    c. The infant will be assigned APGAR scores at 1 and 5 minutes, and thereafter per infant condition.
    d. To have a plastic cord clamp placed on infants' cord, and removed after cord has dried.
    e. To be placed skin to skin as soon as possible after delivery if mother and infant are stable
    f. To be encouraged to keep the infant skin to skin for at least an hour or until the first breastfeeding is accomplished (PN, 546).
    g. If the mother has chosen to breastfeed, the infant should be placed at the breast within the first hour of birth if condition permits (Simpson & Creehan, 2014 p. 589)
    h. If infant needs any resuscitation, infant will be taken to warmer for evaluation and intervention prior to being placed skin to skin. Infant will stay in warmer until noted to be stable or transferred.
    i. To have infant vital signs taken per orders.
    j. To have infant's newborn medications administered within the first hour after birth, unless refused by parent and refusal form signed.
    k. To have a security tag placed on infant as well as 2 wristbands, with the mother getting a matching wristband for infant security, within 2 hours of birth.
    l. To have no children under the age of 14 allowed in OB unit unless they are the parent's own children, or siblings of the newborn.
    m. To have infant weighed and measured only after skin to skin is completed.
    n. To have a crib card filled out with infant's weights and measurements available for the parents to take home.

o. To have a bassinette present in room that includes a bulb syringe, diapers, wipes, thermometer, infant swaddle, burp cloth, and self inflating resuscitation bag for emergency use.
p. To be educated on how and when to use bulb syringe.
q. To be educated on changing diapers and voiding/stooling patterns of newborns.
r. To be educated on newborn feeding practices with exclusive breastfeeding being the expected form of infant feeding unless contraindicated or otherwise specified.
s. To be educated on safe sleep practices and have those practices modeled while in hospital with infant placed on back to sleep.
t. To be offered newborn care and other educational videos while in hospital.
u. To potentially have newborn blood sugars checked by heel stick according to clinical indication.
v. To have a full nursing assessment of the infant performed at least once a shift.
w. To have pediatric provider see infant within 24 hours of delivery, unless immediate attention is indicated.
x. To have pediatric provider see infant every day until discharge.
y. To be taken to the infant warmer or nursery if clinical condition necessitates
z. To be educated on newborn medications.
aa. To have an infant bath completed after 24 hours of life, or sooner/not at all if requested.
bb. To have the infant room-in with mother during hospital stay.
cc. To have on-going breastfeeding support available throughout stay.
dd. To have infant weighed a minimum of at birth, at 24 hours of life and every morning thereafter until discharge.
ee. To have newborn screen done after 24 hours of life, or at a minimum of 12 hours of life if indicated.
ff. To have hearing screen done while in the hospital, and if infant does not pass, will be scheduled for re-test per state guidelines.
gg. To have jaundice checked by a transcutaneous test before discharge, and by blood test if indicated and per orders.
hh. To have Chronic Heart Defect screening performed after infant is 24 hours old.
ii. To stay in OB unit for at least 24 hours post-delivery. If mother was known to be GBS positive or GBS unknown, and did not get adequate treatment, infant will stay a minimum of 48 hours.
jj. To be given discharge instructions with a discharge packet and to have all questions addressed.
kk. To be seen by a lactation consultant or lactation educator before discharge for assistance with breastfeeding.
ll. To have received educations and to have had questions addressed regarding newborn care before discharge from the hospital.
mm. To have hugs tag removed and ID bands checked with mother before discharge from hospital, and to sign infant release.
nn. To bring car seat up to the perinatal unit, and to have a hospital staff member carry infant in car seat to vehicle, unless other arrangements are made.

8. Postpartum Care
   d. To have a Perinatal RN assigned to the immediate recovery of the mother for at least the first two hours of recovery. (GPC, 195)
   e. To be cared for by a qualified LVN or RN after initial recovery period.
   f. To have a diet tray provided after delivery and repair (if indicated), unless contraindicated or ordered.
   g. To have vital signs, fundus, and lochia checked a minimum of per provider orders and as condition warrants.
   h. To potentially have labs drawn following delivery.
   i. To have perineal care performed after delivery and to be taught self perineal care.
   j. To be encouraged to ambulate frequently, unless contraindicated, and to have assistance with ambulation as needed. (GPC, 196)
   k. To receive support and education regarding breastfeeding.

l. To receive support and education on infant feeding if infant is not breastfeeding, or if supplementation is required.
m. To not have no formula given to infant unless medically indicated or per mother's desires, and then only after documented education regarding breastfeeding as best practice.
n. To have an inpatient NEST visit during stay, if staffing permits.
o. To adhere to visitation policy.
p. To receive postpartum immunizations and/or anti-D immune globulin before discharge as indicated.

9. On transfer within house:
    a. To have transferring RN give receiving RN a detailed SBAR-QC report of diagnosis, condition, and current plan of care.
    b. To receive specialized education and needs (ie, breastfeeding) addressed by a qualified RN or LVN.
    c. On discharge/transfer to another facility:
    d. To have a visit from case management and/or social services prior to discharge, if available.
    e. To have discharge instructions reviewed and all questions and concerns addressed.
    f. To have a follow up appointment for herself and her infant at the NEST within 48 hours of discharge, per provider orders.
    g. To be instructed on self-care needs and ordered activity, and what symptoms require immediate medical attention, and when to call OB or pediatric provider.
    h. To be transported or discharged with all personal belongings.
    i. To have completed the birth certificate before discharge, or to have made arrangement to complete birth certificate within required timeframe (5 days).

10. On expiration of the fetus/infant:
    a. To have the opportunity to be with fetus/infant for duration of the mother's choosing.
    b. To receive spiritual counseling if desired.
    c. To receive a visit by the social worker or case manager.
    d. To have post-mortem care completed and body released to Funeral Home or per policy based on gestational age and/or weight.
11. On expiration of the mother:
    a. To have all medical staff assigned to the case, family member/significant other/Power of Attorney/health care surrogate, and organ procurement agency notified of death.
    b. To have all belongings returned to family or sent with body to funeral home.

References:

1. American Nurses Association. (2010). *Nursing Scope and Standards of Practice*. Silver Spring, MD: Nursesbooks.org
2. https://www.pediatriccareonline.org/pco/ub/view/AAP-Textbook-of-Pediatric-Care/394094/0/Follow_Up_Care_of_the_Healthy_Newborn
3. http://brightfutures.aap.org/tool_and_resource_kit.html
4. http://iblce.org/wp-content/uploads/2013/08/scope-of-practice.pdf
5. http://www.cdc.gov/breastfeeding/resources/guide.htm
6. Simpson, K & Creehan, P (AWHONN). (2014) Perinatal Nursing 4th ed. Philidelphia, PA: Lippincott Williams & Wilkins.
7. AAP & ACOG. (2012) Guidelines for Perinatal Care 7th ed.

Cross-reference Hospital policies:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standards of Patient Care in the Perinatal Unit	
Scope: Perinatal Department	Manual: Perinatal Manual
Source: OB Nurse Manager	Effective Date:

1. Patient Rights
2. Plan for the Provision of Nursing Care
3. Admission and Care of the Newborn
4. Neonatal Death, Fetal Demise & Spontaneous Abortion
5. Labor, care during (Lippincott Procedures)
6. Vaginal examination during labor (Lippincott Procedures)

Committee (s) Approval:	**Date:**
CCOC	1/29/18
Perinatal/Pediatrics Committee	12/15/17
Medical Executive Committee	2/6/18
Board of Directors:	
Last Board of Directors Review	

Developed: 12/2017sg
Revised:
Reviewed:

Emergency Room Service Critical Indicators

2018

- Physician and Staff ~~Nursing~~ Concerns
- All non-5150 Transfers
- Formal Patient Complaints
- Pt. Refusal of Treatment, AMA, or Elopements
- Unscheduled Return or Admit Seen Within 48 Hours
- All Codes, Deaths, and Critical Patients
- ED Acquired Infections
- Death Within 24 Hours of Visit
- Laceration Repair With Recheck Concern
- Specific Procedures
  a) Procedural Sedation
- All Incoming Transfers
- Suicide or Attempted Suicide in the ED
- Nosocomial Infections (For Referral)
- Concern Regarding Quality of Pre-Hospital Care
- Unscheduled ED Visit of Pt. Discharged Within 72 Hours

Approved: Emergency Room Service Committee on 1/10/2018

Approved: MEC on 2/6/2018

Approved: BOD on

Medical Services Critical Indicators

2018

- Readmit to hospital w/in 30 days-same or related problem
- Medical death
- Hospice inpatient
- Use of restraints
- Staff Concerns

Approved: Medicine/ICU Committee on 1/25/18

Approved: MEC on 2/6/18

Approved: BOD on

ICU Critical Indicators

2018

- Unexpected Deaths
- Ventilator Associated Complications
- Unexpected Complications After Discharge or Transfer from ICU
- Staff Concerns

Approved: Medicine/ICU Committee on 1/25/18

Approved: MEC on 2/6/18

Approved: BOD on

Originating Site: Hospital Name

Telemedicine Professional Practice Evaluation

Complaints and Adverse Events

Provider Reviewed: _____

Date of Review: _____

Hospital or Care Setting: _____

If the provider has been the subject of any complaints and/or adverse events, please report those events on this form:

Date of complaint or adverse event: _____

Details of complaint or adverse event: _____

_____

_____

_____

_____

_____

_____

Overall Impression:		
Acceptable ☐	Marginal ☐	Unacceptable ☐

Reviewer's Signature: _____ **Date:** _____

Reviewer's Printed Name: _____

Routed to appropriate Distant Site: (*Check one*)

____ GAMC – FAX # (818) 546-5632
____ SJCH – FAX # (661) 869-6954
____ SHNV – FAX # (707) 967-5622
____ SVH – FAX # (805) 955-6909
____ WMMC – FAX # (323) 881-8627
____ LLUMC – FAX # (909) 558 - 6257

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

INTERNAL MEDICINE

Instructions: Please check box next to each core privilege/special privilege requested.

INITIAL CRITERIA

Education/Formal Training:

- Completed accredited residency training in Internal Medicine or equivalent.
- Board Certified/Board Eligible by the American Board of Internal Medicine or equivalent.

INPATIENT CORE PRIVILEGES

Current ACLS certification required

Request	
☐	• Admit, evaluate, diagnose, perform H&P, consult and provide nonsurgical treatment to patients presenting with general medical problems. • Admit, evaluate, diagnose, perform H&P, consult and provide nonsurgical treatment to patients presenting with critical illnesses, needing ICU care. • Ventilator management.

OUTPATIENT CORE PRIVILEGES

Request	
☐	• Admit, evaluate, diagnose, perform H&P, consult and provide nonsurgical treatment to patients presenting with general medical problems to the outpatient setting.

SPECIAL PRIVILEGES

☐ Anoscopy	☐ I&D cutaneous abscess
☐ Arterial line placement	☐ Insertion/management of PA catheters
☐ Arterial puncture	☐ Insertion/management of temporary transvenous pacemaker
☐ Arthocentesis - small joint	☐ IUD insertion
☐ Arthrocentesis - large joint	☐ IUD removal
☐ Aspiration of intra-, subcutaneous cysts, furnucles, etc	☐ Liquid nitrogen treatment warts, keratosis
☐ Bronchoscopy	☐ Lumbar puncture
☐ Buprenophine (Suboxone) – certification required	☐ PFT interpretation
☐ Cancer chemotherapy (in consultation with oncologist per protocol)	☐ Removal of a non-penetrating corneal foreign body, foreign body from conjunctival sac, ear, nose, skin
☐ Central venous line placement	☐ Rigid/flexible sigmoidoscopy
☐ Conscious sedation (requires tutorial and current ACLS certificate)	☐ Skin biopsy
☐ Diagnostic and therapeutic paracentesis	☐ Sleep Study Interpretation (Board certified by American Board of Sleep Medicine or completion of Sleep Medicine fellowship program)
☐ Diagnostic and therapeutic thoracentesis	☐ Stress test interpretation
☐ Diaphragm fitting	☐ Suture minor lacerations
☐ EKG/Holter/Event Monitor interpretation	☐ Therapeutic injection - small or large joint
☐ Electrical cardioversion	☐ Toe nail avulsion
☐ Emergency pericardiocentesis	☐ Tube thoracotomy (chest tube placement)
☐ Emergency tracheostomy/cricothroidotomy	
☐ Endotracheal tube placement	

CONSULTING PRIVILEGES

(for Consulting Staff only)

Request	
☐	• Provide consultation, order, interpret, and evaluate diagnostic tests to identify and assess patients' clinical problems and health care needs on request from Active or Provisional Staff members or Temporary Privileges Practitioners.

Please sign acknowledgment on next page.

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

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

Acknowledgment of Practitioner:
I have requested only those privileges for which by education, training, health status, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Medical Staff Bylaws, Rules and Regulations, and policies and procedures applicable.
(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 Signature *Date*

_____ _____
Chief of Medicine/Intensive Care *Date*

_____ _____
Chief of Surgery *Date*

_____ _____
Chief of Staff *Date*

_____ _____
President, Board of Directors *Date*

Approvals	*Committee Date*
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(Office use only)