

November 20 2019 Regular Meeting

November 20 2019 Regular Meeting - November 20 2019 Reg

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AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
November 20, 2019 at 5:30 p.m.
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. Inyo County First 5 Strategic Plan for 2019-2024, Serena Johnson (*information item*).
4. Transesophageal Program at NIHD (*information item*).
5. Pharmacy construction project update (*information item*).
6. Strategic Plan update, Finance and Market Share Committee report (*information item*).
7. New Business:
 - A. Grievance Mediation Outcome (*information item*)
 - B. Independence School District, Occupational Therapy Services (*information item*)
 - C. Determination of Ad Hoc Committee to fill District Zone 5 Board vacancy (*action item*)
 - D. Policy and Procedure approval, *Repackaging and Compounding of Medications* (*action item*)
 - E. AB 2190 Attestation (*information item*)
 - F. Discussion of California law AB-5 (*information item*)
8. Old Business:
 - A. Revised General Counsel Legal Services Request for Proposal (*possible action*)
9. Reports (*information items*):
 - A. Pioneer Home Health update, Pat West (*information item*)
 - B. Strategic Planning update/follow-up (*information item*)
10. Chief of Staff Report, William Timbers, MD:
 - A. Policy and Procedure approvals (*action items*):
 1. *Admissions, Discharge, Transfer of Patients: Continuum of Care*
 2. *Pediatric Ambulatory Blood Pressure Monitoring Policy*
 3. *Drug Storage and Inspections of Medication Areas*
 4. *Emergency Medications Trays Policy*

5. *Influenza Vaccination Policy*
 6. *Pharmacist Intervention for Iron Replacement*
 7. *Rehabilitation Services Standard of Care*
 8. *Repackaging and Compounding of Medications*
 9. *Sharps Injury Protection Plan*
 10. *Therapy Evaluation/Inpatients, OPO, and Swing Bed Patients*
 11. *Use of Biosimilar Products at Northern Inyo Healthcare District*
- B. Medical Staff Appointments and Privileges (*action items*):
1. Kelly T. Brace, DPM (*podiatry*) – Provisional Active Staff
 2. Matthew Ercolani, MD (*urology*) – Provisional Consulting Staff
 3. Daniel Su, MD (*cardiology*) – Provisional Consulting Staff
 4. Vlad Radulescu, MD (*cardiology*) – Telemedicine Staff
 5. Felix Karp, MD (*internal medicine*) – Provisional Active Staff
- C. Extension of Temporary Privileges through December 31, 2019 (*action items*):
1. Joseph BenPerlas, MD (*internal medicine*)
 2. Sumon Syed, MD (*internal medicine*)
 3. Shiva Shabnam, MD (*internal medicine*)
- D. New Privileges (*action item*):
1. James Fair, MD (*emergency medicine*) – privileges for the performance of transesophageal echocardiograms (TEE)
- E. Recommendations for Advancement (*action items*):
1. Stefan Schunk, MD (*internal medicine*) – advancement from Provisional Active Staff to Active Staff
 2. Atashi Mandal, MD (*internal medicine*) – advancement from Provisional Active Staff to Active Staff
- F. Resignations (*action items*):
1. Jennie Walker, MD (*emergency medicine*) – effective 10/01/19
 2. Jessica Paulson, MD (*emergency medicine*) – effective 10/15/19
 3. H. Charlie Wolf, MD (*emergency medicine*) – effective 12/31/19
 4. Sarkis Kiramijyan, MD (*cardiology*) – effective 12/31/19
 5. Gabriel Overholtzer, DDS (*dentistry*) – effective 12/31/19
- G. Physician recruitment update (*information item*).

Consent Agenda (action items)

11. Approval of minutes of the October 16 2019 regular meeting
12. Financial and statistical reports as of September 2019
13. Chief Nursing Officer Report
14. Chief Executive Officer Report
15. Chief Operating Officer Report
16. Chief Financial Officer Report
17. Compliance Department Quarterly Report
18. Policy and Procedure annual approvals

-
19. Reports from Board members (*information items*).
 20. Adjournment to Closed Session to/for:
 - A. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
 - B. Conference with Labor Negotiators; Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
 - C. Confer with Legal Counsel regarding threatened litigation, 3 matters pending (*pursuant to Government Code Section 54956.9(d)(2)*).
 - D. Discussion of a real estate negotiation regarding price, 152 Pioneer Lane, Bishop, California, Agency negotiators Kevin S. Flanigan MD, MBA and Pioneer Medical Associates partners (*pursuant to Government Code Section 54956.8*).
 21. Return to Open Session and report of any action taken in Closed Session.
 22. 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.



Strategic Plan 2019-2024

ACKNOWLEDGEMENTS

First 5 Inyo would like to thank partners and staff for providing valuable insights and recommendations, and First 5 Inyo Commissioners for their guidance and support.

Special thanks to Little Country School House students for their artwork.



First 5 Inyo is a program of Public Health and Prevention division of Inyo County Health & Human Services (HHS). Inyo County HHS works to “Strengthen Resilience and Well-Being In Our Community.”

*This plan was adopted by the First 5 Inyo Commission on:
June 27, 2019*

About the Commission

In November 1998, California voters passed Proposition 10, the "Children and Families Act of 1998." Its intent was to facilitate the creation and implementation of an integrated, comprehensive, and collaborative system of information and services to enhance optimal early child development, and to ensure that children are ready to enter school and reach their full potential.

The Inyo County Children and Families Commission was created in 1999 by the Inyo County Board of Supervisors to carry out the work of Proposition 10 in the county.

First 5 Inyo Commissioners

Anna Scott, Chair - HHS Director Designee

HHS Deputy Director of Public Health and Prevention

Mark Tillemans, Vice-Chair – County Supervisor

District 4 Supervisor

Jeff Griffiths, Vice-Chair - County Supervisor Alternate

District 2 Supervisor

Melissa Best-Baker - HHS Designee

HHS Fiscal Senior Management Analyst

Heather Carr - Early Child Educator

Inyo County Office of Education Director of Special Education

Eileen Jackson - Parent Representative

Amanda Miloradich - Early Child Health Representative

Bishop Indian Head Start Health Advisor

Barry Simpson - Early Child Educator

Inyo County Office of Education Superintendent of Schools

First 5 Inyo Staff

Serena Johnson, First 5 Director

Barbara Keller, Prevention Specialist

Melissa Ruiz, Prevention Specialist

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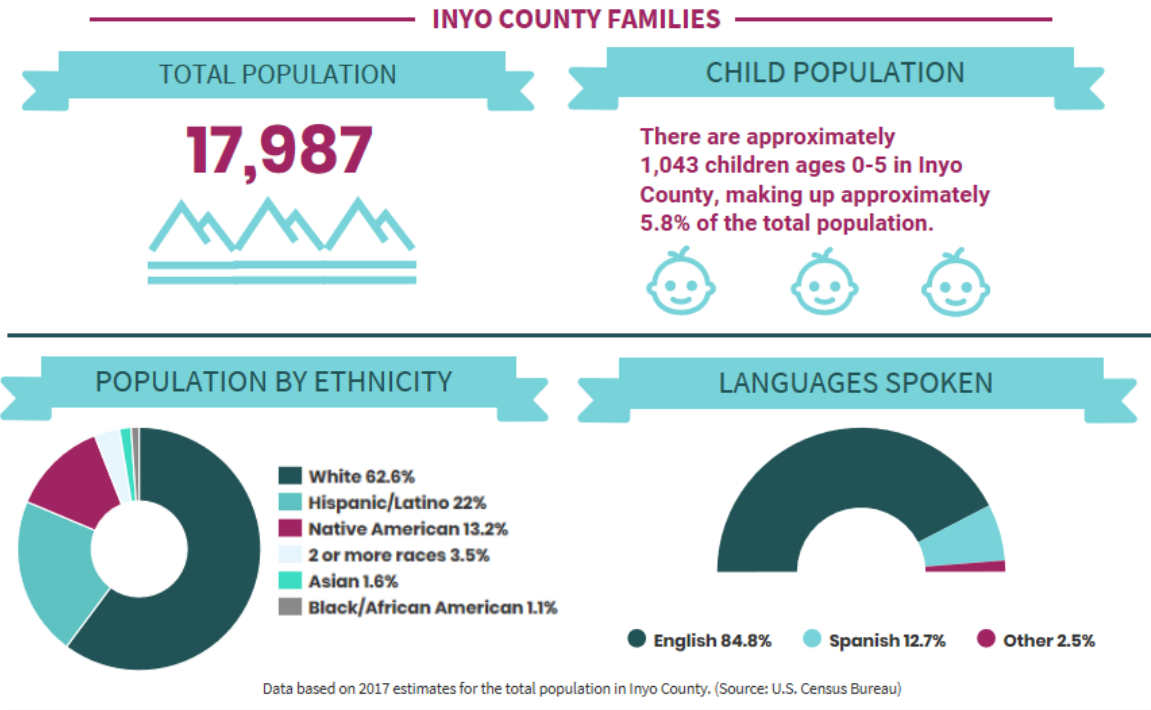
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Introduction

Inyo County contains astounding natural diversity. It includes Owens Valley and parts of Death Valley, and is located between the Sierra Nevada Mountains and the White Mountains along the California and Nevada border. Inyo County offers scenic views and multiple opportunities for outdoor sports enthusiasts in diverse landscapes. Inyo County encompasses both the lowest point in the U.S., Death Valley, and the highest point in the lower 48 states, Mount Whitney. It is the second largest county by area in California with 10,140 square miles; and, with a population of 17,987, Inyo has one of the smallest population densities in the state with only 1.8 persons per square mile.

Overall, low education levels, low household income, high costs of living, and the remote location of communities within Inyo County are compound challenges resulting in high stress on families in Inyo County.



(Source: kidsdata.org)

Our Vision

All children in Inyo County will thrive.

Our Mission

First 5 Inyo builds the early childhood systems and supports needed to ensure Inyo County's young children are healthy, safe and ready to succeed.

Guiding Principles

- › **Equity** is a critical consideration in selecting early childhood interventions. The first five years of a child's life are the most critical for development, and the most vulnerable to adversity, discrimination, and exclusion. First 5 Inyo prioritizes equity to help all children achieve their full potential, despite historical patterns of racial and economic exclusion. Increasing equity closes the gap and ensures all children are on the path to success. First 5 Inyo will utilize data to identify and address inequities, select strategies and funding decisions to eliminate disparities.
- › **Advocacy** to ensure early childhood is a priority in all levels of local and state decision making. First 5 Inyo will facilitate and participate in collaborations across agencies and disciplines to improve outcomes and support systems for children prenatal through age five and their families. These activities include increasing resources, strengthening policies, and promotion for early childhood development.
- › **Collaboration** through the First 5 Network aligns county First 5 Commissions, First 5 Association, and First 5 California as a united voice for California's youngest children. The network strategy focuses on a common language and resources needed in systems change for local and statewide early childhood initiatives. First 5 Inyo will participate in the Network, bringing together partners, leveraging funding sources, and strengthening systems of care through communications, advocacy, collaboration, skill building, innovation, and learning.



Strategic Plan 2019-2024

Strategic Goal First 5 Inyo will be a strong organization that serves as catalyst of sustained positive change for children 0-5 and their families into the future.

First 5 Inyo will focus on four areas: Systems Building, Resilient Families, Comprehensive Health & Development, and Early Child Education.

Goals are the ultimate result and improvement the Commission is striving for.

Outcomes are the impact, change, or benefit that result from implementing certain activities or services.

Indicators are observable, measurable characteristics or changes that represent achievement of an outcome.

Strategies are activities and services that can be implemented to achieve desired outcomes.

Strategic Plan Process

First 5 Inyo Commission is charged with developing a Strategic Plan for disseminating the Proposition 10 funds in a manner that will benefit Inyo County children birth to five and their families.

This strategic plan is the result of a six-month participatory process that included:

- › Sending a survey to over 150 partners, and receiving 60 responses
- › Conducting six in-depth interviews with key stakeholders
- › Convening a retreat with the First 5 Commission and key partners
- › Engaging Inyo County HHS staff, managers, and leadership

For a full summary of stakeholder feedback, please see the Appendix on page 14.



Focus Area 1: Systems Building

Goal: County systems are integrated, strategic, and culturally responsive in their approaches to strengthening and supporting families.

Outcomes

- › Improved policies, infrastructures, and investments to support the healthy development of children prenatal through age 5 and their families
- › Improved public awareness of the needs of young children

Strategies

- › First 5 Network
- › Inyo County Triple P Network
- › Perinatal Taskforce
- › Help Me Grow
- › Quality Counts CA and IM-PACT Hub
- › Inyo Resiliency Collaborative/Trauma Informed Framework
- › Team Inyo for Healthy Kids
- › Inyo Car Seat Collaborative
- › Local Child Care Planning Council
- › Interagency Community Collaborative
- › Education and Outreach

Indicators (Data Sources)

- › Number of participants who reported improved capacity to support children’s healthy development as a result of attending First 5 Inyo professional development opportunities (First 5 Inyo)
- › Number of providers touched by First 5 Inyo programs and investments (First 5 Inyo)
- › Amount of funds leveraged with First 5 Inyo funding each year (First 5 Inyo)



Focus Area 2: Resilient Families

Goal: Families are resilient and raising happy, healthy, and thriving children.

Outcomes

- › Improved parental knowledge, understanding, and engagement in promoting their children’s development



Indicators (Data Sources)

- › Number of parents/guardians who receive Triple P parenting education in a class or workshop (First 5 Inyo)
- › Percent of parents/guardians who reported or demonstrated they gained new knowledge, skills, and resources about parenting (First 5 Inyo)
- › Percent of parents/guardians who reported they read, talk, sing, and play with their children (First 5 Inyo)

Strategies

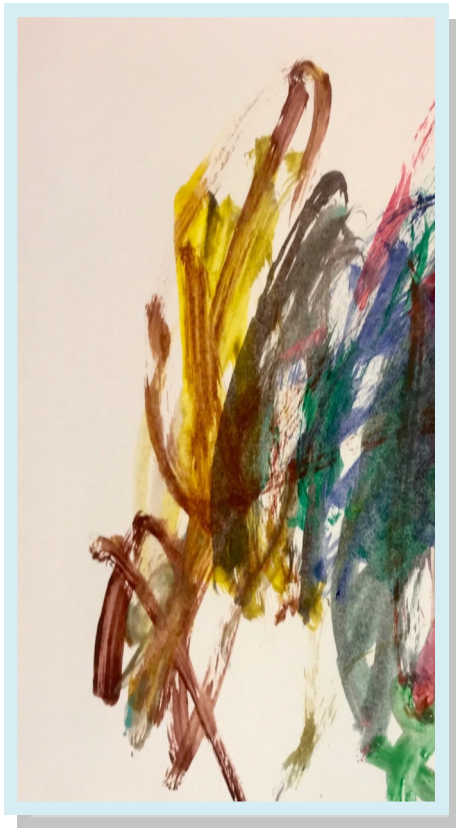
- › Triple P Positive Parenting Program
- › Inyo County Triple P Network
- › Inyo Resiliency Collaborative
- › Home Visiting
- › Outreach and Education
- › Diaper Depot
- › Triple P Media
- › Literacy Activities
- › Parent Education

Focus Area 3: Comprehensive Health and Development

Goal: Children are born healthy and experience optimal physical, behavioral, and developmental health.

Outcomes

- › Children are born healthy
- › Improved screening and intervention for developmental delays, disabilities, and other special needs



Indicators (Data Sources)

- › Percent of children who received regular well-child visits (Bishop Pediatrics)
- › Number of children who received a developmental or behavioral health screening (First 5 Inyo)
- › Number of children with developmental and behavioral needs who were connected to early intervention services (First 5 Inyo)
- › Number of caregivers who receive home visiting services (First 5 Inyo)

Strategies

- › Lactation education and support
- › Home Visiting
- › First 5 New Parent Kit
- › Help Me Grow
- › Ages and Stages developmental screenings
- › Perinatal Taskforce
- › Education and Outreach

Focus Area 4: Quality Early Learning

Goal: All children experience high-quality learning opportunities in all settings.

Outcomes

- › Improved quality and availability of childcare providers
- › Children are successful learners

Indicators (Data Sources)

- › Number of book distributed to children 0-5 (First 5 Inyo)
- › Number of children in licensed and quality child care (Inyo County Office of Education)
- › Number and percent of children who have ever attended a preschool, Pre-K, or Head Start program by the time of kindergarten entry (Inyo County Office of Education)
- › Percent of children ready for kindergarten (First 5 Inyo)

Strategies

- › Literacy Activities
- › First 5 New Parent Kits
- › Quality Counts CA and IMPACT Hub
- › Education and Outreach
- › Countywide Kindergarten Assessment
- › Early Child Education Provider Recruitment



Financial Plan

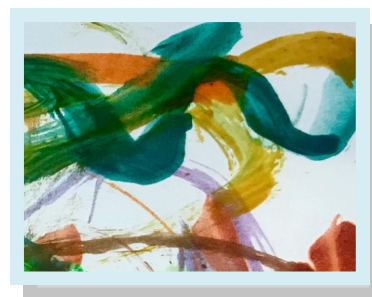
Funding for First 5 will decline 48% by 2020, from \$261 per child to \$135 per child. There has been no new significant reinvestment in First 5 since voters passed Proposition 10 in 1998. As funding streams decline, the First 5 Inyo Commission recognizes the importance of making early childhood a priority across public systems, focusing on prevention as the most effective approach to supporting families and young children, and leveraging resources for greatest impact.

Through FY 2020-2021, First 5 Inyo will receive \$375,000 per year, a blended funding from Prop 10 tax revenue and Small Population County Funding Augmentation (SPCFA) from First 5 California. To ensure the sustainability of First 5 programming, First 5 Inyo Commission will bring together partners and leverage multiple funding sources to strengthen early childhood systems of care.

The First 5 Inyo ending fund balance in FY 2017-18 was \$786,000. This fund balance reflects underspending due to staff shortages, a common challenge for our small budget where staffing is a significant percentage of expenses. The First 5 Inyo Commission is committed to spending down this fund balance to a more modest amount, as responsible and effective use of public funds. The First 5 Inyo Commission will be opening the opportunity for community grants to support local projects in FY 19-20. Due to the uncertainty around future funding, the First 5 Inyo Commission will keep a reserve of \$350,000 in the fund balance to offset any future loss in revenue.

The First 5 Inyo Commission remains committed to investing in the Triple P Positive Parenting Program, Ages and Stages Developmental Screenings, Reach Out and Read Literacy activities, and the Families Intensive Response & Strengthening Team (FIRST) Wraparound program. New areas the strategic plan retreat identified for investment in the long range financial plan include home visiting, Help Me Grow, trauma/resilience systems, early childhood learning, and partner grants.

The Long Range Financial Plan is included below, with predicted revenues, expenditures, and fund balances. Despite the challenges of declining revenues, First 5 Inyo continues to advocate and support the early childhood systems needed to ensure young children are healthy, safe, and succeed in school and life.



First 5 Inyo County- Long Range Financial Plan

Financial Planning for Sustainability

| <i>Fiscal Year ending June 30</i> | Budgeted 2018-19 | Proposed 2019-20 | Projected 2020-21 | Projected 2021-22 | Projected 2022-23 | Projected 2023-24 |
|---|---------------------|---------------------|----------------------|----------------------|----------------------|----------------------|
| REVENUE | | | | | | |
| Prop 10 tax revenue | | | | \$112,169 | \$109,478 | \$106,000 |
| Small County Augmentation | \$375,000 | \$375,000 | \$375,000 | \$187,831 | \$190,522 | \$194,000 |
| Grants | | | | \$15,000 | \$15,000 | \$15,000 |
| Alternative Funding Streams (e.g. MAA, CAPIT) | | | | \$30,000 | \$30,000 | \$30,000 |
| Interest earned | \$4,000 | \$4,000 | \$4,000 | \$4,000 | \$4,000 | \$4,000 |
| Total Revenues | \$379,000 | \$379,000 | \$379,000 | \$349,000 | \$349,000 | \$349,000 |
| EXPENSES | | | | | | |
| <i>Operations</i> | | | | | | |
| Salaries/Benefits | \$186,705 | \$191,118 | \$195,531 | \$199,944 | \$204,357 | \$208,770 |
| County Administrative Costs | \$33,370 | \$40,710 | \$40,000 | \$45,000 | \$45,000 | \$45,000 |
| Office Supplies | \$15,000 | \$15,000 | \$15,000 | \$15,000 | \$15,000 | \$15,000 |
| Annual Audit | \$9,765 | \$9,765 | \$9,765 | \$9,765 | \$9,765 | \$9,765 |
| Travel | \$33,860 | \$19,200 | \$18,000 | \$18,000 | \$18,000 | \$18,000 |
| Motorpool | \$3,915 | \$4,000 | \$4,000 | \$4,000 | \$4,000 | \$4,000 |
| <i>Program</i> | | | | | | |
| FIRST | \$68,000 | \$68,000 | \$68,000 | \$68,000 | \$68,000 | \$68,000 |
| NEST | \$28,000 | \$24,000 | \$24,000 | | | |
| Triple P Parenting | \$12,500 | \$50,500 | \$10,000 | \$10,000 | \$10,000 | \$10,000 |
| Child Abuse Prevention | \$1,000 | \$2,000 | \$2,000 | \$2,000 | \$2,000 | \$2,000 |
| Literacy | \$4,400 | \$3,300 | \$3,000 | \$3,000 | \$3,000 | \$3,000 |
| Developmental Screenings | \$3,000 | \$3,000 | \$3,000 | \$3,000 | \$3,000 | \$3,000 |
| General Wellness | \$2,000 | \$2,000 | \$2,000 | \$2,000 | \$2,000 | \$2,000 |
| Advertising | \$5,000 | \$5,000 | \$5,000 | \$5,000 | \$5,000 | \$5,000 |
| First 5 Association | \$3,450 | \$3,450 | \$4,000 | \$4,000 | \$4,000 | \$4,000 |
| Help Me Grow | | | | | | |
| Home Visiting | | | \$20,000 | \$20,000 | \$20,000 | \$20,000 |
| Early Childhood Learning | | | | | | |
| Trauma/Resilience Systems | | | | | | |
| Partner Request/Grants | | \$15,000 | \$15,000 | \$15,000 | \$15,000 | \$15,000 |
| Misc Program Costs | \$8,150 | \$7,950 | \$6,000 | \$5,000 | \$4,000 | \$4,000 |
| Total Expenditures | \$418,115 | \$463,993 | \$444,296 | \$428,709 | \$432,122 | \$436,535 |
| Revenues less Expenses | -\$39,115 | -\$84,993 | -\$65,296 | -\$79,709 | -\$83,122 | -\$87,535 |
| Total Fund Balance | \$786,000 | \$746,885 | \$661,892 | \$596,596 | \$516,887 | \$433,765 |
| Withdrawal from Fund Balance | \$39,115 | \$84,993 | \$65,296 | \$79,709 | \$83,122 | \$87,535 |
| Ending Fund Balance | \$746,885 | \$661,892 | \$596,596 | \$516,887 | \$433,765 | \$346,230 |

*First 5 California SPFCA funding agreement with First 5 Inyo ends June 2021. Funding is anticipated but total revenue is not known.

Appendix

Our Kids, Our Future: Community Stakeholder Survey Summary

Inyo County HHS facilitated a survey to obtain input on the needs of children and families from community stakeholders of First 5 Inyo. We received a total of 60 responses from representatives across agencies including Inyo County Health and Human Services, early care and education providers, health care professionals, Tribal organizations, public agencies, community-based organizations and advocacy groups.

Fifty percent or more of the respondents stated that they were familiar with the Triple P parenting program, car seat inspections, community outreach, the Ages and Stages Questionnaire and Diaper Depot programs offered by First 5. Only 6 of the 60 respondents stated that they were not familiar with First 5 in any way.

RESULTS

When asked about the main challenge partners felt children and families face most in our community; the largest responses was **access to affordable, quality childcare** (24%). This answer was followed by responses linked to parental support, need for parenting skills and classes (12%) as well as housing and cost of living struggles (11%).

When asked what the needs of families with children ages zero to five in our community; the responses showed that 80 percent of participants believed **housing affordability and high cost of living** was the primary challenge. This answer was followed by parent knowledge of child development (68%), access to family strengthening programs (68%), access to mental health and substance abuse programs (65%) and access to parental support (62%).

Respondents identified **cost of quality childcare** (80%) and **access to childcare** (75%) as the main gaps in early childhood education and care in our community.

The majority of responses thought **access to mental health and substance abuse services** (67%) was the primary service that could improve the health of children in our community. This answer was followed by access to food and nutrition education (54%), access to early identification of developmental needs and intervention (52%), access to oral health education and dental services (52%) and access to information on available resources, including referrals (50%).

First 5 Inyo also asked how we can partner with stakeholders to help families and children in the community. The largest response was reflective of **providing community education and parenting classes** (28%), followed by **community outreach and information on services** (27%) in addition to agency trainings, seminars and community collaboration (15%).

Key Stakeholder Interviews

To inform the strategic plan, Serena Johnson, First 5 Inyo Director, conducted six in-depth interviews with key stakeholders. Three of these interviews were co-conducted with Marissa Whitney, Inyo County Public Health Nurse for Maternal Child Adolescent Health program, as part of their five-year needs assessment.

The following stakeholders were interviewed: Kat Duncan, Director of IMACA Head Start; Raquel Dietrich, Director of the Child Development Division at Inyo County Office of Education; Karen Rathburn, Behavioral Health Child & Family Team at Inyo County Health & Human Services; Lori Gable, NEST Registered Nurse, Northern Inyo Health Care District; Charlotte Helvie, MD, and Colleen McEvoy, FNP, Bishop Pediatrics and Allergy Clinic, Northern Inyo Health Care District; and Holly DeVincent, Social Worker Supervisor with Children's Services, Inyo County Health & Human Services.

Ten common themes emerged from these interviews, ordered below in approximate frequency of topic:

- › Trauma-Informed Care and Education
- › Collaboration and Outreach
- › Developmental Screenings and Referrals
- › Maternal Substance Abuse and Mental Health
- › Absence of Home Visiting
- › Importance of Social-Emotional Learning
- › Quality Child Care and Education
- › Services for Spanish Speaking Clients
- › Transportation
- › Parent Education and Knowledge

There is a metaphor, where we keep saving the babies out of the river, but nobody goes up to the top of the river to find out how they are being thrown in the water. We keep focusing on the interventions, but what is the cause?

– Karen Rathburn

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

| | |
|--|-----------------------------|
| Title: Repackaging and Compounding of Medications | |
| Scope: Departmental | Department: Pharmacy |
| Source: Pharmacy Director | Effective Date: 10/20/03 |

PURPOSE:

To comply with State laws regarding repackaging and compounding of medications and to comply with record-keeping requirements of these laws

POLICY:

1. Repackaging of medications in the pharmacy will be done under the direct supervision of a pharmacist.
2. Medications may be repackaged as follows:
 - a. Unit dose packaging from bulk containers of medications
 - b. Multi-dose packaging of medications from bulk containers for dispensing as after-hours emergency room prescriptions for dispensing by the emergency room physician
 - c. Multi-dose packaging of medications from bulk containers for administration by nursing personnel to patients in the hospital

Unit Dose

3. Unit dose repackaging shall be done utilizing the pharmacy computerized unit dose packaging system. The system shall record:
 - a. The manufacturer, lot number and expiration date of the original bulk package.
 - b. The system-assigned lot number, and expiration date of 6 months or the expiration date of the original package if that date is sooner than 6 months.
 - c. The initials of the packaging technician or pharmacist
 - d. The initials of the checking pharmacist
4. The system shall print a label with the above information for each episode of unit dose packaging. This label shall be affixed to the packaging log, which shall be hand-initialed by the checking pharmacist.
5. The packaging log shall be retained for 3 years.

Prescriptions

6. Multi-dose packaging of medications from bulk containers shall be done on an extemporaneous basis.
7. A technician may count or measure the prescribed amount of medication into a dispensing container.
8. The technician shall leave the dispensing container, the prescription, the label and the bulk container from which the dispensing container was filled together for the pharmacist to check, label, and verify.
9. The pharmacist shall initial the label affixed to the dispensing container and the prescription hard copy (utilizing a permanent sticker from the label set) as proof of checking the technician's work.
10. The hard-copy of the prescription shall be retained for 3 years.

After-hours Emergency prescription prepacks

11. After-hours Emergency prescription repackaging shall be done utilizing the pharmacy computerized unit dose packaging system when necessary as NuCare Pharmacy provides many of these items. The system shall record:
 - a. The manufacturer, lot number and expiration date of the original bulk package.
 - b. The system-assigned lot number, and expiration date of 6 months or the expiration date of the original package if that date is sooner than 6 months.
 - c. The initials of the packaging technician or pharmacist
 - d. The initials of the checking pharmacist

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

| | |
|--|-----------------------------|
| Title: Repackaging and Compounding of Medications | |
| Scope: Departmental | Department: Pharmacy |
| Source: Pharmacy Director | Effective Date: 10/20/03 |

12. The system shall print a label with the above information for each episode of After-hours Emergency prescription packaging. This label shall be affixed to the packaging log, which shall be hand-initialed by the checking pharmacist.
13. The packaging log shall be retained for 3 years.

Multi-dose packaging of medications from bulk containers for administration

14. Multi-dose packaging of medications from bulk containers for administration shall be done on an extemporaneous basis.
15. A technician may count or measure the amount of medication determined by the pharmacist into a dispensing container.
16. The technician shall leave the dispensing container, the physician's order, the label and the bulk container from which the dispensing container was filled together for the pharmacist to check, label, and verify.
17. The pharmacist shall initial the label affixed to the dispensing container and the order hard copy as proof of checking the technician's work.
18. The hard copy of the order shall be retained for 3 years.

Compounding

19. Only a pharmacist or a pharmacy technician under the direct supervision of a pharmacist will perform compounding of pharmaceuticals.
20. The pharmacist shall record the manufacturer and lot numbers of the compounded ingredients on the packaging log together with the date and expiration date of the compounded material.
21. The pharmacist shall initial the entry.
22. The pharmacist shall label the compounded pharmaceutical with the lot number(s) of the ingredients.
23. The packaging log shall be retained for 3 years.

References:

1. FDCA Section 505
2. FDA Law Review 1/18/17 Palmer et al; Final Guidance Addressing Repackaging of Drugs
3. CFR Title 21 Volume 4 4/1/18
4. US Pharmacopeia Forum, Volume 30 (16), Page 2156, CPG SEC 480.200

Cross References:

1. NIH Patient's Own Meds Policy
2. NIH Medication Shortages NIH High Alert Medications
3. Preparation Dispensing and Storage Policy

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

| | |
|--|-----------------------------|
| Title: Repackaging and Compounding of Medications | |
| Scope: Departmental | Department: Pharmacy |
| Source: Pharmacy Director | Effective Date: 10/20/03 |

| Committee Approval | Date |
|--|-------------|
| Clinical Consistency Oversight Committee | 10/21/19 |
| Pharmacy and Therapeutics Committee | 10/16/03 |
| Board of Directors | |
| Board of Directors Last Review | |

Initiated:
Revised:
Reviewed: 10/19fl

Draft



Public Notice

REQUEST FOR PROPOSALS (RFP)

**Individuals, Partnerships, & Firms Encouraged to Apply
Local Practices Strongly Encouraged to Apply**

GENERAL COUNSEL LEGAL SERVICES

Release Date: October 16, 2019

Deadline for Submission: December 31, 2019

Contact person: Sandy Blumberg, Executive Assistant

150 Pioneer Ln, Bishop, CA 93514

Northern Inyo Healthcare District RFP for General Counsel Legal Services

REQUEST FOR PROPOSALS

GENERAL COUNSEL LEGAL SERVICES

RELEASE DATE: _____, 2019

CLOSING DATE: Proposals must be received as a PDF document via E-mail by Thursday, December 31, 2019 by 3:30 PM.

CONTACT PERSON: Sandy Blumberg, Executive Assistant

E-mail: sandy.blumberg@nih.org

Direct: (760) 873-2838 Phone

Northern Inyo Healthcare District

150 Pioneer Ln., Bishop, CA 93514

MORE INFO About the District Please Visit: NIH.ORG

THE DISTRICT

From the time settlers first occupied the Owens Valley until the 1920s, babies were born at home. The sick and elderly were treated by those who could provide nursing care in the community or were taken 200-300 miles to find a hospital or medical expert. During the infamous Water Wars, the City of Los Angeles owned more than 80% of the real estate in this area, which eventually lead to a surplus of large vacant homes. Doctors and nurses in our community were able to acquire the use of such buildings for hospital facilities through the generosity of DWP, however the space and design challenges one faces while utilizing a house for a hospital pushed the issue for adequate health care facilities in 1944.

At this time, Dr. Bambauer, a Rotarian, was operating a small hospital of this nature on the corner of Grove and Fowler streets. This facility was in danger of closing due to financial hardships and was too small to service the needs of the community. The Bishop Rotary Club hosted a meeting to address the issue, which resulted in a committee of 11 citizens charged with addressing the threat of Dr. Bambauer's facility closing and securing adequate facilities for our growing community. This committee gave way to the incorporation of the Bishop Community Hospital and formed a Board of Directors. Collectively, our

community raised \$5.5 million dollars to help support the expenses incurred by the hospital. It became clear that the hospital would need on-going financial support to continue to service the needs of this remote and very rural community. The board decided to form a Hospital District, in order to support the hospital through local tax dollars; the only problem was Hospital Districts did not yet exist.

The visionary board members of the Bishop Community Hospital were instrumental in securing passage of Act S.B. 586, which authorized the legal formation of Hospital Districts in the state of California. In January of 1946, the Northern Inyo County Local Hospital District was formed under the Local Hospital District Law, a division of the Health and Safety Code of the State of California and became the first Hospital District in California. Around the same time, the U. S. Government had abandoned the Japanese Relocation Center at Manzanar; by October of 1946, the Northern Inyo County Local Hospital District had purchased all of the hospital equipment from the Manzanar facility (for \$14,000) and had leased the 18 bed infirmary building at the Bishop Airport. In November of 1946, negotiations had begun for the purchase of the present site of Northern Inyo Hospital. On December 5, 1946, the Northern Inyo County Local Hospital District took over operations of the Bishop Community Hospital. The district was able to gain state and federal funding to help build a new facility (Northern Inyo Hospital), and construction started September 1, 1948. Doctors and nurses began caring for community members at the Northern Inyo Hospital upon its completion in October of 1949.

By 1968, the Northern Inyo Hospital had gained an Acute Care Unit, and a major addition including a lobby, patient rooms, two operating rooms, labor and delivery rooms, emergency treatment facilities and new areas for x-ray, laboratory and pharmacy. In 1981, advances in critical care medicine were met with the opening of the new ICU/CCU wing. Northern Inyo County Local Hospital District has weathered many challenges over the decades: changing from tax based funding for acute care to insurance companies, Medicare, Medicaid, and Medi-Cal; increases in managed care; and increased outpatient services. Yet despite all of these challenges, the district has flourished due to the diligent leadership exhibited both in the hospital and the community. The district, hospital administration and the community have been dedicated to supporting and operating the Northern Inyo Hospital for over 50 years, while managing to expand the auxiliary health care services available to the community through philanthropic and grant based activities.



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Above information may be found at <https://www.nih.org/about-the-district>

INTRODUCTION

The Board of Directors (Board) of the Northern Inyo Healthcare District (District) invites interested firms/practices with a minimum of five (5) years of California healthcare district experience, local government experience, or equivalent experience to submit written proposals to provide General Counsel legal services to District.

Firms are invited to submit proposals for: 1) the full range of legal services, including: general government and healthcare district specific practices. District may opt to contract with one legal firm for all legal services, or multiple services.

As General Counsel, the selected law firm(s) will be expected to provide a wide range of legal services to the District. The law firm(s) will be selected by the Board of Directors, and will work closely with the CEO and District staff as directed by the Board or Chief Executive Officer (CEO) of District

SCOPE OF SERVICES REQUESTED

The anticipated services will include, but are not limited to, the following:

- (a) Represent and advise the Board of Directors and other agencies for which the Board of Directors serve as the governing body and all District Officers in all matters of law pertaining to their offices.
- (b) Represent and appear for any District Officer and/or employee or any former District Officer and/or employee in legal proceedings in which any such officer or employee is entitled by law to representation furnished by the District.
- (c) Attend/or phone in (as requested by the Board or CEO) regular meetings of the Board of Directors and special meetings when called and provide legal advice and opinion as requested by the Board of Directors, CEO or staff. Note—Generally, legal counsel does not attend regular or special Board Meetings unless requested to do so or there is an issue requiring legal counsel attendance. However, the attendance/phone-in may change and become required.
- (d) To be promptly available for telephone consultation and to render written opinions on given issues related to District business in a timely manner.
- (e) Approve the form and content of Board of Directors reports, District contracts and all performance bonds, certificates of insurance and like documents tendered to the District on a requested basis.
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other legal documents as requested by the Board, CEO, or designee.

(g) Provide recommendation and advice when requested by the Board of Directors pertaining to the retention of and employment of outside law specialists in complex and important matters in which the District may be involved.

(h) Investigate all claims and complaints by or against the District and prepare civil cases and act as trial counsel as required and requested by the Board of Directors or CEO.

(i) Review citations for violations of District ordinances in accordance with criminal/civil law and procedures; prepare and try infractions, misdemeanors, and ordinance violations as required and requested by the Board or CEO.

(j) Prepare extended legal opinions of a complex nature as requested by the Board of Directors or CEO.

(k) Generally oversee and manage the legal affairs of the District and ensure that the policies, programs, and activities of the District and its employees and agents are carried out in compliance with all applicable law and that the best interests of the District are otherwise protected to the fullest extent possible.

(l) Work with any District legal counsel and District Compliance Officer as needed.

The law firm(s) selected by District shall provide the full normal range of services of the General Counsel as described above. Among other things, the General Counsel shall have expertise on the Ralph M. Brown Act (California Government Code section 54952 et seq.), the California Public Records Act (Govt. Code section 6200 et seq.), California conflict of interest law (Govt. Code section 1090), the Political Reform Act of 1974 (Govt. Code section 81000 et seq.), the California Tort Claims Act (Govt. Code section 815 et seq.), and the federal Americans with Disabilities Act and in particular how these statutes apply to healthcare districts in California.

The law firm(s) selected by District shall establish and maintain services to the District; in case of their unavoidable absence, through temporary legal services satisfactory to the District. The General Counsel legal counsel will provide the District with education and in-service seminars; as mutually agreed, to maintain a level of education among Northern Inyo Healthcare District for the Board of Directors, staff and management in order, to the fullest extent possible, to increase the knowledge of District staff and Board Members, and to reduce liability.

Attendance at Board of Directors meetings is on a requested or as-needed basis only, and the Board of Directors, generally meets once per month, on the third Wednesday evening of each calendar month. When attendance is requested, the General Counsel may be asked to attend closed sessions and study

sessions (Closed Session may be held prior to or after open sessions; Study Sessions are generally held during the regular open session, or on the rare occasion, may be held prior to a regular Board meeting). The District does not require regular office hours, but expects the law firm(s) selected by the District to be available to attend meetings in person or remotely (via video, web-streaming or teleconference) if needed. Generally, the General Counsel does not attend the District's weekly Executive Team meetings.

Prior to initiation of any work, the District may request a written statement of the estimated cost of the work.

RFP RESPONSE FORMAT

The RFP respondent shall submit an electronic copy (PDF format) of the RFP response with all of the information requested. In order to simplify the proposal evaluation process, the District is seeking RFP responses in the following format:

***Important--Please submit your RFP responses with section breaks/cover pages corresponding to the lettered items in the section below.**

PROPOSAL FORM AND CONTENT

A. Proposal Submittal

All pages of the proposal must be numbered consecutively. The proposal must be organized in accordance with the list of proposal contents. The proposal must provide specific and succinct responses to all questions and requests for information.

Respondents must include the following items in their proposals addressing the Scope of Services above. Proposals and the fee schedule must be valid and binding for 120 days following the proposal due date, and may become part of the agreement with the District.

B. Letter of Transmittal

Include a cover letter signed by a duly authorized representative of the firm. The cover letter must include name, address, telephone number (cell phone number preferred but not required) and e-mail address of the Respondent submitting the proposal. In addition, the name, title, address, telephone number, and e-mail address of the person or persons who are authorized to represent the Respondent and to whom correspondence should be directed shall be included. An unsigned proposal is grounds for rejection.

C. Table of Contents

Include a clear identification of the submitted material by section and by page number.

D. Summary

Introduce the proposal and summarize the key provisions of the proposal. Based on your firm's expertise and qualifications, explain why your firm is best suited to provide the services described herein.

E. Statement of Understanding

Include a detailed statement of understanding of the legal services to be provided. If there are services listed in this RFP that the Respondent will not be able to provide, please be certain to address such in your response.

F. Background and Experience

1. Official name and address and specify the type of entity (partnership, LLC, corporation, etc.).
2. Describe the firm's background and history, including the number of years in practice. Describe in detail the firm's public agency and/or healthcare district legal services expertise.
3. List the location of office(s) that would serve the District. Note—This is an open recruitment, and all qualifying practices/firms are invited to submit proposals.
4. Provide an organization chart and staffing plan identifying key personnel, related lines of authority and responsibility of those team members who will provide the services described in this RFP.

G. Approach to Legal Services

1. Describe your view of the role of the General Counsel.
2. Describe how the firm would keep the District informed about the status of litigation and other legal matters.
3. Provide your best example of a written communication to a governing body about a legal issue, prepared within the past 5 years and not to exceed 6 pages, in which options are explained and a recommendation is given.
4. Describe how you track and manage legal fees and costs.
5. Describe how you would proactively advise the District about legal developments or issues of concern, without being asked. If you use Newsletters, News Briefs, emails, or other

communications, please describe the general content and frequency of publication.

6. Please list relevant specialty services your firm does not provide. Such might include but not be limited to healthcare district law and labor law , civil rights/voting rights; or healthcare finance. For any specialty services your firm does not directly provide, describe how you propose the District would receive such services. Options may include but are not limited to: separate agreement(s) between the District and a specialty services firm selected by the District where the contract is administered by District; separate agreement(s) between the District and a specialty services firm selected by the District where the contract is administered by Respondent for the District; or a specialty services firm subcontract to Respondent. Except as noted in the next paragraph, you are not required to address who would provide such relevant specialty services, just how such services are proposed to be provided.

I. References and Potential Conflicts of Interest

1. Provide contact information for 2 relevant entities or other local government agency clients (preferred) for which services have been provided by the proposed General Counsel and Assistant General Counsel in the last five years, so reference checks can be conducted. Please include the contact person's name, agency, phone and email address.
2. List all public clients within the Inyo, Mono, Kern county areas for whom your firm currently provides services under a fee for services basis or on a retainer basis and indicate the services provided. Identify any foreseeable or potential conflicts of interest that could result from such representation and the manner in which you would propose to resolve such conflicts.
3. For the person proposed as General Counsel, list all public clients that person presently represents as General Counsel, Deputy General Counsel, or Assistant General Counsel, along with the meeting dates and times for each governing body.
4. List all private clients of your firm that could potentially pose a conflict of interest while representing the District.
5. Identify all situations in the last five years in which your firm represented a public entity in a litigated or administrative proceeding and the decision or outcome was adverse to that public entity.

Similarly, please identify all situations within the last five years in which your firm represented a public entity in a litigated or administrative proceeding and the decision or outcome was beneficial to the public entity.

6. If, within the past 10 years the firm, or any of the attorneys employed by the firm has been sued by a District or other local public agency for legal malpractice, been the subject of a legal malpractice claim, been the subject of a complaint filed with the State Bar, or received discipline imposed by the State Bar, please describe in detail the circumstances of said suit, claim, complaint or discipline.

J. Compensation and Reimbursement

For the first eighteen (18) months of service, requests a “Fee-for-Services/hourly billing methodology. Respondent shall identify the applicable hourly rates and list all known non-labor/other direct costs. District will reimburse non-labor/other indirect costs at Respondent’s actual/documentated cost. If Respondent proposes to utilize a subcontractor for rendering of any legal services, it shall identify applicable hourly rates and all known non-labor/other directs incurred in such subcontracted legal services.

Respondent shall provide the same assurances of the competence of subcontractors as it does with respect to itself, plus the demonstrated ability to manage and supervise the subcontracted work. Subcontractors shall not be allowed to further subcontract with others without the prior consent of the District. The District will not provide compensation for any administrative overhead incurred in supervising the work of a subcontractor.

The District may accept and incorporate the proposed fee schedule as part of the award/agreement process without further negotiations or, alternatively, may use it as the basis for negotiations. Consequently, Respondents are encouraged to provide their best pricing. The selected Respondent shall receive no compensation for travel expenses to District. The District anticipates that the General Counsel Legal Services Agreement which may be awarded through this RFP process will be a one year agreement with a thirty (30) day termination provision. Agreement may be renewed annually for nomore than four additional years.

The Respondent shall identify how it proposes to be considered for rate increases and at what intervals. After the initial twelve (12) month period, the District and legal firm(s) selected by NIHD may wish to negotiate a new billing arrangement based upon a monthly flat fee, defining which services would be included in the monthly retainer and which services would fall outside a monthly retainer.

K. Agreement

At the conclusion of the initial evaluation process, negotiations between the District and the selected Respondent for a contract will proceed. If the District engages a Respondent in negotiations and satisfactory agreement provisions cannot be reached, then negotiations may be terminated and the District may elect to contact another Respondent. This sequence may continue until an agreement is reached.

The District contemplates entering into a legal services contract containing its standard terms and conditions which will include specific standards for the firm's billing of costs and services. The contract will also set forth requirements for the scrupulous exercise of good billing judgment, billing documentation, and insurance requirements.

The contract will contain an express provision that in the event of any dispute concerning any matter regarding the agreement, each party agrees to bear its own attorney's fee.

In addition, the contract will require that the Agreement be governed by California law, without regard to conflict of laws principles, and that venue for any dispute be in Inyo County.

L. Additional Information

In this section, provide any other information that the Respondent believes is applicable to the evaluation of the proposal or your qualifications for providing the proposed legal services. You may use this section to address those aspects of your services that distinguish your firm from other firms.

THE SELECTION PROCESS

The Board or CEO will potentially make contact with potential candidates for an in-person or phone interview.

The board will review candidates to determine the best candidate to represent the District. This process may or may not include the use of a Board appointed ad hoc committee, and/or a mix of other District staff.



Public Notice

REQUEST FOR PROPOSALS (RFP)

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Local Practices Strongly Encouraged to Apply**

GENERAL COUNSEL LEGAL SERVICES

Release Date: October 16, 2019

Deadline for Submission: December 31, 2019

Contact person: Sandy Blumberg, Executive Assistant

150 Pioneer Ln, Bishop, CA 93514

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REQUEST FOR PROPOSALS

GENERAL COUNSEL LEGAL SERVICES

RELEASE DATE: ~~October 16~~ _____, 2019

CLOSING DATE: Proposals must be received as a PDF document via E-mail by Thursday, December 31, 2019 by 3:30 PM.

CONTACT PERSON: Sandy Blumberg, Executive Assistant

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Direct: (760) 873-2838 Phone

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sessions (Closed Session may be held prior to or after open sessions; Study Sessions are generally held during the regular open session, or on the rare occasion, may be held prior to a regular-~~or special~~ Board meeting).

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available to attend meetings in person or remotely (via video, web-streaming or teleconference) if needed. Generally, the General Counsel ~~and/or Employment Practices~~ does not attend the District's weekly ~~senior staff~~ Executive Team meetings.

Prior to initiation of any work, the District may request a written statement of the estimated cost of the work.

RFP RESPONSE FORMAT

The RFP respondent shall submit an electronic copy (PDF format) of the RFP response with all of the information requested. In order to simplify the proposal evaluation process, the District is seeking RFP responses in the following format:

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1. Official name and address and specify the type of entity (partnership, LLC, corporation, etc.).

2. Describe the firm's background and history, including the number of years in practice. Describe in detail the firm's ~~water,~~ public agency and/or ~~employment practices~~ healthcare district legal services expertise.

3. List the location of office(s) that would serve the ~~Northern Inyo Healthcare~~ District. Note— This is an open recruitment, and all qualifying practices/firms are invited to submit proposals.

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4. Describe how you track and manage legal fees and costs.

5. Describe how you would proactively advise the District about legal developments or issues of concern, without being asked. If you use Newsletters, News Briefs, emails, or other communications, please describe the general content and frequency of publication.

~~6. Describe the computer resources currently utilized within your office. The District utilizes Microsoft Office software, including Word for Windows word processing software, and requires its contractors to use a compatible version of the Microsoft Office suite for all files provided electronically to the District. The District currently provides electronic agenda files to the General Counsel and has a wireless internet network available in the District Board Meeting Room.~~

67. Please list relevant specialty services your firm does not provide. Such might include but not be limited to healthcare district law and labor law

~~employee relations/human resources~~; civil rights/voting rights; or ~~water utility/enterprisehealthcare~~

finance. For any specialty services your firm does not directly provide, describe how you propose the District would receive such services. Options may include but are not limited to: separate agreement(s) between the District and a specialty services firm selected by the District where the contract is administered by District; separate agreement(s) between the District and a specialty services firm selected by the District where the contract is administered by Respondent for the District; or a specialty services firm subcontract to Respondent. Except as noted in the next paragraph, you are not required to address who would provide such relevant specialty services, just how such services are proposed to be provided.

I. References and Potential Conflicts of Interest

1. Provide contact information for 2 relevant entities or other local government agency clients (preferred) for which services have been provided by the proposed General Counsel and Assistant General Counsel in the last five years, so reference checks can be conducted. Please include the contact person's name, agency, phone and email address.

2. List all public clients within the Inyo, Mono, Kern county areas for whom your firm currently provides services under a fee for services basis or on a retainer basis and indicate the services provided. Identify any foreseeable or potential conflicts of interest that could result from such representation and the manner in which you would propose to resolve such conflicts.

3. For the person proposed as General Counsel, list all public clients that person presently represents as General Counsel, Deputy General Counsel, or Assistant General Counsel, along with the meeting dates and times for each governing body.

4. List all private clients of your firm that could potentially pose a conflict of interest while representing the District.

5. Identify all situations in the last five years in which your firm represented a public entity in a litigated or administrative proceeding and the decision or outcome was adverse to that public entity.

Similarly, please identify all situations within the last five years in which your firm represented a public entity in a litigated or administrative proceeding and the decision or outcome was beneficial to the public entity.

6. If, within the past 10 years the firm, or any of the attorneys employed by the firm has been sued by a District or other local public agency for legal malpractice, been the subject of a legal malpractice claim, been the subject of a complaint filed with the State Bar, or received discipline imposed by the State Bar, please describe in detail the circumstances of said suit, claim, complaint or discipline.

J. Compensation and Reimbursement

For the first eighteen (18) months of service, requests a “Fee-for-Services/hourly billing methodology. Respondent shall identify the applicable hourly rates and list all known non-labor/other direct costs. District will reimburse non-labor/other indirect costs at Respondent’s actual/documentated cost. If Respondent proposes to utilize a subcontractor for rendering of any legal services, it shall identify applicable hourly rates and all known non-labor/other directs incurred in such subcontracted legal services.

Respondent shall provide the same assurances of the competence of subcontractors as it does with respect to itself, plus the demonstrated ability to manage and supervise the subcontracted work. Subcontractors shall not be allowed to further subcontract with others without the prior consent of the District. The District will not provide compensation for any administrative overhead incurred in supervising the work of a subcontractor.

The District may accept and incorporate the proposed fee schedule as part of the award/agreement process without further negotiations or, alternatively, may use it as the basis for negotiations. Consequently, Respondents are encouraged to provide their best pricing. The selected Respondent shall receive no compensation for travel expenses to District. The District anticipates that the General Counsel Legal Services Agreement which may be awarded through this RFP process will be ~~an evergreen~~ one year agreement with a thirty (30) day termination provision. Agreement may be renewed annually for nomore than four additional years.

The Respondent shall identify how it proposes to be considered for rate increases and at what intervals. After the initial ~~eighteen-twelve~~ (12) month period, the District and legal firm(s) selected by NIHD may wish to negotiate a new billing arrangement based upon a monthly flat fee, defining which services would be included in the monthly retainer and which services would fall outside a monthly retainer.

K. Agreement

At the conclusion of the initial evaluation process, negotiations between the District and the selected Respondent for a contract will proceed. If the District engages a Respondent in negotiations and satisfactory agreement provisions cannot be reached, then negotiations may be terminated and the District may elect to contact another Respondent. This sequence may continue until an agreement is reached.

The District contemplates entering into a legal services contract containing its standard terms and conditions which will include specific standards for the firm's billing of costs and services. The contract will also set forth requirements for the scrupulous exercise of good billing judgment, billing documentation, and insurance requirements.

The contract will contain an express provision that in the event of any dispute concerning any matter regarding the agreement, each party agrees to bear its own attorney's fee.

In addition, the contract will require that the Agreement be governed by California law, without regard to conflict of laws principles, and that venue for any dispute be in Inyo County.

L. Additional Information

In this section, provide any other information that the Respondent believes is applicable to the evaluation of the proposal or your qualifications for providing the proposed legal services. You may use this section to address those aspects of your services that distinguish your firm from other firms.

THE SELECTION PROCESS

The Board or CEO will potentially make contact with potential candidates for an in-person or phone interview.

The board will review candidates to determine the best candidate to represent the District. This process may or may not include the use of a Board appointed ad hoc committee, and/or a mix of other District staff.



TO: NIHD Board of Directors
FROM: William Timbers, MD, Chief of Medical Staff
DATE: November 5, 2019
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 and Procedures (*action item*)

1. *Admission, Discharge, Transfer of Patients: Continuum of Care*
2. *Pediatric Ambulatory Blood Pressure Monitoring Policy*
3. *Drug Storage and Inspections of Medication Areas*
4. *Emergency Medications Trays Policy*
5. *Influenza Vaccination Policy*
6. *Pharmacist Intervention for Iron Replacement*
7. *Rehabilitation Services Standard of Care*
8. *Repackaging and Compounding of Medications*
9. *Sharps Injury Protection Plan*
10. *Therapy Evaluation/Inpatients, OPO, and Swing Bed Patients*
11. *Use of Biosimilar Products at Northern Inyo Healthcare District*

B. Medical Staff Appointments and Privileges (*action items*)

1. Kelly T. Brace, DPM (*podiatry*) – provisional active staff
2. Matthew Ercolani, MD (*urology*) – provisional consulting staff
3. Daniel Su, MD (*urology*) – provisional consulting staff
4. Vlad Radulescu, MD (*cardiology*) – telemedicine staff
5. Felix Karp, MD (*internal medicine*) – provisional active staff

C. Extension of Temporary Privileges through December 31, 2019 (*action items*)

1. Joseph BenPerlas, MD (*internal medicine*)
2. Sumon Syed, MD (*internal medicine*)
3. Shiva Shabnam, MD (*internal medicine*)

D. New Privileges (*action item*)

1. James Fair, MD (*emergency medicine*) – privileges for the performance of transesophageal echocardiograms (TEE)

E. Recommendations for Advancement (*action items*)

1. Stefan Schunk, MD (*internal medicine*) – advancement from provisional active staff to active staff
2. Atashi Mandal, MD (*internal medicine*) – advancement from provisional active staff to active staff

F. Resignations (*action items*)

1. Jennie Walker, MD (*emergency medicine*) – effective 10/1/19

2. Jessica Paulson, MD (*emergency medicine*) – effective 10/15/19
3. H. Charlie Wolf, MD (*emergency medicine*) – effective 12/31/19
4. Sarkis Kiramijyan, MD (*cardiology*) – effective 12/31/19
5. Gabriel Overholtzer, DDS (*dentistry*) – effective 12/31/19

G. Physician recruitment update (*information item*)

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| Scope: Nursing Services | Manual: Nursing Administration Manual (NAM) |
| Source: CNO | Effective Date: 11/16/17 |

PURPOSE:

To ensure appropriate patient placement based upon the balance of intensity of services required and the unique needs of the individual patient with staff who have demonstrated the skills and competencies necessary to provide care in an appropriate healing environment. These guidelines will:

1. Provide a consistent process of admission, transfer and discharge of patients.
2. Describe the continuum for patient care.

POLICY:

This policy applies to all patients presenting to any of the hospital-based services at Northern Inyo Hospital.

A. Continuum Provisions

1. Patients are admitted, discharged and transferred by medical provider order only. Admissions are coordinated by medical providers, nurses, case managers and other support disciplines as appropriate. Patients enter the hospital by direct admission, transfer/referral from another healthcare institution, scheduled surgeries or outpatient procedures and emergency admissions.
2. The House Supervisor monitors and evaluates capability and capacity (current staffing, census, admissions, discharges and transfers) in order to coordinate patient placement for admissions and transfers in.
3. Patients who have stable psychiatric concerns and require medical, surgical and/or maternal-child care will be admitted to the appropriate unit to meet their current health care needs. Patients assessed as having unstable medical and psychiatric concerns (potential to harm self and/or others) will be admitted to the appropriate level of care and be provided with continuous observation (per the Patient Safety Attendant or 1:1 Staffing Guidelines Policy) until a mental health evaluation can be performed to determine the appropriate observation required. Once these patients are medically stabilized, they will be evaluated for transfer to the proper facility or treatment service for their psychiatric issues.
4. After an initial medical screening examination, the ED medical provider may determine the patient requires the services of an on-call medical provider such as but not limited to a surgeon or hospitalist. The on-call medical provider will provide further evaluation and/or treatment to stabilize the patient with an emergency medical condition.
5. After completion of a medical screening exam and/or medical evaluation with medical stabilization (See Policy Evaluation and Medical Screening of patients presenting to the Emergency Department), a medical provider may determine that the

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patient requires transfer to another healthcare facility for ongoing treatment and/or tertiary care.

B. Admissions

1. Patients are admitted to Northern Inyo Hospital for care and treatment, in accordance with the requirements of applicable laws, regulations and accreditation standards. Patients are accepted regardless of race, gender, ethnicity creed or ability to pay. Patients with a primary diagnosis of alcoholism or drug abuse are not candidates for admission except for provision of medical stabilization and appropriate consultations and referrals.
 - a. Medical Staff members shall be responsible for the medical care and treatment of patients in the hospitals.
 - b. Within 24 hours after admission or immediately before, every patient shall have a complete history and physical examination completed consistent with the medical staff bylaws.
2. House Supervisor (HS) will assign the bed once the NIHD Privileged medical provider places an admission order.
3. All patients admitted to the hospital will have identification wristbands applied.
4. Patients will receive, upon admission or as soon thereafter as reasonably practical, written information regarding:
 - a. Active participation in decisions regarding medical care
 - b. ~~appropriate~~ Appropriate pain assessment and treatment
 - c. ~~being~~ Being informed or if the patient so authorizes allowing a friend or family/caretaker be provided information about the patients continuing health care requirements following discharge from the hospital
5. Types of admissions include: direct, pre-scheduled, emergent, inter-facility and unplanned from surgery.
 - a. Direct admissions require:
 - i. Diagnosis appropriate for admission to NIHD
 - ii. Discussion regarding the appropriateness of admission between the admitting medical provider and the House Supervisor or nursing representative to ensure adequate nursing staff for needs
 - iii. Additional criteria for pediatric patients:

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- Patient seen by NIHD provider on same day as admission, without change in status since provider visit.
 - No immediate therapy required (e.g. IV fluid bolus, rapid initiation of antibiotics, breathing treatments for respiratory distress or low O2 saturation).
- iv. Additional criteria for infants admitted directly from NEST
(Newborn Evaluation Support and Teaching):
- A NIHD medical provider may directly admit newborns from the NEST with the provision that a physical assessment be performed and orders provided within four hours of admission.
6. The admission order must identify the admitting medical provider and diagnosis, the admission status, and the intensity of service (ICU, Medical etc.) before the patient will be admitted.
 7. Based on bed availability, patients are assigned to a unit specific bed placement based on diagnosis, condition, age, needs of the patient, medical necessity and unit admission criteria. Once a bed assignment has been made, the goal is to move the patient to that bed within 60 minutes. The patient hand-off process is documented in the EHR.
 8. Patients are registered to the assigned unit and specific bed under a patient status classification: Out-Patient Observation (OPO), Inpatient, or Out Patient Procedure.

C. Observation:

Observation services begin and end with an order by a NIHD privileged medical provider. Observation services provides for evaluation and treatment of patients who do not meet admitting criteria. Observation provides time for a medical provider to evaluate a patient's condition and determine the medical necessity for inpatient admission, usually within a 48-hour period. The order for observation services must be written prior to initiation of the service, as documented by a dated and timed order in the patient's medical record. The order may not be backdated. Orders should be clear for the level of care intended, such as "admit to inpatient" or "place in observation." (Admit to observation may also be used).

1. Observation should be considered if the patient is hemodynamically stable and does not meet acute inpatient care criteria. Observation care is a well-defined set of specific, clinically appropriate services that include;
 - a. Ongoing short-term treatment, assessment, and reassessment, that are provided before a decision can be made regarding whether a patient will require further treatment as an inpatient, or may be safely discharged.

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- b. Observation status is commonly assigned to patients with unexpectedly prolonged recovery after outpatient surgery.
 - c. Patients who present to the emergency department and who then require a significant period of treatment or monitoring before a clinical decision is made concerning their next placement. Once there is sufficient information to render this clinical decision, the patient should be expeditiously admitted, appropriately transferred, or discharged.
 - 2. Observation services are not appropriate:
 - a. As a substitute for an inpatient admission;
 - b. For continuous monitoring;
 - c. For medically stable patients who need diagnostic testing or outpatient procedures (e.g., blood transfusion, chemotherapy,) that are routinely provided in an outpatient setting;
 - d. For patients awaiting nursing home placement;
 - e. To be used as a convenience to the patient, his or her family, NIH or NIH staff;
 - f. For routine prep or recovery prior to or following diagnostic or surgical services; or
 - g. As a routine stop between the emergency department and an inpatient admission

D. Discharges

- 1. When it is determined by a patient's attending medical provider that the patient biophysically no longer requires an acute level of care the patient will be discharged.
- 2. Patients and their families are provided interdisciplinary discharge planning services throughout the continuum of care. This process is initiated prior to or at the time of admission in a consistent manner, reflecting each patient's special needs related to age, disability, cultural, spiritual, psychosocial and medical condition and continues until the day of discharge to the appropriate setting.
- 3. A minor shall be discharged only to the custody of his/her parent or to his/her legal guardian or custodian, unless such parent or guardian shall otherwise direct in writing.
- 4. Patients are discharged from Northern Inyo Hospital to a variety of different settings each requiring information about the discharge needs of the patient.

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5. Patients are informed in a timely manner of the need to plan for discharge. Planning for discharge or transfer involves the patient, medical provider, staff, family and significant others involved in the patient’s care, treatment and services.
6. Patients are discharged or transferred with information explaining why they are being discharged and will be provided written information about:
 - a. their diagnosis
 - b. follow up information
 - c. medication regime they are to be following, and
 - d. diagnosis specific education describing the ongoing care needs upon discharge
7. The patient discharge instructions will include information on when to seek follow-up care for emergent or ongoing medical needs and smoking cessation as appropriate.
8. Medical providers will perform ~~Discharge-discharge Medication-medication Reconciliationreconciliation~~, on all patients leaving the hospital, prior to patient discharge.

Patients may be discharged from the hospital to:

1. Discharge to Home
 - a. Patients being discharged to home will have the discharge process completed prior to discharge based upon medical provider’s orders and clinical documentation.
 - b. Nursing staff will review the content of the discharge, instructions and education with the patient and/or family/significant other.
 - c. Nursing staff will have the patient or designee sign the patient instructions and education acknowledging understanding of the information.
 - d. Nursing staff will place the original signed form in the medical record and provide the patient or designee with a copy inclusive of the discharge instructions and education.
2. Discharge to Home with Home Care
 - a. The nursing staff will complete all steps as outlined in section D/6.

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- b. The Case Manager or Social Worker who is responsible for arranging the home care will provide the Home Care agency with copies of pertinent information from the medical record including the printed discharge summary inclusive of the discharge instruction content indicated above. Printing of information may be delegated to other team members of the department.
 - c. If the Case Manager or Social Worker is not available, the RN designated staff member discharging the patient will send all pertinent information to the home care agency.
3. Discharge to skilled Nursing Facility, Board or Assisted Living
- a. The discharging medical provider must determine the appropriateness of discharge to these levels of care based on the patient's medical condition and continuing care needs.
 - b. The Case Manager or Social Worker will provide the patient or designee with contact information for at least one public or non-profit agency or organization dedicated to providing information or referral services relating to community based long term care options in the patient's county of residence and appropriate to the needs and characteristics of the patient. This information should include contact information for the local area agency on aging and local independent living centers. (CHS code section 1262.5)
 - c. When a patient has an accepting facility and the medical provider has cleared them for discharge, nursing staff will give the patient for transfers to an Assisted Living facility, the Residential Care Facility Admission Form (known as a 602 form) will be filled out with all pertinent continued health care information.
 - d. Prior to the patient leaving acute care, the RN will call report to the receiving facility.
 - e. When possible, the patient's family or representative will tour the local SNF or Assisted Living facility and will prioritize to which facility referrals will be made.
 - f. The hospital medical provider will provide the receiving facility with a Discharge (Transfer) Summary containing relevant medical information to ensure the continuum of care for the patient at the receiving facility. Relevant information may include:

1. Patient's diagnosis

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- 2.Hospital course
- 3.Pain management and treatment
- 4.Medications
- 5.Treatments
- 6.Dietary requirements
- 7.Rehabilitative potential
- 8.Known allergies, and
- 9.Discharge treatment plan.

- g. A copy of the Discharge Instructions and Transfer (Discharge) Summary will be given to the patient or the patient's legal representative, if any, prior to transfer to a skilled nursing facility or intermediate care facility. (State Standards HSC 1262.5).
- h. The Nurse will give the patient or patient's legal representative, information about each medication the patient is currently on.
- i. If the discharging medical provider will not be following the patient at the SNF, the medical provider will be responsible for finding a receiving medical provider who will follow the patient. The Case Manager or Social Worker will assist in this process and confirm an accepting medical provider has been secured at the time of discharge.
- j. The discharging medical provider will determine the appropriate mode of transportation and enter the appropriate order in the EHR.
- k. Case Management will arrange transportation to the accepting facility as ordered by the medical provider.

4. Discharge to jail with law enforcement

- a. Nursing staff will complete the appropriate patient documentation, select the appropriate diagnosis specific education content, then sign and print the discharge summary to provide the patient with discharge instruction for the patient as outlined in Section b. Additional required paperwork will be completed by the medical provider.

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- b. Upon discharge, the nurse will provide the patient with the diagnosis specific education content. The patient discharge summary inclusive of the patient's diagnosis, follow-up information, medication regime and discharge education will be given to the forensic staff member accompanying the patient.

E. Transfer, Inter-facility

Transfers to another acute care or psychiatric facility require a medical provider order.

1. When it is determined that the patient has an emergency medical condition and Northern Inyo Hospital (NIH) does not have capability or capacity to provide care, NIH shall:
 - a. stabilize the patient, within the capability and capacity of the hospital-based services; or
 - b. provide, if applicable, for the appropriate transfer of the patient to another medical facility in accordance with these procedures.

2. If a patient has an emergency medical condition that has not been stabilized, the patient may be transferred only if the transfer is carried out in accordance with the procedures set forth below:
 - a. The patient may be transferred if the patient or the legally responsible person acting on the patient's behalf is first fully informed of the risks of the transfer, the alternatives (if any) to the transfer and of the Hospital's obligations to provide either further examination and treatment sufficient to stabilize the patient's emergency medical condition, or an appropriate transfer. Then the transfer may occur if the patient or legally responsible person:
 - i. Makes a request for transfer to another medical facility, stating the reasons for the request; and
 - ii. Acknowledges the request and his or her awareness of the risks and benefits of the transfer by signing the Physicians Certification Form; or
 - iii. The patient has been notified or attempts over a 24-hour period have been made and a responsible person cannot be reached.

 - b. The patient may be transferred if a physician/advanced practice provider, in consultation with a responsible physician, has documented, on the Physician Certification Form that the expected medical benefits from transfer outweigh the risks. A Physicians Certification Form per verbal order shall be countersigned by the qualified medical provider. In the event a consulting

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physician has assumed care of the patient, that physician shall determine that the benefits outweigh the risks of the transfer for the patient and shall document such in the patient's medical record.

3. The hospital-based service shall send the receiving facility copies of all pertinent medical records available at time of transfer, including but not limited to:
 - a. Facesheet
 - b. Medical provider orders
 - c. Medical Provider transfer summary or transfer form
 - d. History
 - e. records related to the patient's emergency medical condition
 - f. observations of signs or symptoms
 - g. preliminary diagnosis
 - h. results of diagnostic studies or telephone reports of the studies
 - i. treatment provided
 - j. results of any tests
 - k. a copy of the medication reconciliation or a medical history list if for an Emergency Department patient; and
 - l. a copy of the informed written request or certification and consent to transfer called the Physicians Certification Form. If an on-call medical provider has refused or failed to appear within a reasonable time after being requested to provide necessary stabilizing treatment, the hospital-based service shall provide the name and address of that medical provider to the receiving facility.
4. When transfer teams from the receiving facility are utilized, they assume responsibility for the patient on their arrival, as long as the patient's condition remains unchanged.
5. If the individual is transferred for non-medical reasons, the transferring medical provider will document that the transfer will not create deterioration or jeopardize the medical condition of the individual or unborn child.

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6. When air or ground ACLS transport is required, medical provider orders for enroute transfer must be completed and signed by M.D.practitioner on appropriate forms.

7. Report by the RN responsible for the patient will be called to the RN receiving the patient at the accepting facility. This will include all hand off information (SBAR = Situation, Background, Assessment, Recommendation) and will include any current isolation procedures being followed.

8. The following must occur and be documented in the medical record:
 - a. The medical provider or another qualified medical person informs the patient of the reason for transfer.
 - b. The medical provider certifies the transfer including the risks, benefits and alternatives of the transfer.
 - c. The patient, or a legal responsible person acting on the patient's behalf, consents to transfer.
 - d. An Emergent Transfer Form shall be filled out if the patient is transferred to another facility.
 - e. The transferring medical provider must obtain agreement to the transfer from the receiving facility and from the medical provider who will assume responsibility for the patient at the receiving facility (the "receiving medical provider "). This includes confirmation that the receiving facility has capability and capacity to care for the patient.
 - f. The transferring medical provider will provide appropriate orders for the transfer that will include mode of transport, level of care required during transport, additional equipment and medical orders during transport.
 - g. The Case Manager, House Supervisor, RN, or designee will arrange for and document appropriate transportation, staffing and expected time of transfer.

9. Documentation by Nursing:
 - a. Completion of emergent or non-emergent transfer form.
 - b. NIH staff needs to document procedures done, IV infusions started, and/or medications given prior to transfer team handoff. In addition, the RN should document any medications, IV infusions or supplies sent with the transport team.
 - c. Notation in nursing record of:

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- i. Time and method of transfer
- ii. Patient's condition on transfer including current ~~V~~Svital signs and cardiac rhythm when applicable
- iii. Disposition of belongings
- iv. Notification of family member if possible

F. BOARD & CARE: (Sterling Heights is our local facility)

1. Physician's Report - State of California Form completed by ~~MD~~MD-practitioner needed for first time admission to facility only (Social Service has copies or the facility will provide)
2. Medical provider Discharge Instructions
3. Copy of Current MAR (this will be a record of last dose of medication given prior to discharge)
4. Copy of facesheet
5. Copy of Power of Attorney/Living Will (if available)
6. ~~For New-new~~ residents only — cCurrent negative TB clearance or documented negative ~~for TB~~-chest X-ray.

G. SKILLED NURSING FACILITY (SNF):

1. Non Emergent Transfer Form
2. PAS-PASARR - Document is completed by Social Services when appropriate (may be completed by Nursing Supervisor if SS not available). Required for all transfers to Nevada Nursing Homes, regardless of insurance source.
3. Copy of Power of Attorney/Living Will (if available).
4. Discharge/ Transfer Summary completed and if possible sent with patient at time of transfer (May need to fax if transfer completed prior to summary completion). Bishop Care center requires, prior to receiving the patient, discharge/transfer summary completed or completion of their medical provider orders for skilled nursing forms.
5. Medical Record Chart Copies including but not limited to:

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- a. Copy of Current MAR (this will be a record of last dose given and what medications patient has been on during hospitalization).
 - b. Nutritional Screening
 - c. History and physical
 - d. Consultations
 - e. Current labs
 - f. X-ray Reports (film copies not necessary unless requested)
 - g. Operative Report
 - h. Copy of Face Sheet
6. Skin Assessment - needed only if there is a skin breakdown, wound, or bruise. Include pictures of these wounds if taken on admit and also those taken at discharge
7. TB Clearance: Clear Chest X-ray or Negative PPD is required unless patient is returning to SNF (Nevada requires report to read "Clear for TB". California does not.)

H. Patients Who Have an Emergency Medical Condition but Refuse to Consent to Treatment or to Transfer:

- 1. The hospital-based service may discharge or transfer a patient with an emergency medical condition before the condition is stabilized only if the patient or legally responsible person has signed a request for transfer or the medical provider has signed a certification or:
 - a. If the patient refuses examination or treatment: If the hospital offers such examination and treatment and informs the patient or legally responsible person of the risks and benefits to the patient of the examination and/or treatment, but the patient or legally responsible person refuses to consent to the examination and/or treatment, the hospital shall take all reasonable steps to have the patient or legally responsible person sign a "Refusal of Treatment". In addition, the medical record shall contain a description of the examination, treatment, or both if applicable, that was refused by or on behalf of the individual.
 - b. A patient who has refused further medical examination and treatment may nevertheless be transferred in accordance with the procedures set forth in this policy.

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- c. If the patient is a dependent minor and the parents refuse advised medical treatment, the parent(s) would sign the "Refusal of Treatment" form and, depending on the severity of the illness, a CPS Report may be completed.
 - d. If the patient refuses transfer: The hospital may discharge a patient who has an emergency medical condition if, after the hospital offers to transfer the patient to another medical facility, and after the hospital informs the patient or legally responsible person of the risks and benefits to the patient of the transfer, the patient or legally responsible person refuses to be transferred. The Hospital shall take all reasonable steps to have the patient or legally responsible person sign the "Refusal of Treatment" form. In addition, the medical record shall contain a description of the proposed transfer that was refused by or on behalf of the individual.
2. Hospital Administration, Compliance, and Quality Improvement shall be advised when a patient who has an emergency medical condition refuses to consent to further examination and treatment or to an appropriate transfer.
3. Patients ~~Who~~who do not have an ~~Emergency~~emergency ~~Condition~~condition
- a. When the patient is determined as a result of a medical screening examination not to have an emergency medical condition, the patient may be transferred to another health care facility (if in need of further care) or discharged (if not in need of further care).

I. Transfer, Intra-facility: Procedural Transfers

1. Transfers for ~~i~~Invasive ~~p~~Procedures
- a. When transferring a patient, the assigned staff of the sending unit is responsible for the management of the patient until completion of report and placement of the patient in the receiving department.
 - b. Patients transferring to a monitored bed in ICU or Telemetry must be accompanied by an ACLS certified healthcare provider.
 - c. Patients receiving monitored medication must be accompanied by ~~an~~an ~~RN~~appropriate practitioner or personnel.
 - d. The Procedural Consent form if needed may be obtained at either transferring or receiving department but must be documented on the consent form specific to the location of the procedure.
 - e. Verbal report is given between the transferring staff and the receiving staff.

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- f. Nursing transfer note will consist of the following:
 - i. A quick check will occur immediately prior to transfer
 - ii. Documentation of the SBAR handoff
 - iii. Communication will be inclusive of:
 - Report given to
 - Transfer to Location
 - Transfer from location
 - Transfer mode
 - Patient family notified
- g. Nursing documentation of the patient care handoff will be documented by the receiving RN. The content documented will consist of the following:
 - i. Name of transferring RN providing report
 - ii. Quick check

J. Record Keeping

- 1. The hospital-based services, whether transferring or receiving patients, must maintain the following:
 - a. Medical and other records related to patients transferred to or from the hospital-based services for a period of seven (7) years from the date of the transfer
 - b. A list of medical providers who are on call for duty after the initial examination to provide treatment necessary to stabilize a patient with an emergency medical condition; and
 - c. Information on each patient who comes to the emergency department seeking assistance and whether he or she refused treatment, was refused treatment, or whether he or she was transferred, admitted and treated, stabilized and transferred, or discharged can be found in the EHR.

K. Reporting

- 1. The Hospital must file with the California Department of Public Health quarterly the Emergency Department Transfer Communication (EDTC) report that shall describe

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the aggregate number of transfers made including but not limited to the reasons for transfer.

2. The Hospital's Medical Staff members and employees have the following reporting obligations:
 - a. The Hospital's Medical Staff members and employees who know of an apparent violation of the patient transfer laws on the part of the Hospital in its capacity as a receiving facility shall immediately report such violation to Hospital Administration, and Hospital Administration shall be responsible to report the violation to the Regional CMS office within one week of the suspect transfer.
 - b. The Hospital's Medical Staff members and employees who know of an apparent violation of the patient transfer laws on the part of the Hospital in its capacity as a transferring hospital shall immediately report such violation to Hospital Administration.
 - c. The Hospital's Medical Staff members and employees shall be provided with a copy of this Policy and advised that all hospitals are required to comply with federal and state laws regarding emergency transfers, as set forth in this policy. Risk Management and the Performance Improvement departments shall immediately investigate any suspect transfer, whether to or from the Hospital.
 - d. The Hospital shall not retaliate, penalize, or take adverse action against any Hospital Medical Staff member or employee for reporting violations of federal state transfer laws to the proper authorities.

L. Posting Signs

1. The Hospital shall post conspicuously, signs stating whether or not the Hospital participates in the Medi-Cal program.
2. The Hospital shall post conspicuously, in the emergency department, signs specifying rights of patients under law with respect to examination and treatment for emergency medical conditions and of women who are pregnant and are having contractions.

M. Requirements for Receiving Facilities Special Units

1. Regional referral centers or hospitals that have specialized capabilities or facilities, such as a burn unit, a shock-trauma unit or a neonatal intensive care unit, may not refuse to accept from a referring hospital an appropriate transfer of a patient who

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requires such specialized capabilities or facilities if the receiving facility has the capacity to treat the individual.

SERVICE DEFINITIONS AND ADT CRITERIA

A. Outpatient Services

The provision of emergent and/or non-emergent health care services to patients who require less than 24 hours of care with the appropriate staff equipment, space, and supplies.

1. Emergency Department

- a. Definition: Patients of any age or condition presenting for emergency care will be provided a medical screening exam, stabilizing care, discharged with a plan of care, admitted for further treatment or transferred according to the guidelines of this policy. (See Policy: Evaluation and Medical Screening of Patients Presenting to the Emergency Department)
- b. Exclusions: Non-emergent elective patient procedures i.e. elective transfusions, bronchoscopy, endoscopy, general anesthesia, prolonged monitoring or procedures requiring operating room techniques except in trauma resuscitation.
 - i. At Northern Inyo Hospital, patients with an OB related complaint, caring a fetus above the gestational age of 20 weeks, who present to the ED with a non-life threatening emergency, will be sent to the Labor and Delivery department for medical screening.
- c. Demand beyond capacity: The Emergency Department may divert non-emergent ambulances only if the diverting facility is on internal disaster.

2. Surgical Patients / Outpatient Procedures

- a. Definition: Provide individualized patient care to patients requiring therapeutic procedures, elective and urgent ~~outpatient~~^{OP} surgical elective, ~~IP~~^{inpatient} surgical (pre operatively), diagnostic procedures (i.e., liver and kidney biopsy, patients).
- b. Exclusions: Neonates less than 28 days of age. Patients requiring monitoring and or constant observation or assistance.

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- c. Demand beyond capacity: Patients will be assessed for appropriate nursing unit for direct admit or transfer. Elective procedures may be evaluated for rescheduling. Pre op appointments may be rescheduled. Surgical patients may be held in PACU pending bed availability.

3. Infusion Center

- a. Definition: Provide outpatient infusion services for adult and pediatric patients
- b. > 27 days. Patients requiring treatment; provide nursing care related to venous access devices; provide other (limited) outpatient infusion or injection services. Provides outpatient services for adults requiring medical oncology and/or hematology services.
- c. Exclusions: TPN, continuous heparin, infusions exceeding 8 hours,
- d. Demand beyond capacity: If census exceeds capacity or if patient needs services started late in the day with treatment period exceeding clinic hours; refer to approved home care agency for injection or infusion services if allowed for patient comfort and for capacity issues. Patients are prioritized according to medical needs or first available appointment.

B. Inpatient Services

The provision of acute inpatient care that is medically necessary for the required treatment of the patient's illness/diagnosis.

If demand exceeds capacity of the appropriate unit, consider the following:

- Place the patient at a higher level of care as an overflow patient
- Provide the appropriate level of care by assigning additional, appropriately skilled staff in an alternative setting until the appropriate level of care is available.
- The patient's medical provider will be responsible for making decisions for the disposition of the patient in the event both physical and staffing capacity is exceeded.

1. Medical-Surgical and/or Acute Care Unit:

- a. Definition: Acute medical or surgical condition requiring nursing intervention at least every 4-8 hours for medical/surgical level of care. Telemetry monitoring is available for adult patients. Care is also provided to pediatric patients presenting

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with a wide range of medical and/or surgical problems. Patients younger than 28 days of age may be admitted if both medical provider and unit manager are in agreement as to the appropriateness of the admission to the medical/surgical unit.

- b. Exclusions: Adult patients requiring intervention and assessment that exceeds the unit standard including but not limited to: invasive monitoring, ventilator management, medication titration. Pediatric patients that should be transferred to a tertiary pediatric care center include but are not limited to:
 - i. Inadequate medical and/or nursing support to care for a sick infant/child either in numbers of staff available or experience level of staff.
 - ~~ii. An infant/child who requires assisted ventilation.~~
 - ~~iii. An infant/child with a congenital malformation or other condition requiring pediatric surgery that is beyond our capability.~~
 - ~~iv. An infant/child with unstable heart disease requiring intensive monitoring and follow up.~~
 - ~~v. An infant/child with multi-system trauma or multi-system failure.~~
 - vi.ii. An infant/child with complex problems requiring subspecialty consultation not available at NIH

2. Intensive Care Unit (ICU)

- a. Definition: Acute ~~cardiac~~, medical or surgical condition requiring nursing interventions at least every 1-2 hours, invasive hemodynamic monitoring, mechanical ventilation, cardiac monitoring in patients 18 years and older.
- b. Exclusions: Pediatric patients unless extenuating circumstances are present and agreed upon by the Medical Director of the ICU and CEO of NIHD; Patients who do not meet intensity criteria.

3. Labor & Delivery

- a. Definition: Comprehensive and individualized nursing care to pregnant women requiring antepartum management for pregnancy induced low risk medical problems, intrapartum management for low risk obstetrical patients, and for women and their babies requiring management during the immediate post-delivery recovery phase of pregnancy. This may include patients deemed unstable for transfer by a qualified medical screening exam.

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- b. Exclusions: High Risk Pregnant patients deemed to need higher level of care by attending medical provider.

4. Mother-Baby

- a. Definition: Provide individualized, family-centered care to postpartum women and their newborn infants.
- b. Exclusions: Postpartum patients deemed to need a higher level of care by their attending medical provider.

5. Pediatric/Neonate

- a. Definition: Infants requiring increased observation, stabilization and/or interventions post delivery.
- b. Exclusions: As determined by medical provider when infant requires higher level of care.

6. Rehabilitation, Inpatient Services

- a. Definition: Provide physical therapy, occupational therapy and speech-language pathology services to patients of all ages in inpatient settings.
- b. Exclusions: Patients requiring therapy services in a home setting are referred to the home health agency.
- c. Demand beyond capacity: Patients are triaged according to severity of needs.

REFERENCES:

1. Council of the Society of Critical Care Medicine, Society of Critical Care Medicine. Guidelines on Admission and Discharge for Adult Intermediate Care Units. Critical Care Medicine 1998; 26(3):607-610.
2. Humbreet, D. & Reilly, T. A nurse managed remote telemetry model. Critical Care Nurse 2007; 27 (3):22-32.
3. Barclays official California Code of Regulations Title 22. Division 5. Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies. 2013
4. California Health and Safety code sections 1262.5, 1262.6
5. State Operations Manual Appendix W. Survey protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs)and Swing beds in CAHs 165, 12-16-16
6. ACOG Committee Opinion, July 2016

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| Source: CNO | Effective Date: 11/16/17 |

CROSS REFERENCE P&P:

1. Admission, Discharge, Transfer of Patients: Continuum of Care
2. Capacity Management Plan
3. Patient Admission Procedure to ICU
4. Newborn Discharge procedure
5. Admission Procedure of the Pediatric patient
6. Admission Procedure to the Acute/Sub Acute Department
7. Admission Procedure of the Hospice Patient
8. Admission Assessment of the Obstetrical Patient
9. Admission Procedure and Care of the Newborn
10. Patient Placement Policy
11. PACU Discharge Criteria
12. Preoperative Preparation and Teaching
13. Opening and Closing ICU and Acute/Sub Acute Departments
14. Discharge Planning for the Hospitalized Patient
15. Admission Procedure of the Emergency Room Patient to the Hospital
16. Transfer to Other Medical Facilities Maternal and Infant
17. Admission, Documentation, Assessment, Discharge, and Transfer of Swing Bed Patients

| Approval | Date |
|--------------------------------|-------------|
| CCOC | 8/26/19 |
| Med Services / ICU | 10/3/19 |
| Peri Peds | 9/26/19 |
| MEC | 11/5/19 |
| Board of Directors | 11/15/17 |
| Last Board of Directors Review | 4/18/18 |

Developed: 6/17la

Reviewed: 2/19jn

Revised: 6/19jn

Supersedes: Patient Discharge, Admission of a patient to Northern Inyo Hospital, Patient transfer/Discharge to Another Facility, Outpatient Observation (OPO) Policy, Patient Transfer Accepting a, Patient Discharge from Medical Surgical Department

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|---|----------------------------|
| Title: <u>Pediatric</u> Ambulatory Blood Pressure Monitor | |
| Scope: Outpatient Clinics | Manual: Outpatient Clinics |
| Source: Chief of Pediatrics | Effective Date: |

PURPOSE:

Several studies have shown that in-clinic and home blood pressure measurements are unable to provide the same level of in-depth information that a 24 hour study can provide and is therefore superior in predicting target organ damage, morbid events, or cardiovascular risk.

Ambulatory Blood Pressure Monitor (ABPM) can assist in the diagnosis of hypertension including the detection of:

- Possible white coat hypertension
- Unusual variability of blood pressure
- Evaluation of nocturnal hypertension
- Hypertension response to medication
- Determining the efficacy of drug treatment over 24 hours

POLICY:

24 hour ABPM will be performed with a provider order in patients who need further evaluation of high blood pressure diagnosed at routine office visits or for monitoring of patients who have high-risk conditions for hypertension or who take medication for hypertension. The ABPM will be applied in the clinic with education of the patient and family in the care and use of the device.

PROCEDURE:

1. Enter patient information on laptop computer with ABPM software loaded. Attach ABPM with USB cable and initialize patient information to device.
2. To put monitor on patient ask patient to remove his/her top only. Switch monitor "~~on~~" and place inside pouch.
3. Show the patient the on/off switch and explain the display screen before putting in the pouch.
4. Place cuff on non-dominant arm unless there is a 20/10mmHg difference between arms in which case use arm with higher reading, or a clinical reason not to use a particular arm (eg lymphoedema).
5. Wind tubing around the back of the patient's neck and down his/her front and attach tubing to the monitor.
6. Strap the monitor to the patient's hip opposite the side on which the cuff is worn. If possible secure the monitor using the patient's own belt. When using the shoulder strap, use a belt to provide additional security.
7. Ensure the accuracy of blood pressure measurements through proper cuff selection and application.
8. Verify proper monitor operation by taking one or more blood pressure readings. Push the ACTION key to begin a measurement.
9. Show the patient how to enter information in the Patient Diary.
10. Ensure that the device has fresh batteries or provide replacement batteries to patient or responsible caregiver to use if needed.

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| Title: Pediatric Ambulatory Blood Pressure Monitor | |
| Scope: Outpatient Clinics | Manual: Outpatient Clinics |
| Source: Chief of Pediatrics | Effective Date: |

11. Instruct the patient to turn off device after recording has completed at least 24 hours of readings.
12. See ~~mManufacturer's Operation-operation Manual-manual~~ for ~~Caring-caring~~ for the equipment. Ensure that all parts of the device are cleaned appropriately when it is returned to the clinic.
13. Special Considerations:
 - a. Physician/APP order required: Yes
 - b. Procedure may be performed by: ~~M.D., N.P., RN/LVN Staff~~physician, advanced practice provider, or RN/LVN staff
 - c. Special education required to perform procedure: The device shall be operated only by suitably competent personnel trained in the use and procedures of Ambulatory Blood Pressure monitors for diagnostic purposes.
 - d. Age specific considerations: ABPM is intended for use on patients aged 3 years and above
14. Equipment:
 - a. ABPM
 - b. Disposable blood pressure cuff fitted for patient
 - c. Recorder carrying case
 - d. Belt and/or shoulder strap

PRECAUTIONS:

1. Patients for ABPM must be capable of coping with and caring for the recorder.
2. The ABPM must be comfortable for the patient to wear. An appropriately sized cuff containing the correct size bladder must be used. If discomfort persists the patient should fully remove the cuff and inform the doctor.
3. A measurement can be stopped at any time by pressing the 'ACTION' key. This will deflate the cuff and the unit will continue at the next scheduled measurement time.
4. Ensure the patient is instructed in the removal of the cuff in the event that it fails to deflate within two and a half minutes.
5. If the cuff becomes uncomfortable during a reading, make certain that the patient knows how to terminate the readings by pressing the 'ACTION' button on the front of the monitor.
6. Child mode should be selected if the unit is going to be worn by a 3 to 12 years old child. The main characteristic of child mode is setting a lower Initial target pressure of 130 mmHg.
7. Normal activity should be maintained during ABPM except when measurements are being made, except driving.
8. The patients arm should be still and held at heart level during measurement.
9. The monitor allows the patient to temporarily suspend readings for the purposes of taking a bath/shower etc. Switching the unit back on will resume readings. It is recommended that the maximum suspension time should not exceed 1 hour.
10. Ensure that patients are aware that the air hose must not be knotted, twisted or compressed especially when sleeping.

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| Title: <u>Pediatric</u> Ambulatory Blood Pressure Monitor | |
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| Source: Chief of Pediatrics | Effective Date: |

11. Ensure patients are made aware that the cuff must only be worn on the upper arm and precautions taken to ensure that neither the air hose or shoulder strap can ever become wrapped around the neck and that the air hose is worn under outer clothing especially at night.
12. In the case of non fully competent patients, the unit is only to be worn under supervision.

REFERENCES:

1. SpaceLabs On Track User’s Manual V4 2018.

CROSS REFERENCE P&P:

1. Fitting blood pressure cuff

| Approval | Date |
|--------------------------------|-------------|
| CCOC | 9/23/19 |
| PeriPeds | 10/20/19 |
| MEC | 11/5/19 |
| Board of Directors | |
| Last Board of Directors Review | |

Developed: Charlotte Helvie 9/3/2019
 Reviewed:
 Revised:

**NORTHERN INYO HOSPITAL
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|--|-----------------------------|
| Title: Drug storage and inspections of Medication Areas | |
| Scope: Facility wide | Department: Pharmacy |
| Source: Pharmacy | Effective Date: |

PURPOSE:

To ensure that storage of drugs is accomplished to meet the requirements of Title 22 CCR 70263 (q).

POLICY:

1. Test agents, germicides, disinfectants and other household substances shall be stored separately from drugs.
2. External use drugs in liquid, tablet, capsule or powder form shall be segregated from drugs for internal use.

Drugs shall be stored at appropriate temperatures.

- a. Medication refrigerator temperatures shall be between 2.2°C (36°F) and 7.7°C (46°F).
- b. Medication freezers temperatures shall be between -15°C (5°F) and -50°C (-58°F).
- c. Medication room temperature shall be between 15°C (59°F) and 30°C (86°F).
- d. Fluid Warmers temperatures shall be between 37°C (100°F) and 40°C (104°F).
3. Refrigerator and freezer temperatures shall be continuously monitored by the electronic temperature monitoring system. Temperatures shall be recorded twice daily in a permanent record maintained for 3 years.
4. Out of range alarms will occur in the following situations:
 - a. Room temperature out of range for 60 minutes.
 - b. Refrigerators not containing vaccines for children (VFC) temperature out of range for 60 minutes.
 - c. VFC refrigerators and freezers alarm immediately upon temperature going out of range.
 - d. Freezers not containing VFCs temperature out of range for 60 minutes.
 - e. Fluid Warmers' temperature out of range for 60 minutes.
5. Out of range temperature alarms shall be transmitted:
 - a. During normal business hours for the pharmacy (630a-5p, 7 days per week) an automated email gets sent to the pharmacy tech group email (all pharmacy staff, via email).
 - b. After normal pharmacy business hours an automated email gets sent to the pharmacy tech group email (all pharmacy staff, via email) and;
 - i. Inside Main hospital (not including main pharmacy): Nursing House supervisor receives a notification via automated text to the

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| Source: Pharmacy | Effective Date: |

assigned house supervisor cell phone and all pharmacy staff receive an automated email alert.

- ii. All areas outside main hospital (main pharmacy and clinics): An automated text and/or call is placed to the pharmacist-on-call's cell phone and all pharmacy staff receive an automated email alert.

6. Back-up method
 - a. 630a pharmacy staff member will see automated alert via email seven days per week.

7. All alarms shall be responded to and an appropriate actions taken. Actions taken shall be documented in the temperature monitoring system software.
 - a. Responses to alarms may include, but are not limited to:
 - i. Adjustment of thermostat
 - ii. Closure of doors
 - iii. Removal of medication and notification of clinical engineering

8. Pharmacist-in-charge or designee shall check the medication temperature monitoring system daily to ensure no temperature alarms are missed.
 - a. Designee checking the temperature alarm monitoring system shall document this check daily.

9. Escalation method:
 - a. COO receives an email if an alarm has not been addressed in 24 hours.

10. Drugs shall be stored in an orderly manner in well-lighted cabinets, shelves, drawers or carts of sufficient size to prevent crowding.

11. Drugs shall be accessible only to personnel authorized to dispense or administer medications at NIH, or to the patient as provided in the "Administration of Drugs: Self-Administration" Policy.

12. Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use. Such drugs shall be quarantined and returned to the manufacturer or destroyed via Reverse Wholesaler in accordance with the "Unusable Drugs" Policy.

13. A pharmacist shall inspect drugs maintained on the nursing unit at least monthly. Any irregularities shall be reported to the director of nursing service and to the unit managers.

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| Title: Drug storage and inspections of Medication Areas | |
| Scope: Facility wide | Department: Pharmacy |
| Source: Pharmacy | Effective Date: |

REFERENCES :

Beckers 2-1-2012 “How hospitals can comply with CMS medication storage requirements” Redak et al.

Joint Commission, MM .01.01.03

Patient Safety, 08/08, maintaining Compliance with JCOH MM Standards

CROSS REFERENCES:

NIH Access to medications in the absence of a pharmacist

| Committee Approval | Date |
|-------------------------------------|-------------|
| CCOC | 10/21/19 |
| Pharmacy and Therapeutics Committee | 10/17/19 |
| Medical Executive Committee | 11/5/19 |
| Board of Directors | |
| Last Board of Directors Review | |

Revised 4-7-15, 11/2/2018 (PD)
 Reviewed 10/06, 10/09, 10/12, 9/13
 Supersedes

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| Title: Emergency Medication Trays Policy | |
| Scope: Hospital Wide | Manual: Nursing All Unit, Pharmacy |
| Source: Director of Pharmacy | Effective Date: |

PURPOSE:

The purpose of this policy is to ensure that all emergency medications and crash cart equipment and supplies in the hospital are consistently available, controlled, and secure.

POLICY:

1. The Director of Pharmacy shall ensure the availability of a sufficient inventory of medical staff approved emergency drugs in the pharmacy and patient care areas.
2. All crash carts with the exception of Broselow carts will be arranged similarly and contain identical medications and supplies, to ensure the most efficient use of these by all hospital staff. Broselow carts have a specific inventory of medications and implements which vary from regular crash carts. Each crash cart has a specific inventory list attached/or on the cart.
3. Emergency drugs shall be readily available to the patient-care staff but not accessible to patients, visitors, and unauthorized personnel.
4. Crash carts will be functional for all ages – pediatric through geriatric. All crash carts will have ACLS and PALS algorithms for emergency therapy. Of note the District has added Broselow carts specifically for pediatric use.
5. Additional neo-natal emergency equipment will be kept in the Obstetrical Department.
6. Emergency drugs supplies shall not be used as a routine or stat source, but shall be reserved for emergency use when immediate availability is necessary.
7. The Pharmacy and Therapeutics Committee, with advice from the ED and ICU Committees (Resuscitation ED Subcommittee) , will determine the drugs and quantity of each to be kept in the Crash Carts (Emergency Drug Supply) and will review the supply yearly.
8. Emergency medications in the regular crash carts shall be located in drawers (currently the supply is divided into 4 separate drawers). Each drawer shall contain a clearly marked portable container (called a tray), which is sealed by a pharmacist in such a manner that a seal must be broken to gain access to the drugs within. Broselow carts will have compartmented slots to house medications (trayless).
9. The contents of the container shall be listed on the outside cover and shall include the earliest expiration date of any of the drugs within.

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| Title: Emergency Medication Trays Policy | |
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| Source: Director of Pharmacy | Effective Date: |

10. If the medications are used during regular working hours, the pharmacist will replace the tray(s) used and will reseal the crash cart with a breakaway red lock.
11. If the medications are used after pharmacy hours, the shift supervisor will take the used tray to a secure storage area and will replace it with a pre-filled and sealed replacement tray located in the secure area. Pharmacy will be notified of the use as soon as they reopen.
12. The supervisor will reseal the crash cart with a yellow lock.
13. The next morning, a pharmacist will replenish trays or drawers that were opened while the pharmacy was closed. These trays will be restocked, checked, have the lists updated and will be signed by the pharmacist that reseals the tray. These trays will be taken to the crash cart that was opened after pharmacy hours and the pharmacist checks that the crash cart is complete and updates the outdate list on the crash cart, and re-seals crash cart with a red lock.
14. All Crash Carts will be checked as per the Crash Cart and defibrillator Check Policy.
15. In addition to crash cart locations for emergency drug supplies, other departments store special emergency drug supplies. These are approved yearly by the Pharmacy and Therapeutics committee.
16. A pharmacist shall seal these special emergency drug supplies with a breakaway lock, and the contents with expiration dates shall be listed on the outside of the box.
17. A pharmacist shall inspect the emergency drug supply at least every 30 days. Records of such inspections shall be kept for at least three years.

REFERENCES:

1. AM Pearson, et al: Crash Cart Drug Drawer Layout and Design. Proceedings of the Human Factors and Ergonomics Society 56th Annual Meeting 2012. Human Factors and Ergonomics Society Inc.
2. Are You Ready for an Emergency? Don't Get Caught Unprepared. *Same-Day Surgery*, September 2010;34(9)97-101

CROSS REFERENCES:

1. **NIHD** Access to Medications in the Absence of a Pharmacist

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| Title: Emergency Medication Trays Policy | |
| Scope: Hospital Wide | Manual: Nursing All Unit, Pharmacy |
| Source: Director of Pharmacy | Effective Date: |

| Committee Approval | Date |
|--|-------------|
| Clinical Consistency Oversight Committee | 10/21/19 |
| Pharmacy and Therapeutics Committee | 10/17/19 |
| Medical Executive Committee | 11/5/19 |
| Board of Directors | |
| Board of Directors Last Review | |

| | |
|----------|-------------------------------------|
| Revised | 10/10 4/19FGL |
| Reviewed | 10/05, 9/06, 9/07, 9/08, 9/09, 9/10 |

Draft

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|--------------------------------------|--|
| Title: Influenza Vaccination Policy* | |
| Scope: Hospital Wide | Manual: CPM - Infection Control Orange (ICO) |
| Source: Employee Health | Effective Date: 6/1/2014 |

PURPOSE:

CDC recommends an annual flu vaccine as the first and best way to protect against influenza. Science clearly supports influenza vaccination for Healthcare ~~personnel~~ **Workers** (HCW).

1. To reduce the risk of influenza illness to patients, health care personnel and their friends/family.
2. To prevent transmission of influenza from personnel to persons at high risk for complications. Higher influenza vaccination coverage among HCW is associated with reductions in nosocomial influenza among hospital patients.
3. To reduce personnel absenteeism during community outbreaks.

POLICY:

1. Free influenza vaccinations will be offered **per CDC recommendations, once** from the time they become available in September or October **at least** through March 31st of the following year.
2. **The flu season may be extended by the Inyo County Public Health Officer.**
3. **If a vaccine shortage occurs or if the CDC recommendations are altered, the Inyo County Health Officer and NIHD Employee Health Medical Director may suspend or revoke all parts of this policy and procedure.**
4. Data will be collected to determine rates of vaccinations and declinations.
5. All efforts will be made to improve our program and thereby improve our rates of vaccinations.

PROCEDURE:

1. Northern Inyo Healthcare District (NIHD) requires annual influenza vaccinations for all HCW:
 - a. Employees who receive a direct paycheck from NIHD.
Any employment status (Regular; permanent part-time; per diem; temporary agency employees)
 - b. Licensed Independent Practitioners (LIP) who work on-site in any of the patient care buildings.
 - c. Travelers.
 - d. Contract workers.
 - e. **Volunteers and Auxiliary on NIHD campus**
 - i. ~~Ladies Auxiliary~~
 - ii. ~~Hospice~~
 - f. Students/Trainees
 - g. Vendors will check in through Vendormate, and if no documentation of current influenza vaccine will be required to wear a mask at all times on NIHD campus.
2. Education will be provided on hire and annually. Education topics will include:
 - a. Education on the influenza vaccine- the different types offered. Education will involve information on the ingredients; ~~which type is best for specific ages and health concerns.~~
 - i. **Inactivated injectable Influenza Vaccines available to HCW at NIHD for the current flu season.**
 - ii. ~~Inactivated intramuscular vaccine~~
 - iii. ~~RIV3 (FluBlok)~~
 - iv. ~~Other types as they become available. At some time we may consider using intradermal and high dose.~~
 - b. On-going education is also provided related to non-vaccine control and prevention measures. This education is also provided at length through the Aerosolized Transmissible Disease policy. It addresses, among other topics, information on how flu is transmitted; cold and coughs etiquette; not coming to work ill; mask protection.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|--------------------------------------|--|
| Title: Influenza Vaccination Policy* | |
| Scope: Hospital Wide | Manual: CPM - Infection Control Orange (ICO) |
| Source: Employee Health | Effective Date: 6/1/2014 |

- e. ~~When available, the Inyo County Health Officer, will continue to be encouraged to give a lecture on influenza prior to the start of vaccinations being offered. A video will be made of his lectures and made available to everyone on the hospital's Intranet site.~~
- 3. The influenza vaccine is free of charge to all Healthcare Workers on NIHD campus. It is freely accessible to prevent any perceived difficulty. **It is available through Employee Health, House Supervisors, Rural Health Clinic, and** through the Emergency Department 24/7.
 - a. Influenza vaccinations will typically begin **when they become available in September or October.**
 - b. **Starting During** the 2013-2014 Influenza season, dots will be placed on each employee's name badge who receives the vaccination. The color of the dot **will be changed** each season. This is to help department managers more easily see who has and has not had a flu vaccination. This in turn should help with patient assignments.
 - e. ~~Depending on an individual staffing situation, a non-vaccinated worker will be required to wear a mask at all times while on NIHD campus.~~ That is clearly the responsibility of the Nurse Manager, the Department Head, the Infection **Prevention** practitioner. Manager and the **Employee Health Specialist.**
 - d. ~~Every employee, independent practitioner, volunteer, contract worker, student~~ **All HCWs** must either receive the vaccination, or sign a declination and agree to wear a mask.
 - e. Masks will be worn continuously by all unvaccinated employees throughout the facility beginning November 1st of each year until March 31st of the next year **or until the Inyo County Public Health Officer** determines it has concluded.
- 4. NIH strives to improve vaccination rates and see a decrease in declinations.
 - a. Education
 - i. regarding the benefit/risk profile of the vaccination
 - ii. myths and realities- via CDC flyers, posters, e-mails
 - iii. on the seriousness of influenza-especially for high risk populations
 - b. Annual consideration of measures for consequences for those who decline the vaccine.
 - c. Annual plans for promotional activities to increase employee interest and response.
- 5. ~~At this time, our~~ Our yearly goal will be 98%. ~~depend on how our rates change adding in all of the LIPs. At this time, early in the 2011-2012 year, the goal is:~~
 - a. ~~80% by 2014~~
 - b. ~~84% by 2016~~
 - e. ~~86% by 2018~~
 - d. ~~90% or greater by 2020~~
- 6. **Influenza vaccine administration** data will be collected by Employee Health and ultimately sent by the Infection Control Preventionist to be entered into the NHSN database.
- 7. NIHD does require a signed declination. Employee Health will collect the declinations, and the reasons for the declinations will be reviewed. This will be done without specifying any individuals. The purpose will be to find any potential trends or areas of concern that can be changed by education or other measures. ~~This collection and review will occur at least annually.~~
- 8. Our plan is to improve our rates annually. Those rates will go to the Infection Control Committee at the first available meeting after March 31 of each year for review.
- 9. Employee Health will annually provide influenza rate **and declination** data to those leaders and managers who have a stake in the vaccination rate of the hospital staff and Licensed LIPs.
 - a. ~~Infection Control Preventionist/~~Infection Control Committee

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|--------------------------------------|--|
| Title: Influenza Vaccination Policy* | |
| Scope: Hospital Wide | Manual: CPM - Infection Control Orange (ICO) |
| Source: Employee Health | Effective Date: 6/1/2014 |

- b. NIHD Administrator/ Chief Operations Officer
- c. **Nurse Executive Team**
- d. Department Heads
- e. Medical Staff via the medical staff office.
- f. **Board of Directors**
- g. **Quality Improvement Operational Team**

REFERENCES:

~~California Department of Public Health Influenza Surveillance Program, Mandatory Masking Policies by Local Health Department, California 2013-14 Flu Season.~~
<http://www.cdph.ca.gov/programs/cehho/Pages/MandatoryofRecommendedInfluenzaVaccinationofHealthcareWorkers.aspx>

~~a. Table of LHDs with Mandatory Masking Policies 2015-2016 season~~

~~b. Map of LHDs with Mandatory Masking Policies, CA 2015-2016 season~~

1. Special Article Guideline for Infection Control in Health Care Personnel, 1998, The Hospital Infection Control Practices Advisory Committee of the Centers for Disease Control.
<http://www.cdc.gov/hicpac/pdf/InfectControl98.pdf> Retrieved 8/21/19
2. California Department of Public Health, Influenza and Other Respiratory Diseases.
<https://www.cdph.ca.gov/Programs/CID/DCDC/pages/immunization/influenza.aspx> Retrieved 8/21/19
3. California Department of Public Health, Healthcare Associated Infections (HAI) Program, Healthcare Personnel Influenza Vaccination in California Hospitals, 2017-2018.
https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/HealthcarePersonnelInfluenzaVaccinationReportInCA_Hospitals.aspx Retrieved 8/21/19
4. 2009, California Occupational Safety & Health Standards Board (OSHSB) (2009), General Industry Safety Orders, Aerosolized Transmissible Diseases, Title 8, Chapter 4, Subchapter 7, Article 109, Section 5199, <http://www.dir.ca.gov/OSHSB/atd0.html> Retrieved 8/21/19
5. Center for Disease Control, How is Pandemic Flu Different from Seasonal Flu.
<https://www.cdc.gov/flu/pandemic-resources/basics/about.html> Retrieved 8/21/2019
6. Institute of Medicine. Preventing Transmission of Pandemic Influenza and Other Viral Respiratory Diseases: Personal Protective Equipment for Healthcare Workers: Update 2010. Washington, DC: The National Academies Press, 2011.
7. National Healthcare Safety Network (NHSN), Healthcare Personnel (HCP) Influenza Vaccination Summary Reporting in NHSN. <https://www.cdc.gov/nhsn/faqs/vaccination/faq-influenza-vaccination-summary-reporting.html> Retrieved 8/21/19

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|--------------------------------------|--|
| Title: Influenza Vaccination Policy* | |
| Scope: Hospital Wide | Manual: CPM - Infection Control Orange (ICO) |
| Source: Employee Health | Effective Date: 6/1/2014 |

8. Prevention and Control of Seasonal Influenza with Vaccines Recommendations of the Advisory Committee on Immunization Practices – United States, 2018-19 Influenza Season. Morbidity and Mortality Weekly Report, CDC August 24, 2018.
<https://www.cdc.gov/mmwr/volumes/67/rr/rr6703a1.htm>

| Approval | Date |
|-------------------------------|-------------|
| CCOC | 8/26/2019 |
| P & T | 10/17/19 |
| Infection Committee | 8/27/2019 |
| MEC | 11/5/19 |
| Board of Directors | |
| Last Board of Director review | |

Developed 2/12
 Revised 11/13, 4/14, 9/16 NH, 8/19 mm
 Reviewed 3/15 NH,
 Supersedes

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|---|
| Title: Pharmacist Intervention for Iron Replacement | |
| Scope: Medical Staff; Nursing Staff; Pharmacy Staff | Manual: Infusion Center, Medical Staff, Pharmacy, Rural Health Clinic |
| Source: Director of Pharmacy | Effective Date: |

PURPOSE:

To streamline the process which patients presenting to the infusion area of the district receive Iron Replacement Therapy.

POLICY:

~~Physicians-Practitioners~~ will-may send their patients to the ~~District-Outpatient Infusion center~~ to receive Iron replacement. Prior to such physicians can write orders which state “Iron Replacement pursuant to policy”.

PROCEDURE:

1. The ~~physician-practitioner~~ will transmit the order to the NIHD Outpatient Infusion.
2. The order will contain clearly state “Iron Replacement Per Policy”. The order will also include the specific diagnosis for the Iron replacement with any other pertinent details such as recent lab data, height & weight, allergy info, patient change of condition, etc.. Pharmacy, specifically pharmacist on duty will receive this order, assess and select the most suitable product and therapy option available for the patient, calculate the dose and arrange for the sterile compounding of the preparation.

STANDARDS:

Iron replacement is a routine approach to treat individuals with Iron Deficiency. It can be accomplished with oral agents or for those patients that cannot tolerate oral iron or the therapy is not sufficient to successfully treat infusions are the next logical step to accomplish this task.

Reasons for incorporating infusions of iron:

1. Poor adherence or gastrointestinal side effects of oral iron.
2. Prefer to replete iron stores in one or two visits rather than over the course of several months.
3. Ongoing blood loss that exceeds the capacity of oral iron to meet needs ~~(heavy uterine bleeding, mucosal telangiectasias).~~
4. Anatomic or physiologic condition that interferes with oral iron absorption.
5. Coexisting inflammatory state that interferes with iron homeostasis

Presently there are three agents on the NIHD formulary representing the practice standard for Iron replacement therapy. They are:

1. Iron Sucrose (Venofer)
2. Iron Dextran (Dexferrum)
3. Iron Carboximaltose (Injectafer)

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|--|--|
| Title: Pharmacist Intervention for Iron Replacement | |
| Scope: Medical Staff; Nursing Staff; Pharmacy Staff | Manual: Infusion Center, Medical Staff, Pharmacy, Rural Health Clinic |
| Source: Director of Pharmacy | Effective Date: |

Each item has select characteristics and benefits and the pharmacist on duty careful selection will result in the most significant benefit to the patient with minimal consequence. The frequency of serious adverse events does not vary among the products with the exception of Iron Dextran. This agent has a greater frequency of allergic reactions.

REFERENCES:

1. Up To Date “Treatment of Iron Deficiency Anemia” 9/19
2. Lexicomp Drug Information for Advanced Practice Pharmacist 2018
3. Gut 2017 66:863 Oral versus intravenous iron replacement therapy.

CROSS REFERENCE P&P:

1. NIHD Policy “ Drug Orders”
2. NIHD Policy “Pharmacist Clinical Interventions”
3. Iron Dextran Administration

| Approval | Date |
|--|-------------|
| Clinical Consistency Oversight Committee | 10/21/19 |
| Pharmacy and Therapeutics Committee | 10/17/19 |
| MEC | 11/5/19 |
| Board of Directors | |
| Last Board of Director Review | |

Developed: 8/19fl

Reviewed:

Revised:

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|-------------------------|
| Title: Rehabilitation Services Standard of Care | |
| Scope: OT, PT, PTA, ST therapists | Manual: Rehabilitation |
| Source: Director of Rehab. Services | Effective Date: 12/2015 |

PURPOSE/STATEMENT: To Outline the Standard of Care for patient/family at the Northern Inyo Healthcare District (NIHD) Rehab Therapy Service Department so the patient /family knows what to expect when admitted to therapy services.

The patient age-specific population served is:

- Pediatric: 28 days of age to 13 years of age
- Adult: 13 years of age to 65 years of age
- Geriatric: > 65 years of age

Prior to Admission:

1. Patients will be called within 3 business days to schedule an appointment once an order is received from their provider.

2. Rehab registration and referral team will insure that the referral thoroughly outlines the type of service required and will verify all insurance authorizations have been obtained.

3. If we are unsuccessful at reaching the patient there will be at least 2 more attempts to make contact with them before the referral is sent back to the provider.

On Admission:

1. Upon arriving for the scheduled appointment the patient reviews a copy of their NIHD facesheet to verify that all patient information is correct.

2. Patients are required to provide insurance cards if needed at the first appointment and with any change in insurance coverage.

3. Patients are required to sign the standardized hospital consent form and the Rehabilitation Services cancellation/ no show policy.

4. For most physical therapy evaluations a functional questionnaire will be provided to be completed by the patient in the lobby prior to the appointment or with the treating therapist if necessary.

5. Patients appointment will begin promptly on time and will last between 45-90 minutes depending on the diagnosis.

6. Upon exit or end of evaluation the scheduling clerk will schedule the entire treatment cycle through anticipated discharge and provide the patients schedule a week at a time.

7. The patient will receive reminder calls and/or texts 24 hours before each visit.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|-------------------------|
| Title: Rehabilitation Services Standard of Care | |
| Scope: OT, PT, PTA, ST therapists | Manual: Rehabilitation |
| Source: Director of Rehab. Services | Effective Date: 12/2015 |

Throughout Stay:

1. The Standards of Care for patients identified here are considered applicable to all patients but should be adapted to meet the individual needs of each patient.
2. The Standards of Care describe the minimal care acceptable for each patient.
3. Services will be provided in a caring manner with confidentiality and personal privacy as allowed by the environment.
4. Language interpretation will always be provided in the language that the patient and or guardian state is the preferred language for communication.
5. Throughout each visit the patient, as appropriate, will receive information needed to explain all visit procedures.
6. Patients will receive care based on assessment of their age-specific needs.
7. The Occupational Therapist or the Physical Therapist shall supervise treatment rendered by aides and assistants.
8. There shall be sufficient equipment and supplies appropriate to the needs of the services offered.
9. Smoking will be prohibited.
10. Pediatric patients must be accompanied by an adult that remains on hospital premises during treatment.
11. Safety
 - a. As much as possible, each patient will be assigned one Therapist or Combination of one Therapist and one Therapy Assistant.
 - b. Environment will be:
 - i. Clean and free of clutter
 - ii. Properly lighted
 - iii. Free of any defective or unsafe equipment
 - iv. Environment of Care inspection by assigned staff member is done monthly and as needed.
 - c. Electrical Safety precautions to include:
 - i. Outlet plugs in place throughout the facility
 - ii. Use of grounded equipment
 - iii. Spilled liquid to be cleaned immediately
 - d. Infection Control

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|-------------------------|
| Title: Rehabilitation Services Standard of Care | |
| Scope: OT, PT, PTA, ST therapists | Manual: Rehabilitation |
| Source: Director of Rehab. Services | Effective Date: 12/2015 |

- i. Hand Hygiene using the WHO “5 Moments of Hand Hygiene”
 - ii. Standard Precautions for all patients
 - iii. Follow the other precautions: Contact, Droplet and Airborne as required by individual circumstances

12. Emotional Support provided to Patient and Caregivers by therapy staff that includes:
 - a. Use of AIDET customer service
 - b. Individualized, respectful care
 - c. Promotes freedom to ask questions and improve understanding
 - e. Give a thorough explanation of procedures
 - f. Listen attentively
 - g. Avoid talking about patient in his presence and in presence of the family unless they are included.
 - h. Encouragement for patient and caregiver/family to participate in their Home Program

13. Documentation of the care given will be completed in the electronic health record and patient assessments will be used to formulate an ongoing plan of care which will be documented in the electronic medical record in a within 72 hours.

14. Concerns will be communicated to the referring physician/practitioner, via the electronic medical record or hospital phone.

15. Results of the evaluation will be reviewed with the patient/caregiver and a care plan will be established with input from the patient. The discharge plan will also be discussed at this point in time.

16. Patient and Caregiver/Family education will be provided as required.
 - a. Use illustrated handouts if applicable
 - b. Use written instruction if applicable
 - c. Use Verbal Instruction, Demonstration and Teach-Back

17. A re-assessment will be performed at the end of a treatment cycle and a new care plan will be established if the patient is not discharged.

Upon Discharge:

1. Once a patient has achieved their discharge plan there will be one final consultation with the evaluating therapist in order to review maintenance programs and any further education necessary.

2. Achievement of or progress towards goals will be reported to the referring physician/practitioner in a discharge summary and reviewed with the patient.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|-------------------------|
| Title: Rehabilitation Services Standard of Care | |
| Scope: OT, PT, PTA, ST therapists | Manual: Rehabilitation |
| Source: Director of Rehab. Services | Effective Date: 12/2015 |

Reference:

1. www.aafp.org (The American Academy of Family Practice)
2. The Joint Commission 2019 Comprehensive Accreditation Manual for Critical Access Hospitals.
 - EC.02.06.01 safe, functional environment
 - EC.02.01.03 smoking
 - NPSG.07.014.01 hand hygiene
3. Barclays Official California Code of Regulations Title 22. Social Security
 - 70515-70527 Occupational Therapy
 - 70559-70563 Physical Therapy
 - 70639-70647 Speech Therapy

Cross-Reference P&P:

1. Standard of Care in the outpatient Infusion Unit
2. Standard of Care-Outpatient
3. Standard of Care- RHC
4. Patients' Rights
5. Universal Protocol
 - a. Rehabilitation- Scope of Assessment Policy
 - b. Rehabilitation- Discharge Planning Policy
 - c. Interpretive Services- Language Access Services Policy

| Approval | Date |
|---|---------|
| Clinical Consistency Oversight Committee (CCOC) | 8/26/19 |
| Med Services/ICU | 10/3/19 |
| Medical Executive Committee (MEC) | 11/5/19 |
| Board of Directors | |
| Last Board of Director review | |

Developed: 12/15

Reviewed: 11/2016, 1/18/17

Revised: 01/2017, 8/2019rh

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|-------------------------|
| Title: Rehabilitation Services Standard of Care | |
| Scope: OT, PT, PTA, ST therapists | Manual: Rehabilitation |
| Source: Director of Rehab. Services | Effective Date: 12/2015 |

PURPOSE/STATEMENT: To Outline the Standard of Care for patient/family at the Northern Inyo Healthcare District (NIHD) Rehab Therapy Service Department so the patient /family knows what to expect when admitted to therapy services.

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- Pediatric: 28 days of age to 13 years of age
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- Geriatric: > 65 years of age

Prior to Admission:

1. Patients will be called within 3 business days to schedule an appointment once an order is received from their provider.

2. Rehab registration and referral team will insure that the referral thoroughly outlines the type of service required and will verify all insurance authorizations have been obtained.

3. If we are unsuccessful at reaching the patient there will be at least 2 more attempts to make contact with them before the referral is sent back to the provider.

On Admission:

1. Upon arriving for the scheduled appointment the patient reviews a copy of their NIHD facesheet to verify that all patient information is correct.

2. Patients are required to provide insurance cards if needed at the first appointment and with any change in insurance coverage.

3. Patients are required to sign the standardized hospital consent form and the Rehabilitation Services cancellation/ no show policy.

4. For most physical therapy evaluations a functional questionnaire will be provided to be completed by the patient in the lobby prior to the appointment or with the treating therapist if necessary.

5. Patients appointment will begin promptly on time and will last between 45-90 minutes depending on the diagnosis.

6. Upon exit or end of evaluation the scheduling clerk will schedule the entire treatment cycle through anticipated discharge and provide the patients schedule a week at a time.

7. The patient will receive reminder calls and/or texts 24 hours before each visit.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|-------------------------|
| Title: Rehabilitation Services Standard of Care | |
| Scope: OT, PT, PTA, ST therapists | Manual: Rehabilitation |
| Source: Director of Rehab. Services | Effective Date: 12/2015 |

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4. Language interpretation will always be provided in the language that the patient and or guardian state is the preferred language for communication.
5. Throughout each visit the patient, as appropriate, will receive information needed to explain all visit procedures.
6. Patients will receive care based on assessment of their age-specific needs.
7. The Occupational Therapist or the Physical Therapist shall supervise treatment rendered by aides and assistants.
8. There shall be sufficient equipment and supplies appropriate to the needs of the services offered.
9. Smoking will be prohibited.
10. Pediatric patients must be accompanied by an adult that remains on hospital premises during treatment.
11. Safety
 - a. As much as possible, each patient will be assigned one Therapist or Combination of one Therapist and one Therapy Assistant.
 - b. Environment will be:
 - i. Clean and free of clutter
 - ii. Properly lighted
 - iii. Free of any defective or unsafe equipment
 - iv. Environment of Care inspection by assigned staff member is done monthly and as needed.
 - c. Electrical Safety precautions to include:
 - i. Outlet plugs in place throughout the facility
 - ii. Use of grounded equipment
 - iii. Spilled liquid to be cleaned immediately
 - d. Infection Control

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|-------------------------|
| Title: Rehabilitation Services Standard of Care | |
| Scope: OT, PT, PTA, ST therapists | Manual: Rehabilitation |
| Source: Director of Rehab. Services | Effective Date: 12/2015 |

- i. Hand Hygiene using the WHO “5 Moments of Hand Hygiene”
 - ii. Standard Precautions for all patients
 - iii. Follow the other precautions: Contact, Droplet and Airborne as required by individual circumstances

12. Emotional Support provided to Patient and Caregivers by therapy staff that includes:
 - a. Use of AIDET customer service
 - b. Individualized, respectful care
 - c. Promotes freedom to ask questions and improve understanding
 - e. Give a thorough explanation of procedures
 - f. Listen attentively
 - g. Avoid talking about patient in his presence and in presence of the family unless they are included.
 - h. Encouragement for patient and caregiver/family to participate in their Home Program

13. Documentation of the care given will be completed in the electronic health record and patient assessments will be used to formulate an ongoing plan of care which will be documented in the electronic medical record in a within 72 hours.

14. Concerns will be communicated to the referring physician/practitioner, via the electronic medical record or hospital phone.

15. Results of the evaluation will be reviewed with the patient/caregiver and a care plan will be established with input from the patient. The discharge plan will also be discussed at this point in time.

16. Patient and Caregiver/Family education will be provided as required.
 - a. Use illustrated handouts if applicable
 - b. Use written instruction if applicable
 - c. Use Verbal Instruction, Demonstration and Teach-Back

17. A re-assessment will be performed at the end of a treatment cycle and a new care plan will be established if the patient is not discharged.

Upon Discharge:

1. Once a patient has achieved their discharge plan there will be one final consultation with the evaluating therapist in order to review maintenance programs and any further education necessary.

2. Achievement of or progress towards goals will be reported to the referring physician/practitioner in a discharge summary and reviewed with the patient.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|-------------------------|
| Title: Rehabilitation Services Standard of Care | |
| Scope: OT, PT, PTA, ST therapists | Manual: Rehabilitation |
| Source: Director of Rehab. Services | Effective Date: 12/2015 |

Reference:

1. www.aafp.org (The American Academy of Family Practice)
2. The Joint Commission 2019 Comprehensive Accreditation Manual for Critical Access Hospitals.
 - EC.02.06.01 safe, functional environment
 - EC.02.01.03 smoking
 - NPSG.07.014.01 hand hygiene
3. Barclays Official California Code of Regulations Title 22. Social Security
 - 70515-70527 Occupational Therapy
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Cross-Reference P&P:

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2. Standard of Care-Outpatient
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4. Patients' Rights
5. Universal Protocol
 - a. Rehabilitation- Scope of Assessment Policy
 - b. Rehabilitation- Discharge Planning Policy
 - c. Interpretive Services- Language Access Services Policy

| Approval | Date |
|---|-------------|
| Clinical Consistency Oversight Committee (CCOC) | 8/26/19 |
| Med Services/ICU | 10/3/19 |
| Medical Executive Committee (MEC) | 11/5/19 |
| Board of Directors | |
| Last Board of Director review | |

Developed: 12/15

Reviewed: 11/2016, 1/18/17

Revised: 01/2017, 8/2019rh

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

| | |
|--|-----------------------------|
| Title: Repackaging and Compounding of Medications | |
| Scope: Departmental | Department: Pharmacy |
| Source: Pharmacy Director | Effective Date: 10/20/03 |

PURPOSE:

To comply with State laws regarding repackaging and compounding of medications and to comply with record-keeping requirements of these laws.

POLICY:

1. Repackaging of medications in the pharmacy will be done under the direct supervision of a pharmacist.
2. Medications may be repackaged as follows:
 - a. Unit dose packaging from bulk containers of medications.
 - b. Multi-dose packaging of medications from bulk containers for dispensing as after-hours emergency room prescriptions for dispensing by the emergency room physician.
 - c. Multi-dose packaging of medications from bulk containers for administration by nursing personnel to patients in the hospital.

Unit Dose

3. Unit dose repackaging shall be done utilizing the pharmacy computerized unit dose packaging system. The system shall record:
 - a. The manufacturer, lot number and expiration date of the original bulk package.
 - b. The system-assigned lot number, and expiration date of 6 months or the expiration date of the original package if that date is sooner than 6 months.
 - c. The initials of the packaging technician or pharmacist.
 - d. The initials of the checking pharmacist.
4. The system shall print a label with the above information for each episode of unit dose packaging. This label shall be affixed to the packaging log, which shall be hand-initialed by the checking pharmacist.
5. The packaging log shall be retained for 3 years.

Prescriptions

6. Multi-dose packaging of medications from bulk containers shall be done on an extemporaneous basis.
7. A technician may count or measure the prescribed amount of medication into a dispensing container.
8. The technician shall leave the dispensing container, the prescription, the label and the bulk container from which the dispensing container was filled together for the pharmacist to check, label, and verify.
9. The pharmacist shall initial the label affixed to the dispensing container and the prescription hard copy (utilizing a permanent sticker from the label set) as proof of checking the technician's work.
10. The hard-copy of the prescription shall be retained for 3 years.

After-hours Emergency prescription prepacks

11. After-hours Emergency prescription repackaging shall be done utilizing the pharmacy computerized unit dose packaging system when necessary as NuCare Pharmacy provides many of these items. The system shall record:
 - a. The manufacturer, lot number and expiration date of the original bulk package.
 - b. The system-assigned lot number, and expiration date of 6 months or the expiration date of the original package if that date is sooner than 6 months.
 - c. The initials of the packaging technician or pharmacist.
 - d. The initials of the checking pharmacist.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

| | |
|--|-----------------------------|
| Title: Repackaging and Compounding of Medications | |
| Scope: Departmental | Department: Pharmacy |
| Source: Pharmacy Director | Effective Date: 10/20/03 |

12. The system shall print a label with the above information for each episode of After-hours Emergency prescription packaging. This label shall be affixed to the packaging log, which shall be hand-initialed by the checking pharmacist.
13. The packaging log shall be retained for 3 years.

Multi-dose packaging of medications from bulk containers for administration

14. Multi-dose packaging of medications from bulk containers for administration shall be done on an extemporaneous basis.
15. A technician may count or measure the amount of medication determined by the pharmacist into a dispensing container.
16. The technician shall leave the dispensing container, the physician's order, the label and the bulk container from which the dispensing container was filled together for the pharmacist to check, label, and verify.
17. The pharmacist shall initial the label affixed to the dispensing container and the order hard copy as proof of checking the technician's work.
18. The hard copy of the order shall be retained for 3 years.

Compounding

19. Only a pharmacist or a pharmacy technician under the direct supervision of a pharmacist will perform compounding of pharmaceuticals.
20. The pharmacist shall record the manufacturer and lot numbers of the compounded ingredients on the packaging log together with the date and expiration date of the compounded material.
21. The pharmacist shall initial the entry.
22. The pharmacist shall label the compounded pharmaceutical with the lot number(s) of the ingredients.
23. The packaging log shall be retained for 3 years.

References:

FDCA Section 505

FDA Law Review 1/18/17 Palmer et al
Final Guidance Addressing Repackaging of Drugs

CFR Title 21 Volume 4 4/1/18

Cross References:

NIH Patient's Own Meds Policy

NIH Medication Shortages

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

| | |
|--|-----------------------------|
| Title: Repackaging and Compounding of Medications | |
| Scope: Departmental | Department: Pharmacy |
| Source: Pharmacy Director | Effective Date: 10/20/03 |

| Committee Approval | Date |
|-------------------------------------|-------------|
| CCOC | |
| Pharmacy and Therapeutics Committee | 10/17/19 |
| Medical Executive Committee | 11/5/19 |
| Board of Directors | |
| Last Board of Directors Review | |

Revised:

Reviewed:

Supersedes:

Responsibility for review and maintenance:

Index Listings:

Initiated:

Revised/Reviewed:

Draft

NORTHERN INYO HOSPITAL POLICY AND PROCEDURE

| | |
|--|--|
| Title: Sharps Injury Protection Plan | |
| Scope: NIHD | Department: Infection Control Orange Manual |
| Source: Quality Informatics Nurse/Infection Prevention Manager | Effective Date: August 2007 |

PURPOSE:

The purpose of engineered sharps safety is to increase protection from sharps injuries, which can transmit HIV, hepatitis B, hepatitis C and other bloodborne pathogens. This is accomplished by stronger requirements for employers to use needles and other sharps which are engineered to reduce the chances of inadvertent needle sticks or other sharps injuries.

COMMITTEE GOAL:

The goal of the NIHD Sharps Prevention Program is to continue to progress in reducing the risk of sharps injuries to NIHD healthcare workers, patients and visitors. This committee will focus on five pivotal areas:

1. Improving sharps safety in surgical settings.
2. Understanding and reducing exposure risks in all hospital, nonhospital settings, and home settings.
3. Involve frontline workers in the selection of safety devices.
4. Address gaps in available safety devices and encouraging innovative designs and technology.
5. Enhance healthcare worker education and training.

~~“Besides being the right thing to do, creating and maintaining a culture of safety that minimizes occupational health risks goes a long way toward increasing job satisfaction, which in turn reduces staff turnover. Engaging frontline healthcare workers is a priority in any effort to create a culture of safety—not just for sharps safety but for the general health, safety, and wellness of all healthcare employees, patients, and the public.” (Karen A. Daley President, American Nurses Association (2012).~~

POLICY:

1. Needles/syringes shall not be recapped, broken, clipped, bent or otherwise manipulated by hand.
2. Needles/syringes will have safety features, if they are available in the marketplace.
3. If a needle/syringe does not have an incorporated safety feature, additional safety equipment will be used.
4. IV catheters with safety features are used.
5. The only exemption to the use of safety needles or devices is in the Nuclear Medicine Department, where safety equipment for needles is incompatible with safety equipment for radiation exposure.
6. The employee or physician performing the procedure **MUST** dispose of ~~their~~ his/her own sharps.
7. Contaminated sharps will be placed in appropriate sharps container.

DEFINITIONS:

1. Passive safety: A feature that requires no action by the user.
2. Safety Engineered Devices: A device that has a built in sharps injury protection mechanism such as an attached sheath covering the needle or scalpel after use or needles that retract.
3. Sharps: Devices or objects capable of cutting or piercing. Examples include scalpels, razor blades, broken glass, microscope slides, and needles.
4. Sharps container: Rigid puncture resistant container with a secure lid that can safely store sharps waste.

PROCEDURE:

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

| | |
|--|--|
| Title: Sharps Injury Protection Plan | |
| Scope: NIHD | Department: Infection Control Orange Manual |
| Source: Quality Informatics Nurse/Infection Prevention Manager | Effective Date: August 2007 |

1. Needles/syringes shall be disposed of immediately after activation of the safety feature, and placed into the closest sharps container provided on each medication cart, patient room, and other designated work areas in the nursing and patient treatment units. This may require placing a portable sharps container in the area of point of use. Sharps used for radioactive materials shall be disposed of in lead shielded sharps containers and shall be transported in closed and shield lead boxes.
2. Do not place sharps on bedding, drapes, and tables or into trash.
3. Do not transport uncovered needles.
4. Be responsible to discard needles yourself- avoid handing to another person unless safety feature is activated.
- ~~5. During any surgical or diagnostic procedure, as well as suturing of intravenous or intra-arterial catheters, place suture needles on designated towel, collection unit, or on disposable tray.~~
- ~~6.5.~~ Avoid placing hands, yours or someone else's, in close proximity of suturing, cutting or injecting.
- ~~7.6.~~ Needles found on floor, trays, linen, tables, etc. must **NOT** be picked up by hand; use needle holder, tongs, or dustpan and broom to retrieve.
- ~~8.7.~~ For needles without attached engineered safety protection, use point lock needle protection device protector to protect used needles before discarding or removing needle from syringe.
- ~~9.8.~~ When safety syringe/needle is used, safety feature must be activated immediately after use. Use a hard surface to activate the safety feature.
- ~~10.9.~~ Always dispose of needles into sharps box with one-handed technique; do not open lid with second hand.
- ~~11.10.~~ During blood draws, it is preferable to use:
 - a. Safety vacutainer
 - b. Safety butterfly systemIf using a needle:
 - ~~i. Utilize a needle with engineered safety protection~~
 - i. Utilize a needle with engineered safety protection
 - ii. Draw blood
 - iii. Activate the safety feature of the needle immediately; or stab into tip protector immediately
 - iv. Discard in sharps container
 - v. Use transfer dome to fill tubes/bottles
 - vi. Dispose of sharps in appropriate receptacle
- ~~12.11.~~ After drawing up medication to inject:
 - a. Activate safety feature and dispose of needle at med cart- do not take into patient room
 - b. Cover tip with port protector or cap from syringe tip for transport.

RECAPPING OF CONTAMINATED NEEDLES:

1. NIHD utilizes safety needles, or device therefore recapping is unnecessary.

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

| | |
|--|--|
| Title: Sharps Injury Protection Plan | |
| Scope: NIHD | Department: Infection Control Orange Manual |
| Source: Quality Informatics Nurse/Infection Prevention Manager | Effective Date: August 2007 |

2. Due to the use of lead syringe shields, safety needles are often unable to be used in the Nuclear Medicine department. Safety needles shall be used when shielding is not needed. All non-safety needles shall be recapped with a one-handed recapping techniques.

SHARPS DISPOSAL SYSTEMS:

1. Sharp boxes shall:
 - a. Be clearly marked as sharps disposal systems and have clearly visible Biohazard labels.
 - b. Be puncture and leak-proof.
 - c. Have opening easily accessible and safe to use. Do not place items on top of sharps container
 - d. Staff must ensure that no items are sticking out of opening, and sharps are not stuck in the opening of sharps container.
 - e. Be designed to prevent used sharps from being easily removed or spilled.
 - f. Be stable/or secured to avoid tipping.
 - g. Not be overfilled - maximum 3/4 full. Sharps container must be changed if at the fill line.
 - h. Be sealed and placed in designated dumpster for sterilization *before* disposal to the landfill.
 - i. Be locked to wall brackets to prevent removal when placed in patient rooms.
2. Environmental Services is responsible for checking sharps containers daily and is responsible for their removal and disposal.
3. IV and phlebotomy trays, other carts may have small sharps disposable boxes for needle disposal.

ACCEPTING COMMUNITY NEEDLES:

IT IS IMPERATIVE THAT THIS PRACTICE IS ADHERED TO STRICTLY!

1. NIHD will accept contaminated needles from the community for disposal
2. Refer questions from persons with needles to infection control or maintenance.
3. A sharps disposal unit is at the front of the hospital and all community sharps may be placed in this unit.
4. Sharps containers may not be sold or given to patients or other individuals for home use.
5. Sharps disposal located at NIHD front entrance (large **red** receptacle with the wording “sharps”)
 - a. Must be in a rigid hard plastic bottle or container with screw lids.
 - b. Sharp boxes designed for sharps
 - c. Will not be accepted otherwise.
6. Any ambulance service may dispose of their needles/infectious waste at NIHD, at any time, but must dispose of it themselves in appropriate infectious waste containers.

DOCUMENTATION:

1. NIHD is required to keep a sharps injury log, which records the date and time of each sharps injury, as well as the type and brand of device involved in the exposure incident, the task being done when the injury occurred and whether the injury occurred before, during or after the task was performed. This log is used to evaluate sharps products and employee practices to prevent further exposures.
2. These logs will be maintained for 5 years.
3. Records shall be shredded at disposal specified site

**NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE**

| | |
|--|--|
| Title: Sharps Injury Protection Plan | |
| Scope: NIHD | Department: Infection Control Orange Manual |
| Source: Quality Informatics Nurse/Infection Prevention Manager | Effective Date: August 2007 |

4. A record disposal log shall be maintained will all facility disposal records.

REFERENCES:

1. American Nurse today. (2019). To reduce sharps injuries, all of us must create a culture of safety in our workplace (Sept 2012). Retrieved from <https://www.americannursetoday.com/to-reduce-sharps-injuries-all-of-us-must-create-a-culture-of-safety-in-our-workplaces/>
2. Centers for Disease Control and Prevention. (2015). Workbook for Designing, Implementing and Evaluating a Sharps Injury Prevention Program. Retrieved from https://www.cdc.gov/sharpsafety/pdf/sharpsworkbook_2008.pdf
3. International Sharps Injury Prevention Society. (2017) Scalpel Injuries are a major source of bloodborne pathogen exposure in the OR. Retrieved from http://www.isips.org/page/scalpel_injuries

CROSS REFERENCE P&P:

1. Bloodborne Pathogen Exposure Control Plan
2. Work Related Accidents/Exposures
3. Medical Waste Management Plan

| Approval | Date |
|--------------------------------|-------------|
| CCOC | 8/26/2019 |
| Safety Committee | 9/11/2019 |
| Sharps Committee | 08/06/2019 |
| Infection Control Committee | 08/27/2019 |
| MEC | 11/5/2019 |
| Board of Directors | 12/13/2017 |
| Last Board of Directors Review | 7/18/2018 |

Developed: 4/92

Reviewed:

Revised: 12/93, 12/94, 1/95, 2/97, 8/99, 6/01, 4/03, 9/03, 1/04; 8/04, 11/04, 5/05; 8/07; 8/08, 6/11JB; 9/12 BS; 11/15 NH, 6/17RC, 7/19RC

Supersedes: Handling and Disposal of Contaminated needles/Syringes.

Index Listings: Sharps, injury

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|----------------------------|
| Title: Therapy Evaluation/Inpatients, OPO, and Swing Bed Patients | |
| Scope: OT, PT, ST therapists | Manual: Rehabilitation |
| Source: Director of Rehabilitation Services | Effective Date: 12/16/2015 |

PURPOSE: Functional assessment, evaluation / plan of care and reassessment of each identified patient will be performed in a manner that will insure a comprehensive method of data aggregation, analysis, interpretation and professional recommendation for benefit of the patient.

POLICY:

1. The Therapist conducts screening and evaluations in a wide variety of patients (See Scope of Care).
2. When Therapy is ordered on an Inpatient, OPO Patient, or Swing Bed Patient:
 - The Therapist will evaluate the patient and formulate a Plan of Care (POC).
 - The evaluation will be signed by the referring physician, or the hospitalist, showing authorization and agreement with the POC.
 - The patient will be followed per the Therapist's Plan of Care.

PROCEDURE:

1. Evaluation Process for Inpatients:
 - A. All physician orders for Therapy will be initiated within 24 hours of receipt by the Therapy staff during regularly scheduled department hours. Evaluation and treatments of inpatients occur in the patient room, hallways, or in the Rehabilitation Therapy Department as needed.
 - B. The medical record will be reviewed with relevant information recorded (in a comprehensive format) in the Plan of Care / Evaluation in the electronic medical record. A concerted effort will be made to get a verbal report of the patient's current status from the attending nurse prior to the evaluation.
 - C. The Therapist will determine the most appropriate evaluation materials and instruments to utilize for the evaluation of the patient as an individual.

Therapy Evaluation / Plan of Care will include:

- PT/ST/OT order for services
- Surgery or reason for admit
- Surgery date or admit date
- Precautions
- Pain
- PLOF
- Communication
- Follow Commands
- Insight into deficits
- Level of Consciousness
- Orientation
- Subjective

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|----------------------------|
| Title: Therapy Evaluation/Inpatients, OPO, and Swing Bed Patients | |
| Scope: OT, PT, ST therapists | Manual: Rehabilitation |
| Source: Director of Rehabilitation Services | Effective Date: 12/16/2015 |

- Assessment
 - Prognosis
 - Treatment
 - Education
 - Response to Education
 - Measurable Goals/Short and Long Term
 - Treatment Duration
 - Treatment Frequency
 - Intervention Plan
 - Discharge Recommendations/Plan as it pertains to therapy
 - Time in
 - Time out
 - Total time
2. Projected Prognosis – Documentation and Communication:
- Upon completion of the evaluation the Therapist will document findings and complete a Plan of Care in the electronic medical record within 24 hours.
 - A reasonable effort will be made to verbally notify the In-Patient’s, OPO or Swing Bed Patient’s attending physician and/or the nurse of the evaluation’s findings.
3. The Director of Rehab services will oversee the auditing of clinical therapy evaluations and documentation.

REFERENCES:

1. http://www.apta.org/uploadedFiles/APTAorg/About_Us/Policies/BOD/Practice/DocumentationPatientClientMgmt.pdf
2. The Joint Commission 2019 Comprehensive Accreditation Manual for Critical Access Hospitals. (RC.01.01.01, RC.01.02.01, RC.01.03.01, PC 01.02.03, RC.02.01.01)
3. <https://www.asha.org/practice/reimbursement/module-three/>

CROSS REFERENCE P&P:

1. **Scope of Care in Rehabilitation Services**
2. **Chart Check guidelines- ICU, Med/Surg &Perinatal**

| Approval | Date |
|-----------------------------|-------------|
| CCOC | 8/26/2019 |
| Med Services/ICU | 10/3/19 |
| Medical Executive Committee | 11/5/19 |
| Board of Directors | |
| Board last Review | |

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|----------------------------|
| Title: Therapy Evaluation/Inpatients, OPO, and Swing Bed Patients | |
| Scope: OT, PT, ST therapists | Manual: Rehabilitation |
| Source: Director of Rehabilitation Services | Effective Date: 12/16/2015 |

Reviewed: 10/18/2016,

Revised: 8/2019 rh

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|------------------|
| Title: USE OF BIOSIMILAR PRODUCTS AT NIHD | |
| Scope: District Wide | Manual: Pharmacy |
| Source: Director of Pharmacy | Effective Date: |

PURPOSE: To define the use of biosimilar products at Northern Inyo Healthcare District.

POLICY:

1. **Statement:** Northern Inyo Healthcare District (NIHD) is committed to providing safe quality care for its patients. This includes the addition to formulary and incorporation for use a newer class of biologic agents. These agents identified as “**BIOSIMILARS**” are clinically identical although not chemically identical from the parent biologic. That is although they produce the same result as the parent biological they may vary in their stereo chemical structural appearance.
2. The governing bodies including the FDA and the various laws that have been promulgated to provide oversight and guidance for the use of biosimilars are quite specific. The use of the Purple Book identifies those products which have been approved for use. However, at this time there are no interchangeable products that is (like generic drugs) a pharmacist cannot automatically substitute one biosimilar for another or parent biological compound without physician direction and approval.
3. The goal of this policy is to allow the pharmacist to interpret a physician order for a potentially available biosimilar product and convert this order to the biosimilar product available in the department.

PROCEDURE:

1. Presently, there are 20 biosimilar products available for various indication and use that fall under four categories Anti-Diabetic, Hematopoietic, Anti-rheumatic, and Antineoplastic. (see appendix)
2. When a biologic or biosimilar product is ~~ordered~~ the pharmacist after notifying the physician will provideselect the a-clinically identical product on formulary~~from the items listed contained~~ in the Purple Book from within the same biosimilar class. ~~for distribution to service with proper ultimate use without the necessity to contact the prescribing physician.~~
3. The biosimilar will be prepared, dosed, administered, monitored for efficacy and tolerance according to the manufacturer’s literature for use by health professionals.
4. Specific biosimilars are contraindicated when prior use has resulted in adverse consequences.
5. The active list of biosimilar agents will be modified as new products are approved and made available and products are deleted.
6. P&T will approve additions and deletions to this formulary.

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|------------------|
| Title: USE OF BIOSIMILAR PRODUCTS AT NIHD | |
| Scope: District Wide | Manual: Pharmacy |
| Source: Director of Pharmacy | Effective Date: |

Appendix:

FDA-Approved Biosimilar Products

| Drug Name | Approval Date | More Information |
|----------------------------------|----------------------|---|
| Eticovo (etanercept-ykro) | April 2019 | Eticovo Information |
| Trazimera (trastuzumab-qyyp) | March 2019 | Trazimera Information |
| Ontruzant (trastuzumab-dttb) | January 2019 | Ontruzant Information |
| Herzuma (trastuzumab-pkrb) | December 2018 | Herzuma Information |
| Truxima (rituximab-abbs) | November 2018 | Truxima Information Press Release: FDA approves first biosimilar for treatment of adult patients with non-Hodgkin's lymphoma |
| Udenyca (pegfilgrastim-cbqv) | November 2018 | Udenyca Information |
| Hyrimoz (adalimumab-adaz) | October 2018 | Hyrimoz Information |
| Nivestym (filgrastim-aafi) | July 2018 | Nivestym Information |
| Fulphila (pegfilgrastim-jmdb) | June 2018 | Fulphila Information Press Release: FDA approves first biosimilar to Neulasta to help reduce the risk of infection during cancer treatment |
| Retacrit (epoetin alfa-epbx) | May 2018 | Retacrit information Press Release: FDA approves first epoetin alfa biosimilar for the treatment of anemia |
| Ixifi (infliximab-qbtx) | December 2017 | Ixifi information |
| Ogivri (trastuzumab-dkst) | December 2017 | Ogivri information Press Release: FDA approves first biosimilar for the treatment of certain breast and stomach cancers |

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|------------------|
| Title: USE OF BIOSIMILAR PRODUCTS AT NIHD | |
| Scope: District Wide | Manual: Pharmacy |
| Source: Director of Pharmacy | Effective Date: |

| | | |
|------------------------------------|-------------------|---|
| Mvasi (Bevacizumab- awwb) | September 2017 | Mvasi information Press Release: FDA approves first biosimilar for the treatment of cancer |
| Cyltezo (Adalimumab- adbm) | August 2017 | Cyltezo information |
| Renflexis (Infliximab-abda) | May 2017 | Renflexis information |
| Amjevita (Adalimumab - atto) | September 2016 | Amjevita information Press Release: FDA approves Amjevita |
| Erelzi (Etanercept-szsz) | August 2016 | Erelzi information Press Release: FDA approves Erelzi |
| Inflectra (Infliximab-dyyb) | April 2016 | Inflectra information Press Release: FDA approves Inflectra |
| Zarxio (Filgrastim-sndz) | March 2015 | Zarxio information Press Release: FDA approves first biosimilar |
| Glargine | April 2019 | Basaglar Insulin |

REFERENCES:

1. FDA Guidance on Biosimilar Interchangeability; Conti & Hawana May 2019
2. Biosimilars in Hospital Settings; Picard & Nabham 5/2019
3. Biosimilars in the Hospital Market; Pane April 2019

CROSS REFERENCE P&P:

1. P&P Drug Orders
2. P&P Administration of Drugs and Biologicals
3. P&P Pharmacist Clinical Intervention

| Approval | Date |
|-------------------------------------|----------|
| CCOC | 10/21/19 |
| Pharmacy and Therapeutics Committee | 10/17/19 |
| Medical Executive Committee | 11/5/19 |
| Board of Directors | |
| Last Board of Director Review | |

**NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE**

| | |
|---|------------------|
| Title: USE OF BIOSIMILAR PRODUCTS AT NIHD | |
| Scope: District Wide | Manual: Pharmacy |
| Source: Director of Pharmacy | Effective Date: |

Developed: 7/19fl

Reviewed:

Revised:

Supersedes:

Draft

- CALL TO ORDER** The meeting was called to order at 5:30 pm by Mary Mae Kilpatrick, President.
- PRESENT** Mary Mae Kilpatrick, President
Jean Turner, Vice President
Robert Sharp, Secretary
M.C. Hubbard, Treasurer
Jody Veenker, Member at Large
Will Timbers MD, Chief of Staff
Kevin S. Flanigan MD, MBA, Chief Executive Officer
Kelli Davis, MBA, Chief Operating Officer
John Tremble, Chief Financial Officer
Tracy Aspel RN, BSN, Chief Nursing Officer
- OPPORTUNITY FOR PUBLIC COMMENT** Ms. Kilpatrick stated at this time persons in the audience may speak on any items not on the agenda for this meeting on any matter within the jurisdiction of the District Board. Speakers will be limited to a maximum of three minutes each, and members of the audience will have an opportunity to address the Board on every item on the agenda. Stacey Brown, MD acknowledged Northern Inyo Healthcare District's (NIHD's) recent designation as the Association of California Healthcare Districts (ACHD's) District of the Year for 2019. Doctor Brown stated one reason the District received the prestigious award was implementation of a Medication Assisted Treatment (MAT) program to address substance abuse disorders in this community. He noted, however, that the award is not given for just one program and that it is the result of hard work on the part of the entire NIHD team in many different areas.
- INYO COUNTY FIRST 5 STRATEGIC PLAN** Chief Executive Officer (CEO) Kevin S. Flanigan MD, MBA stated that presentation of the Inyo County First 5 Strategic Plan will be tabled to the month of November, due to the fact that the presenter was unable to attend this meeting.
- PATIENT EXPERIENCE COMMITTEE REPORT** The NIHD Patient Experience Committee provided an update on the activities of the patient experience-related goals of the District's Strategic Plan. The Committee's presentation included the following:
- The group's current areas of focus are Customer Service and Access to Patient Care
 - Improving patient wait times and informing patients about service delays are two of the group's main initiatives
 - The Committee is conducting staff observations and rounding to different service areas to provide feedback on employee delivery of AIDET (customer service skills)
 - Press Ganey patient experience scores are reviewed on an ongoing basis, and in-house customer satisfaction surveys are being conducted as well

- Overall, we have seen improvement in patient wait times District-wide and at the NIHD Rural Health Clinic
- Door-to-Doc times in the Emergency Department are currently being assessed
- Improvement in speed of patient discharge is also an area of focus for the group

QUALITY AND
PERFORMANCE
IMPROVEMENT
COMMITTEE REPORT

The NIHD Quality and Performance Improvement Committee also provided an update on the activities and accomplishments of the quality and performance improvement-related goals of the District's Strategic Plan. The Committee's presentation included the following:

- A report on the District's employee influenza vaccination rates (as of October 11 2019, 76% of District Staff, Medical Staff, and volunteers have been vaccinated)
- Update on efforts to reduce incidents of severe sepsis, including community education and efforts to raise awareness of the early warning signs of sepsis
- Report on safety measures implemented at NIHD to help create a culture of safety, including daily safety huddles, development of a Safety Coach program, etc.
- It was noted that the District has distributed educational materials relating to sepsis in both English and Spanish, and that a Healthy Lifestyles Talk on the topic of sepsis has been scheduled for November 14 2019

NEW BUSINESS

DISTRICT BOARD
RESOLUTION 19-07
AND MEMORANDUM
OF UNDERSTANDING
BETWEEN NIHD AND
AFSCME

Doctor Flanigan called attention to District Board Resolution 19-07 and a proposed Memorandum of Understanding (MOU) between NIHD and the American Federation of State, County, and Municipal Employees (AFSCME) Council 57. He noted that the proposed MOU represents months of negotiations between the two groups, and that negotiations were difficult but concluded in a cordial manner. He additionally noted that if approved, the proposed MOU will be effective for a period of three years, and that Board approval must be followed by approval by the AFSCME general membership. It was moved by Jean Turner, seconded by Jody Veenker, and unanimously passed to approve both District Board Resolution 19-07 and the Memorandum of Understanding between NIHD and AFSCME as presented.

DISTRICT BOARD
BYLAWS UPDATE

Doctor Flanigan also called attention to amended Northern Inyo Healthcare District Bylaws, which have been reviewed and updated with only minor changes being made. He noted the wording has been changed to refer to the Board Chair rather than the Board President, and that language more appropriately covered by policy has been deleted. He additionally noted that updates may be made to the Bylaws in the future to better align them with NIHD Medical Staff bylaws. It was moved by M.C. Hubbard, seconded by Robert Sharp, and unanimously passed to

approve the proposed (updated) NIHD bylaws as presented, with one additional housekeeping change being made.

GENERAL COUNSEL
REQUEST FOR
PROPOSALS

Director Sharp called attention to a proposed Request for Proposals (RFP) for NIHD General Counsel Legal Services, noting the intent of the RFP is not to exclude any of the District's existing attorneys, but to receive general interest in the provision of legal services and establish a price point for that service. Review and discussion of the proposed RFP followed, during which housekeeping changes were made and a reduction was made to the probationary period referenced to 12 months. Dr. Flanigan recommended further review of the language contained in the document, and it was determined that the RFP will be reviewed by Doctor Flanigan, Director Sharp, and Compliance Officer Patty Dickson, then it will be re-submitted for final approval at the November meeting of the District Board. It was then moved by Ms. Turner, seconded by Ms. Hubbard, and unanimously passed to table approval of the RFP for NIHD General Counsel Legal Services to the November regular Board meeting.

RESOLUTION 19-08,
REIMBURSEMENT
RESOLUTION

NIHD Chief Financial Officer (CFO) John Tremble called attention to proposed District Board Resolution 19-08 regarding reimbursement expenditures relating to the acquisition of land and construction of a health facility, to include the NIHD Rural Health Clinic. Mr. Tremble explained it is best practice for an organization beginning construction of a new building to have an established reimbursement resolution in place, and that Resolution 19-08 is being presented in concept now and will be refined later to meet the specifics of the District construction project. It was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve the concept of a reimbursement resolution at this time but to table approval of District Board Resolution 19-08 until such time as it has been modified to meet the specifics of the upcoming NIHD construction project.

SURPRISE BILLING
LEGISLATION

Mr. Tremble also called attention to information on the topic of surprise billing legislation and Senate Bill 1895, requesting Board support of a request to exclude Critical Access Hospitals (CAH's) from the *No Surprises Act* contained in HR 2328, in order to prevent increased financial strain on CAH's in general and on Northern Inyo Healthcare District in particular. It was moved by Mr. Sharp, seconded by Ms. Hubbard and unanimously passed to approve NIHD requesting the exclusion of CAH's from surprise billing legislation as it is currently written.

ESEP QUARTERLY
REPORT

Sierra Bourne MD provided an Eastern Sierra Emergency Physicians (ESEP) quarterly report, which included the following information:

- Many exciting things are going on in the District's Emergency Physician group, including implementation of new educational opportunities for the physician members
- The ESEP group is now completely made up of permanent

physician members

- Dr. James Fair who is fellowship trained in ultrasound has joined the ESEP group
- ESEP has overhauled its peer review format to enhance education and improve patient care
- ED Committee meetings will now include hands-on educational sessions beginning in the month of November
- A healthy lifestyles program known as *Walk With A Doc* will begin in the next couple of months

MEDICAL STAFF
SERVICES PILLARS OF
EXCELLENCE
QUARTERLY REPORT

Medical Staff Services Coordinator Dianne Picken presented the Medical Services Pillars of Excellence quarterly report for the first quarter of fiscal year 2019/2020. She called attention to an increase in the average time for completion of Medical Staff applications submitted, noting that the increase is due to a significant increase in the number of applications received.

CHIEF OF STAFF
REPORT

Chief of Staff William Timbers, MD reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following District Wide Policies and Procedures:

POLICY AND
PROCEDURE
APPROVALS

1. *Medical Screening Examination of the Obstetrical Patient*
2. *Care and Donning of a Powered Air Purifying Respirator*
3. *Access to Medications in the Absence of a Pharmacist*
4. *Pharmacist Clinical Interventions*
5. *Drug Orders*

It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve Policies and Procedures 1 through 5 as presented.

DISTRICT WIDE
QUALITY ASSURANCE
AND PERFORMANCE
IMPROVEMENT PLAN

Doctor Timbers also called attention to a proposed District-Wide Quality Assurance and Performance Improvement (QAPI) Plan for the fiscal year ending in 2020, which is a collaborative program between District staff and the NIHD Medical Staff. It was moved by Ms. Veenker, seconded by Ms. Turner, and unanimously passed to approve the District-Wide Quality Assurance and Performance Improvement Plan as presented.

CHIEF MEDICAL
OFFICER UPDATE

Doctor Timbers additionally reported the Medical Staff as a whole has come to a consensus on what the Chief Medical Officer (CMO) position should look like, noting that the biggest sticking point was previously the reporting structure for the new position. Following discussion on this topic it was determined that the approval of the CMO position will be tabled until a decision has been made on desired qualifications for the position, and until such time as a final job description and salary range has been determined. It was moved by Mr. Sharp, seconded by Ms. Veenker and unanimously passed to approve the concept of the CMO position, with final approval being requested once the qualifications, job description, and salary structure for the position has been determined.

PHYSICIAN
RECRUITMENT
UPDATE

Doctor Timbers additionally reported that physician recruitment is underway for the specialties of urology and surgical oncology. He also noted that a potential hospitalist will visit NIHD in November, and that an additional physician has been added to the ESEP physician group.

CONSENT AGENDA

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

- *Approval of minutes of the September 18 2019 regular meeting*
- *Approval of minutes of the September 25 2019 special meeting*
- *Approval of minutes of the October 8 2019 special meeting*
- *Financial and statistical reports as of August 2019*
- *Policy and Procedure annual approvals*

It was moved by Ms. Hubbard, seconded by Mr. Sharp, and unanimously passed to approve all five Consent Agenda items as presented.

BOARD MEMBER
REPORTS

Ms. Kilpatrick asked if any members of the Board of Directors wished to comment on any items of interest. Director Sharp expressed kudos regarding the Bishop Chamber of Commerce mixer recently held at the Joseph House. Director Kilpatrick reported she will attend the upcoming Bishop Union High School Board of Directors meeting in support of the Healthcare District's interests. She additionally noted that Ms. Ruby Allen has been chosen to be Pat West's successor at Pioneer Home Health. Director Turner reported the ACHD annual meeting was a worthwhile experience, and that it was with great pride that the District Board and Chief Executive Officer accepted the *Healthcare District of the Year* award for 2019. Director Hubbard then read a letter of her resignation from the NIHD Board of Directors effective December 31, 2019. Ms. Hubbard expressed her desire to continue to support NIHD in spite of the fact that she will retire as a Board member, following approximately 13 years of service. The Board expressed their heartfelt appreciation of Ms. Hubbard's years of dedication and service to the members of the Healthcare District.

Doctor Flanigan also reported on the academic achievements of members of the NIHD staff:

- *Physical Therapist Laura Molnar, cancer exercise therapist certification*
- *District Education Coordinator Marjorie Routt, Bachelor of Arts degree*
- *Marnie Davis, Certified Coding Specialist*
- *Speech Language Pathologists Chelsea MacDonald and Charissa Kile, certification in swallow assessment*

ADJOURNMENT TO
CLOSED SESSION

At 7:18 pm Ms. Kilpatrick announced the meeting would adjourn to Closed Session to allow the Board to:

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

- B. Conference with Labor Negotiators; Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
- C. Confer with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d)(2)*).
- D. Conduct Public employee performance evaluation, Chief Executive Officer (*pursuant to Government Code Section 54957*).

RETURN TO OPEN
SESSION AND REPORT
OF ACTION TAKEN

At 9:07 pm the meeting returned to Open Session. Ms. Kilpatrick reported the Board took no reportable action.

ADJOURNMENT

The meeting was adjourned at 9:08 pm.

Mary Mae Kilpatrick, President

Attest:

Robert Sharp, Secretary

November 2019 Board of Directors

Chief Nursing Officer Report

Fall Prevention Project Team: Meeting occurred in September to review data on falls at the District; includes patient, visitors and staff fall at any location on campus. It was determined that further work on the “unusual occurrence report” format would help to obtain better information for the future risk assessment. Work is in process to meet this expectation. Best practices remain in place for inpatient fall prevention.

Board of RN Hearing: Robin Christensen and Tracy Aspel provided testimony in BORN hearing to determine status of RN license for past NIHD team member. Testimony experience relative to professional nursing practice created opportunity for education of nursing leaders, as well as front line RN staff, which highlighted accurate charting and working within RN scope of practice.

Influenza Vaccinations: NIHD Staff flu vaccines data as of 10/31/19 show a 92% vaccination rate of staff, contracts and volunteers. As of 11/1/19, non-vaccinated staff are required to wear a mask while inside of any District building. It is anticipated NIHD will end the flu season with a 98% rate. For early in the season, this is excellent. Last year, national healthcare flu vaccination rate was 78.4% overall. Employee Health has collaborated with pharmacy and the clinics to protect the staff and patients via providing flu vaccine.

Language Services:

- Interpreter Intelligence software project is moving forward. We will have qualified medical interpreters scheduled in advance to provide live interpreting services for patient visits at the District. Our goal is to use our internal Dual and Single role interpreters to provide services for our Spanish Limited English Proficiency (LEP) patients more often.
- Mexican Consulate was in Bishop October 28 to 31st. During their visit to assist Mexican citizens living in the eastern sierra, NIHD collaborated with the Consulate by providing health education. Jose Garcia and Denice Hynd, RD, presented information on nutrition and diabetes in Spanish. The event happened at the Eastern Sierra Campus of Cerro Coso College.
- The first National Healthcare Interpreter Certification Summit took place in Minneapolis, MN. On October 12th. Jose Garcia was a panelist (presenter) for this sold out conference, which was also streamed live across the nation. His expertise was utilized to help other healthcare organizations provide improved communication services to LEP patients and family/caregivers.

Social Services: Helen French, LCSW, resigned from NIHD. Heather Edwell, LCSW, will begin orientation on Nov 18th to fill this position. She comes to us from Mono County Health and Human Services, where she has experience in working with Adult Protective Services, Child Protective Services and Behavioral health. She is excited to be a part of the NIHD Team.

Infection Control Meeting: Daily rounding in construction zone to assure infection control practices are being followed. Rounding in other clinical departments is providing opportunities for improvements. Staff have been receptive to learning the why behind the requirements.

Medication Administration Safety:

- Medication Administration Improvement Committee continues to meet monthly to work on standard work for safe practice. Additionally a team has been meeting to determine processes to use consistent practice to work around the gaps in the Athena Health program for the inpatient side of the District.
- Special team revised the Heparin Administration policy, documentation and provider order sets. Nursing, Pharmacy and Physician staff are being educated to the improved process.
- Special team will begin work on Insulin administration process in the next few weeks.
- SMART IV Pump Purchase Project: Project team including key stakeholders has worked to choose new IV pumps to replace end of life equipment with state of the art pumps designed to improve safety for patients. Project Lead is Alison Feinberg, RN and Project Manager is Lynda Vance. This team is comprised of Material Management, Finance, Clinical Engineering, Pharmacy, Nursing and Project Management. Anticipated 'go live' date is April 1, 2020.

Perioperative Services:

- Julie Allen, BSN, has accepted the Surgery/Sterile Processing/Anesthesia Nurse Manager job role. She will report directly to Ann Wagoner, DON Perioperative Services.
- Hannah Brown has accepted the Infusion/Outpatient Clerk position.

CEO Report to the Northern Inyo Healthcare District Board of Directors

November 2019

The last several months have seen a number of changes that raise concern about trends but none that have yet proven to be conclusive in regards to overall direction and general health of the District.

HR- NIHD continues to work with MRG, our consultant on completing a formal review of NIHD HR department, policies, standards, knowledge base, current state and current goals/expectations. Complicating factors to a published report this month has been ongoing data collection and the announced retirement effective December 31, 2019 of Laurie Longnecker. Laurie is currently the only staff member with full knowledge of the NIHD benefits and benefits management process. HR is undergoing a 'knowledge transfer' process and expects a near complete transfer by her announced retirement date. NIHD CEO and COO have completed a review of options going forward for a staffing model and how best to realign staff for the transition of moving HR from the CEO report line to the COO report line.

Physician retirements/resignations- November has been an unexpectedly busy month. Dr. Souders has submitted his resignation with a 90-day notice earlier this month. Additionally, Dr. Allison Robinson has submitted her 90-day notice of resignation.

At the request of Dr. Souders, a meeting was held in my office with him, Dr. Harness, Larry Weber and me. During that meeting, Dr. Souders itemized concerns he had with the support he was receiving and frustrations he has with the functionality of some of the software current in use. I had thought we had a clear and agreed to plan of action going forward. However, less than a week later he submitted to me and the Board a 90-day notice. I have since met with him one more time to review his reasoning and to gain a full understanding of his definition of the current Breast Imaging program and what next level services need to be added. We also discussed the reasoning for his retirement. He noted that he originally agreed to come to NIHD for several weeks; that was 11 years ago. He now finds the five-hour drive up and back to his residence twice a month increasingly difficult and no longer finds joy in the work here. Going forward I have scheduled a meeting with Dr. Harness to review his suggestions for moving the Breast Imaging program to the next level and await Dr. Souders agreed to submission of a written document. Tahoe Carson Radiology has right of first refusal for the next mammography reading service but we have not yet submitted to them the expectations of what that program will look like so talks have not progressed at this point.

In regards to Dr. Allison Robinson, she met with me and was gracious in her discussion. It has always been her and her family's intent to live in Washington State since she and her husband lived there early in her Navy career. An opportunity in the town they wish to return to arose in which she will be part of

a formal Colo-Rectal Surgery program. She thus accepted noting she will have the ideal job in the town she and her husband have always wanted to live.

The Chief of Staff is fully aware of these departures and is working on recruitment for a surgeon. Concurrently, Larry Weber will work with TCR on their contract modification if they are agreeable to our program design.

In the meantime, we are working with Dr. Bowersox on establishing a long-term rotation for him. We will also be working with locums companies on a traveling surgeon to help with office and call responsibilities.

IT Services- NIHD is in discussions with Toiyabe and SIHD about shared staffing for Cybersecurity and Systems Administration support. If this model can be developed, it is viewed as an opportunity to begin to establish permanent partnership lines that will not be dependent upon who fills what leadership role. Additionally, it opens the potential for a unified EHR for the county as a whole. We are also making strides with internal collaboration amongst the various part of the organization regarding who does what from an IT and data standpoint. Bringing the various internal players into the same office space will allow for greater collaboration and efficiencies.

In regards to the EHR NIHD has begun the first steps for evaluation companies that might be considered for replacing Athena. The first phase is intended to assess the type of company, the business model, any risks that can be anticipated from the business model and if the service product is structured in a way that meets NIHD expectations.

Organizational Structure going into the 3rd Quarter- With the anticipated delivery of a final report from MRG NIHD expects to complete a reorganizational structure of HR. Additionally, NIHD has planned reorganization of other departments, which have been developed, with an implementation plan of January 1, 2020. These will include moving District Education to HR, creating a Project Management Department, moving all Environment of Care (except for Bio-Engineering) under the COO, having the CNO assume responsibility for the QAPI plan implementation and having HIM/Charge Capture under the CFO. Some of these moves have to do realignment that is expected to result in improved efficiencies and others have to do with responses to those moves that will allow for even distribution of responsibilities among leaders.

Partnerships- It is reaffirming to realize the number of entities in Eastern Sierra that wish to begin or expand partnerships and collaborative efforts with NIHD. From those mentioned above to community members encouraging the Bishop Unified School District to work with NIHD on a student health, injury management and injury prevention program. Toiyabe and SIHD worked closely with NIHD and Eastern Sierra Cancer Alliance during Breast Cancer Awareness month, which was a resounding success. Both organizations also continue to work with NIHD on new avenues of partnership.

Inyo County HHS similarly maintains close working relationships and ideas sharing efforts for grants and care delivery. Most notably through work with Dr. Helvie and the pediatrics team as well as grant proposal development.

Grants- Work continues under the Bridge Grant with an expected but difficult to plan for growth rate in service demands. Going forward new staff will need to be added in alignment with the Strategic Plan that is being finalized.

New opportunities are continuously brought to our attention and these options are reviewed for applicability and for potential for joint submission with our local partners.

Respectfully submitted

Kevin S. Flanigan, MD MBA

CEO

NIHD Board of Director's Monthly Meeting

Chief Operating Officer Report

November 20, 2019

While all areas continue to focus on day-to-day workflow and workforce needs, Athena & related system navigation, specialized department projects and budget preparation, additional highlights for include:

Staffing Update

The search continues for an Interim Rehabilitative Services Director and HIM Manager. We are receiving candidate resumes and both teams are actively involved in reviewing and determining next steps for interviews.

Kevin Christensen, CardioPulmonary Director, retired on October 25th after 31 years of service to the District.

Longtime District employee, Amy Stange, Respiratory Therapist, has accepted the position of CardioPulmonary Manager. The CardioPulmonary Department will now report under Diagnostic Services with Larry Weber, Director, providing oversight.

Points of Interest:

Community Workplace Safety Taskforce Meeting – Met on October 10. Next meeting is December 12 – Partnering between NIHD, Toiyabe Indian Health and Tribal Resources, Wild Iris, Inyo County Office of Education, Inyo County HHS, City of Bishop Chief of Police, Bishop Care Center, Dwayne's, Chamber of Commerce, Sterling Heights and Bishop School District. The October meeting focus was on events each representing organization is facing, the finalization of the community awareness campaign, including education/training, introductory packets for new taskforce members, alignment of training efforts being done within each member's organization, visual review and approval of the graphic design development and selection of the "Safe Town" logo for signage to provide consistent messaging when the sign is present:

1. Participates in the Community Workplace Safety Taskforce; community safety collaboration of Eastern Sierra partners;
2. The safety & wellbeing of anyone who enters the business (staff, patients, students, visitors etc) is a top priority

Breast Cancer Awareness/Diagnostic Imaging Services – Another very successful year has been reported for the mammography services provided by our NIHD Diagnostic team and others. With the addition of Sunrise Mammograms, direct access between NIHD and community organizations, shuttle services and more, October was certainly a very busy month. Numbers and comparisons will soon be available.

NIHD Board of Director's Monthly Meeting

Chief Operating Officer Report

November 20, 2019

Best of Inyo – The NIHD Rehabilitative Services received the honor and recognition for Best of Inyo – PT Services. The team felt great pride in receiving this award and enthusiastically submitted a letter of appreciation to the community for the impact and role they hold in this award. Barb Laughon was instrumental in guiding all aspects of the media for the team.

Safety –

The Safety Huddle meets Monday through Friday (except on holidays) at 8:00am. This group of leaders and designees report on departmental volumes for the day, organizational safety concerns that have occurred within the last 24 hours, are currently happening and/or are anticipated to occur within the next 24 hours and local/state/national happenings that the District should be aware of. In the months of September and October, there were 89 safety related concerns, ideas or events that were reported and worked through the Safety Huddle. These ranged from violent behavior risks, fall risks, unlocked doors, signage issues, parking & speeding, food recalls, system downtimes, equipment issues and so forth.

Employee Occupational Safety meets as an ad hoc of the Safety Committee with a focus of providing feedback/recommendations to Safety Committee on occupational safety efforts for NIHD workforce.

The most recent meeting inspiration included *“If you put good people in bad systems, you get bad results. You have to water the flowers you want to grow – Stephen Covey*

This group continues to focus on the following agenda items:

- Video Taping of Ergonomics/Safe Patient Handling Training
- Departmental Ergonomic Assessments
- Cal-OSHA Hazard Assessments
- Musculoskeletal Injury Prevention Plan

Individual departments are being surveyed for safety and risk prevention.

Violence Prevention Assessment Team (VPAT) meets on a monthly basis to review and discuss workplace violence (WPV) events that have occurred, (the cause, participants, resolution and risk prevention), District training, regulatory updates and policy. September saw 7 reported WPV events and October had 1 reported. Recent meetings have included the annual review of the NIHD Workplace Violence Prevention Plan, with the annual Board of Director review anticipated for December.

Two ad hoc VPAT meetings were called in September and October to review risk mitigation involving 2 separate individuals.

NIHD Board of Director's Monthly Meeting

Chief Operating Officer Report

November 20, 2019

Monthly Operations' Team Meetings – September and October Focus Areas

| | | |
|---|---|---|
| Name of Group: NIHD Operations Team | Date of Meeting: September 17, 2019 | Time of Meeting: 2:00 – 3:00pm Location: AMR |
| Title of Meeting: Monthly Operations Team Meeting | | |
| Meeting Called By: Kelli Davis, Chief Operating Officer | | Location: AMR |
| Participants: | | |
| Cheryl Brooks Cori Stearns Denice Hynd Frank Laiacona Jalaine Beems | Kevin Christensen Larry Weber Lindsey Hughes Raychel Hosch Rich Miers | Guest(s): Mary Mae Kilpatrick |
| Meeting Objectives(s): Communication, Collaboration & Education Amongst Operations' Team Members | | |

| Pillar | Agenda/Minutes | |
|----------------|---|--|
| 1. People | <p><i>“When mutual understanding and respect are present, the spirit of synergy inevitably starts to develop”. Stephen R. Covey</i></p> <ul style="list-style-type: none"> • Welcome • Coaching for Change | Kelli Davis Group Discussion |
| 2. Quality | <ul style="list-style-type: none"> • Developing a Work-Life Balance Culture • 5 Intangible Benefits Of Hospital Strategic Planning | Group Discussion Information Item |
| 3. Growth | <ul style="list-style-type: none"> • Leadership – “Synergy” – Habit #6: When people begin to interact together genuinely, and they are open to each other's influence, they begin to gain new insight. The capability of inventing new approaches is increased exponentially because of differences. • Video: Landfill Harmonic | Group Discussion Group Discussion |
| 4. Finance | <ul style="list-style-type: none"> • The Future of Rural Hospitals • The Top Five Financial Pressures Facing Healthcare Organizations | Group Discussion Group Discussion |
| 5. Round Table | <ul style="list-style-type: none"> • Upcoming Department Events/Changes <ul style="list-style-type: none"> - Success Stories - Projects - Challenge Areas/Need for Support - Staffing – Incoming/Departing | Group Discussion “Improving our communities, one life at a time: One Team. One Goal. Your Health.” |
| | | |

NIHD Board of Director’s Monthly Meeting

Chief Operating Officer Report

November 20, 2019

| | | |
|---|---|---|
| Name of Group: NIHD Operations Team | Date of Meeting: October 15, 2019 | Time of Meeting: 2:00 – 3:00pm Location: AMR |
| Title of Meeting: Monthly Operations Team Meeting | | |
| Meeting Called By: Kelli Davis, Chief Operating Officer | | Location: AMR |
| Participants: | | |
| Cheryl Brooks Cori Stearns Denice Hynd Frank Laiacona Jalaine Beems | Kevin Christensen Larry Weber Lindsey Hughes Rich Miears Sarah Yerkes | Guest(s): Mary Mae Kilpatrick |
| Meeting Objectives(s): Communication, Collaboration & Education Amongst Operations’ Team Members | | |

| Pillar | Agenda/Minutes | |
|-----------------|--|--|
| 6. People | <p><i>“Renewal is the principle – and the process – that empowers us to move on an upward spiral of growth and change, of continuous improvement”. Stephen R. Covey</i></p> <ul style="list-style-type: none"> • Welcome • Benefits/Enrollment | Kelli Davis Laurie Longnecker |
| 7. Quality | <ul style="list-style-type: none"> • EHR Implementation | Group Discussion |
| 8. Growth | <ul style="list-style-type: none"> • Leadership – “Sharpen the Saw” – Habit #7 • Video: Daily Private Victory • 21 Irrefutable Laws of Leadership | Group Discussion Group Discussion |
| 9. Finance | <ul style="list-style-type: none"> • Why Rural Hospitals Should Start Operating More Like a Medical Clinic to Survive • Charge Capture Update | Group Discussion Wendy Runley |
| 10. Round Table | <ul style="list-style-type: none"> • Upcoming Department Events/Changes <ul style="list-style-type: none"> - Success Stories - Projects - Challenge Areas/Need for Support - Staffing – Incoming/Departing | Group Discussion “Improving our communities, one life at a time: One Team. One Goal. Your Health.” |

Compliance Report November 2019

1. Comprehensive Compliance Program review
 - a. As November 8, 2019, 94.3% District's employee (including temporary, traveler, and contract workers) workforce have reviewed the Compliance Program. Twenty of the 35 remaining who are due to read the program are within 90 days of their first day of employment. This number fluctuates due to employee turnover.
 - b. 92% of District workforce, including providers, have completed HIPAA training for CY 2019.
2. Breaches
 - a. Calendar Year (CY) 2019 (Charts and graphs will return in future reports)
 - i. 82 alleged breaches of PHI (Protected Health Information) potentially affecting more than 500 patients have been investigated by the Compliance Office
 - ii. 4 of the alleged breaches of PHI have been reported to California Department of Public Health (CDPH) and/or the Office of Civil Rights (OCR)
 1. CDPH has completed investigation of two cases. Both were substantiated, but assigned no deficiency.
 2. One (1) cases is still pending CDPH investigation.
 3. Several cases from prior years are still pending letters of findings, indicating that at least several may incur some level of deficiency and penalty.
 - a. We received a deficiency for a 2018 breach. Currently working on a corrective action plan. May incur civil monetary penalty.
 - iii. Nine of the reported potential breaches/privacy concerns are currently under investigation by the NIHD Compliance Department.
3. Issues and Inquiries
 - a. CY 2019 – Several hundred requests for research and input on a wide variety of topics have been made to the Compliance Department.
 - i. Compliance and regulation research tops the list.
 - ii. Policy advice and research

- iii. Potential compliance concerns that do not reach the level of a full investigation. (Usually require training and education)
 - b. Compliance currently reviews all new referring physicians to verify they are not on a Federal or State exclusions list. To date in 2019, Compliance has verified several hundred providers. It is considered fraud to bill any government payer for diagnostic or treatment claims, if ordered by an excluded provider.
 - i. Compliance has identified two referring providers on an exclusions list. We have notified Administration, and have properly addressed the issues.
- 4. Audits
 - a. Employee Access Audits (Charts and graphs will return in future reports) - The Compliance Office manually completes audits for access of patient information systems to ensure that employees 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 has updated the methodology to ensure audits are done within days of patient visits rather than the beginning of the following month, as previously performed. This allows for thorough auditing within days of any event.
 - iv. Compliance performs between 300-500 audits monthly.
 - 1. Each audit ranges from hundreds of lines of data to thousands of lines of data.

2. September Employee Access Audits

Sept 2019

Emergency: 693

Audit - 39

IP: 283 (This includes perinatal, transfers from Emergency to IP, and ICU)

Audit - 22

Outpatient: 2966 (This includes lab visits, DI, OP nursing, etc.)

Audit - 381

High risk charts:

EAP (Employee as Patient) audits: 123

HPP (High Profile Patient or Diagnosis) audits: 15

SLN (Same last name as employee) audits: 305

New Employee audits: 6

For Cause audits: 8

Flags (unusual activity on audit, require additional follow up) - 9

Outcome – Appears Compliant - 4

Appears Non-Compliant

Ongoing Investigation - 5

3. October Employee Access Audits

Oct 2019

Emergency: 686

Audit - 25

IP: 307

Audit -

Outpatient: 3437

Audit - 23

High risk charts:

EAP (Employee as Patient) audits: 103

HPP (High Profile Patient or Diagnosis) audits: 23

SLN (Same last name as employee) audits: 180

New Employee audits: 17

For Cause audits: 2

Flags (unusual activity on audit, require additional follow up) - 0

Outcome – Not Applicable

- v. Protenus has been selected to provide semi-automated auditing software services to NIHD, however, Athena has been unable to meet its requirements for the data feeds. Protenus will be reassessed as the changes to NIHD EHR evolve.
 - b. Business Associates Agreements (BAA) 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 approximately 130 Business Associates Agreements.
 - c. PACS (Picture Archival and Communication System) User Access Agreements – Compliance is now processing access agreements for external entities/providers to gain access to the NIHD PACS Portal (electronic Imaging system).
 - d. HIMS scanning audit – small sample audit of patient charts demonstrated 100% compliance with scanned document locations
 - e. Language Access Services Audit – Small sample audit of limited English proficiency (LEP) patient charts for 5-7 areas of documentation each found 0 charts with 100% correct documentation. Compliance and Language Access Services working to develop plans for tools and additional education for workforce.
 - f. HIPAA Security Risk Assessment – Due November 2019 - in progress (requires collaboration between Compliance Officer and Security Officer)
 - i. Annual requirement to assess security and privacy risk areas as defined in 45 CFR 164.3. Review of 157 privacy and security elements performed in conjunction with Information Technology Services.
 - ii. Will work with ITS (Information Technology Services) to develop and update the Risk Management plan.
 - iii. NIHD is currently in a “soft roll out” of the VendorMate (GHX) vendor credentialing software. This allows us to be compliant with our Vendor Credentialing Policy, and several facility security elements of 45 CFR 164. Hard go-live is tentatively scheduled for January 2020.
5. Conflicts of Interest questionnaires
- a. Compliance sent the Conflict of Interest Questionnaires out in the beginning of August 2019.
 - b. We have received 76% of completed questionnaires from NIHD workforce.

- c. Those received have been preliminarily processed and, as appropriate, conflict of interest letters of findings and mitigation plans are sent to leadership.
6. CPRA (California Public Records Act) Requests
 - a. The Compliance office has responded to 19 CPRA request in CY 2019.
 - i. 3 requests throughout the year for companies that harvest purchasing data from healthcare organizations to aid their marketing products.
 - ii. 1 from Transparent California
 - iii. 8 are from District resident, Ms. Freeman.
 - iv. 7 requests have been from the ASCFME organizer or their legal representatives.
 7. Compliance Workplan (attachment A)
 - a. The Department of Health and Human Services Office of Inspector General's (OIG) creates an annual workplan for auditing, based on areas of high concern for fraud, waste, and abuse. The Centers for Medicare/Medicaid Services Medicare Administrative contractors (MACs) also create an annual audit workplan.
 - b. OIG recommends that annual Compliance Department workplans are created, based on the facility Compliance Program, and the OIG and MAC workplans, along with areas of risk for the organization.
 - c. The attached work plan was updated in November 2019 for progress and is scheduled for review in the Compliance and Business Ethics Committee.
 8. Unusual Occurrence Reports (UOR) (Attachment B)
 - a. All unusual events are reported through the UOR system. (complaints, med errors, unusual events, Corrective Action Plan tracking items, etc)
 - b. See attached reports – please note while data has been validated, we are still getting the reports “dialed in”
 - i. Some labeling needs to be corrected
 - ii. Some layout features need to be corrected
 - c. ComplyTrack- tracking software – system went live on 4/15/2019.
 9. CDPH Licensing Survey Response Monitoring
 - a. Compliance has been working with Department leadership teams to follow corrective actions and monitor for sustained compliance. Those metrics will be reported here, no less than annually.
 - i. E 239 - Referral arrangements from non-staff ordering providers. – Monitoring in progress 11/2019

- ii. E 242 - Pediatric Consultations – Monitoring in progress 11/2019
- iii. E 276 - Code Amber drills – Goal achieved. Monitoring complete.
- iv. E 280 - RN Competency Validations – Goal achieved. Monitoring complete.
- v. E 475 - Sterile compounding area ceiling - Goal achieved. Monitoring complete.
Refrigerator temperature monitoring – Goal achieved. Monitoring complete.
- vi. E 479 - Malignant Hyperthermia cart – Goal achieved. Monitoring complete.
- vii. E 480 - Add crash cart medication list to Crash Cart Policy – Goal achieved. Monitoring complete
- viii. E 485 - Titratable sedatives and sedation scale use – Goal achieved. Monitoring complete
- ix. E 503 - Proper storage of clove oil in ED dental box – Clove oil removed from supplies and supply list. Goal achieved. Monitoring complete
- x. E 511 - Beyond-use-date labeling of medications – Goal achieved. Monitoring complete
- xi. E1363 - Expired supply in crash cart - Monitoring in progress 11/2019
- xii. E 2115 - TB Surveillance program – letter of compliance sent to CDPH. No additional monitoring is required.
- xiii. E 2150 - Infection Prevention Program monitoring – Monitoring in progress 10/2019
 - 1. Infusion supplies - Goal achieved. Monitoring complete
 - 2. Cleaning Wet time – ongoing monitoring 11/2019
 - 3. Paper towel installed near sink – Complete
 - 4. Sterilized Instrument Packs - Goal achieved. Monitoring complete
 - 5. Crash Cart Supplies - Goal achieved. Monitoring complete
 - 6. Patient Refrigerators marked- Goal achieved. Monitoring complete
 - 7. Single Use Thickener packets - Goal achieved. Monitoring complete
- xiv. E 2151 - Workforce N95 mask fit testing – Goal achieved. Quarterly monitoring for 2 additional quarters.
- xv. E 2354 - Equipment preventative maintenance stickers – Goal achieved. Monitoring complete

10. The Joint Commission Survey Response

- a. Submitted and accepted



Northern Inyo Healthcare District

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

b. Will provide monitoring in January quarterly report

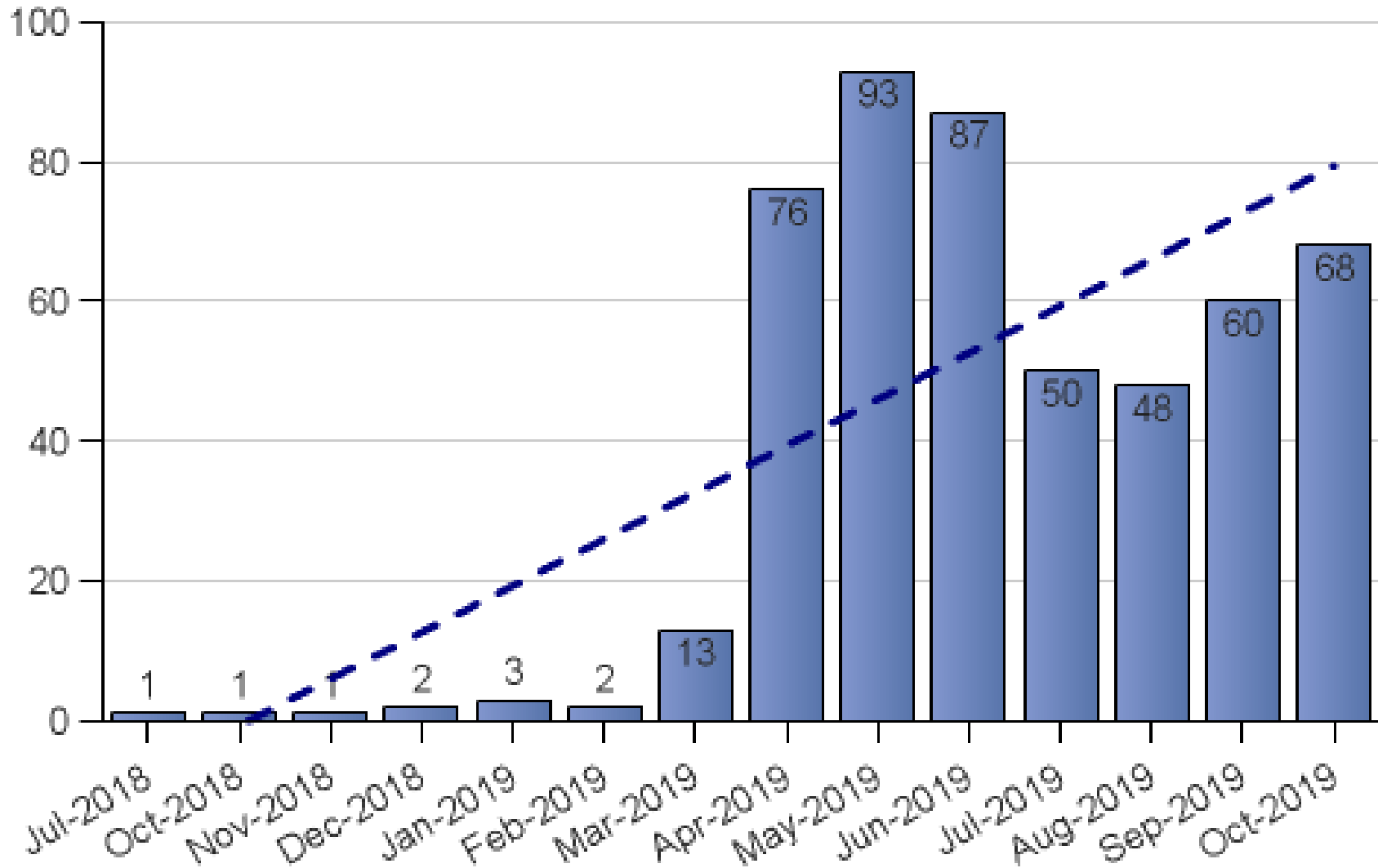
| No. | Item | Reference | Comments |
|--|--|--|---|
| Compliance Oversight and Management | | | |
| 1. | Review and update charters and policies related to the duties and responsibilities of the Compliance Committees. | NIHD Compliance Program (p.17) | Completed Jan 2019 |
| 2. | Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program. | NIHD Compliance Program (p.17) | Colin Coffey, Jan 2019. Also CO briefing and updates in August 2018. “Takeaways” from monthly HCCA magazine |
| 3. | Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities. | | In progress 010/2019 |
| Written Compliance Guidance | | | |
| 4. | Audit of required Compliance related policies. | | Annual review conducted on regular monthly schedule Throughout the year |
| 5. | Annual review of Code of Conduct to ensure that it currently meets the needs of the organization and is consistent with current policies. (Note: Less than 12 pages, 10 grade reading level or below) | | 05/2019 |
| 6. | Verify that the Code of Conduct has been disseminated to all new employees and workforce. | | In progress |
| Compliance Education and Training | | | |
| 7. | Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance Committee. | | January 2019 |
| 8. | Review and assess role-based access for EHR and partner programs. Implement/evaluate standardized process to assign role-based access. | R-BAT created 7/2018. Currently working with Athena to update RBA controls. | Stalled due to lack of granularity of Athena access control security |
| 9. | Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or receiving remuneration to induce referrals and other current legal standards. | Completed at Orientation. Need to send to Med Staff. PPM and Relias for current workforce. | |

| Compliance Communication | | | |
|--|---|--|--|
| 11. | Review investigation log. Prepare summary report for Compliance Committee on types of issues reported and resolution | Update for Complytrack | Quarterly UOR report 2019 |
| 12. | Develop a report that evidences prompt documenting, processing, and resolution of complaints and allegations received by the Compliance Department. | Will create report from Complytrack | In progress – 10/2019 |
| 13. | Document test and review of Compliance Hotline. | | Completed 4/2019 |
| 14. | Physically verify Compliance hotline posters appear prominently on employee boards in work areas. | | Completed 10/2019 |
| Compliance Enforcement and Sanction Screening | | | |
| 15. | Verify that sanction screening of all employees/workforce and others engaged by NIHD against OIG List of Excluded Individuals and Entities has been performed in a timely manner, and is documented by a responsible party. | Ongoing – HR performs employees/travelers/temps monthly. Compliance verifies new providers. MSO verifies all medical staff. Accounting verifies all vendors. | Current through 10/2019 |
| 16. | Develop a review and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented. | | On Hold 10/2019 |
| 17. | Audits | | |
| | a. Telehealth audits | Derm completed Ongoing by Telehealth MA | 10/2019 |
| | b. EMTALA | Up-to Date | 10/2019 |
| | c. Cost reports | Wipfli | In progress - Wipfli |
| | d. Payment patterns | | |
| | e. Bad debt/ credit balances | Will work with J. Tremble. | |
| | f. OPS – Home health and DME | HHS OIG target | Audit in progress – 10/2019 |
| | Lab services | MAC target | On hold |
| | Imaging services (high cost/high usage) | MAC target | On hold |
| | Rehab services | HHS OIG workplan | On-hold |
| | Proper documentation of use of Language Access Services | Small sample audit demonstrated 0 charts with 100% correct documentation. | Working with Language Access Services to implement workforce tools 11/2019 |
| 18. | Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review. | | |
| | a. Annual Security Risk Assessment | Compliance officer and Security officer | Security Risk Assessment in progress Nov 2019 |

| | | | |
|--|--|---|---|
| | b. Periodic update to SRA | | |
| | c. Monthly employee access audits | | Current through 10/2019 |
| 19. | Audit required signage | | Proper signage is posted in all areas |
| 20. | Audit HIMS scanned document accuracy | Small sample audit in September 2019 – 100% accuracy | 09/2019 |
| 21. | Develop metrics to assess the effectiveness and progress of the Compliance Program | | |
| 22. | Implement automated access monitoring/auditing software (Protenus) | | On hold until new EHR implemented 11/2019 |
| 23. | Review CMS CoPs (CAH) | | |
| Response to Detected Problems and Corrective Action | | | |
| 24. | Verify that all identified issues related to potential fraud are promptly investigated and documented | In progress. Documented in Complytrack | 8/2019 |
| 25. | Review all corrective action measures taken related to compliance to verify they have been completed and validated as being effective. Prepare a summary report for the CBEC | CDPH 2018 survey CAP tracking up-to-date TJC 2019 CAP tracking in progress | 10/2019 |
| 26. | Conduct a review that ensures all identified overpayments are promptly reported and repaid. | Working with WJ, MET, HIMS dept to review all audits, recoupments | |
| 27. | UOR tracking and trending – UOR/Unusual occurrence reporting is now a function on the Compliance Department. UOR tracking on-going through Complytrack. | Complytrack – live 04/2019 | UOR quarterly reports distributed to Exec Team, Compliance and Business Ethics Committee, and Board of Directors. 11/2019 |
| | a. Provide trend feedback to leadership to allow for data driven decision-making | | UOR reports to leadership teams as requested 11/2019 |
| | I. Overall UOR process | | 11/2019 |
| | II. Workplace Violence | | 11/2019 |
| | III. Sharps | Working with Infection prevention to split out biohazard exposure incidents from non-biohazard exposure events. | 11/2019 |
| | IV. Overweight laundry | Corrective Action Plan implemented – No further reported incidents | October 2019 |

| | | | |
|-----|--|---|----------------------------------|
| 28. | Pioneer Home Health and Hospice of the Owens Valley Compliance Review, ACE agreement | | 1/2019 |
| 29. | Patient complaints | Tracked/reviewed through Complytrack. Restructure adds these to Compliance Workplan | In progress |
| 30. | Breach Investigations | On-going | On-going – see Compliance report |

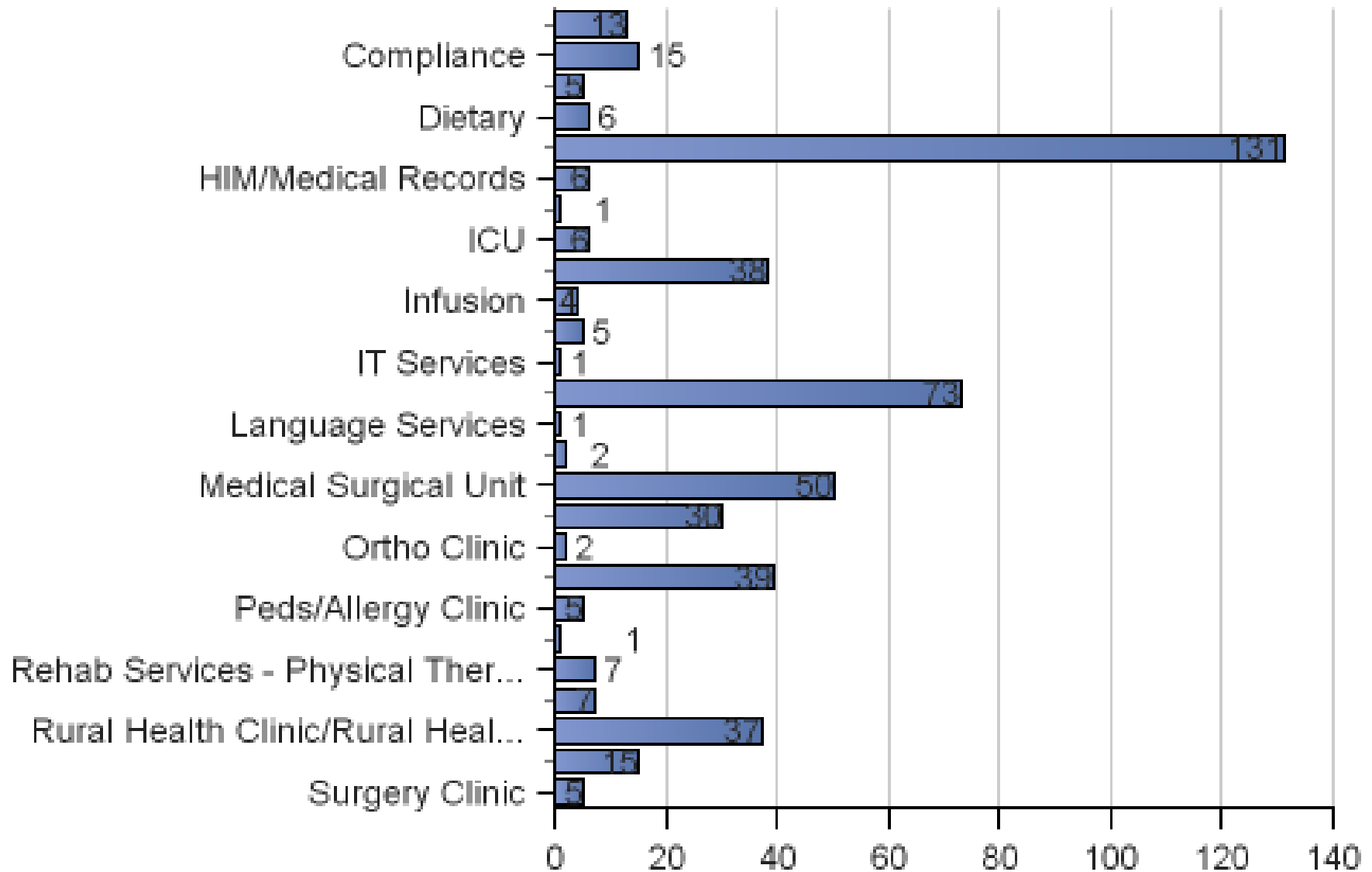
UORs



Sharp drop in reporting beginning in July is due to the ED medical staff changing critical indicators, AMA/elopement is no longer reported. UOR reporting through the ComplyTrack System started on 04/15/2019.

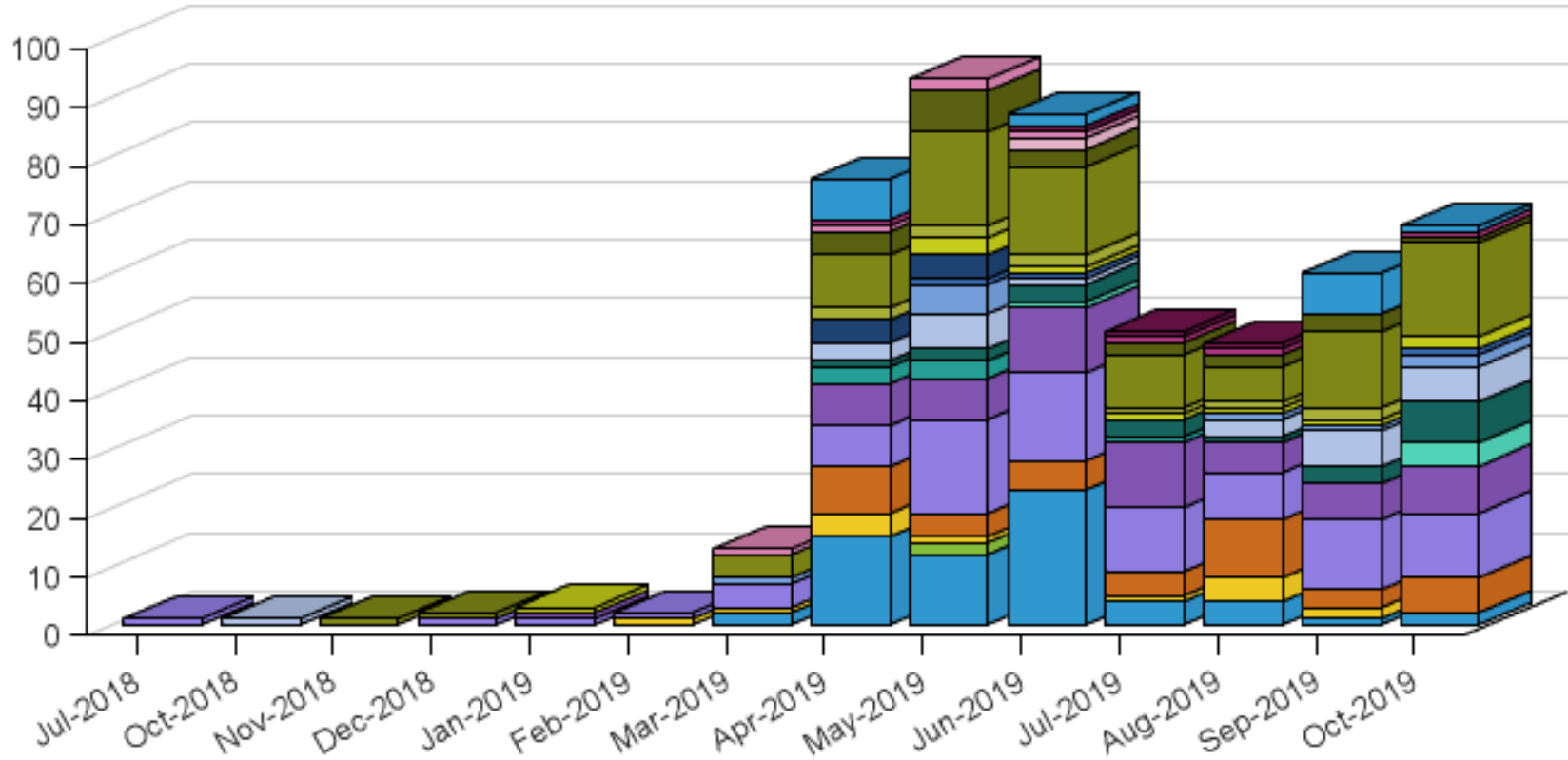
Some incidents show up before this date, as they were reported after 4/15, but the incident occurred prior to that date.

UORs by Location



Compliance is working with report writing experts at Complytrack to ensure all labeling shows up. I currently do not have the ability to get the additional lines of information to print on the chart. The longest line is ED.

UORs by Category

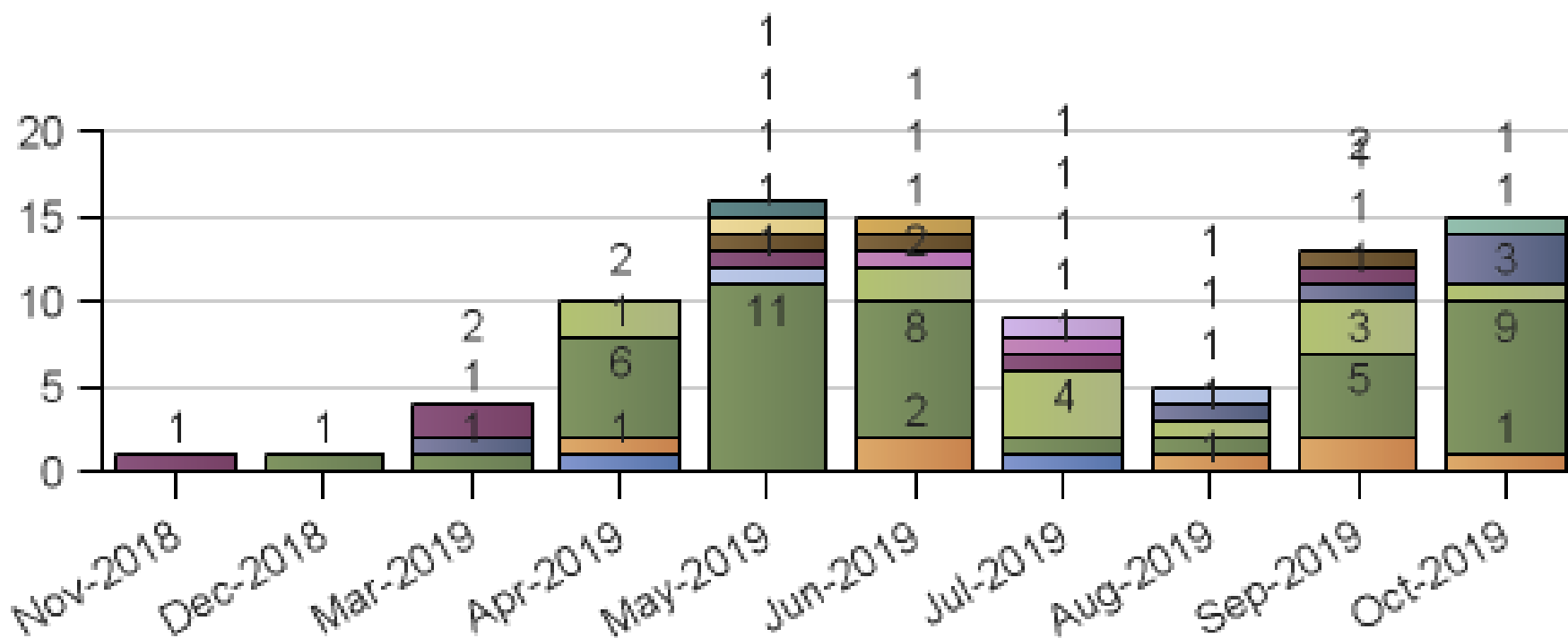


- AMA/Elopement/LWBS
- Communication
- Critical Indicator
- Falls/Slips
- Medication Occurrence/Error
- Procedure/Test/Specimen problem
- Surgery
- Workplace Violence
- Anesthesia
- Complaints/review request
- ED
- IV issues/Blood transfusion issues
- Med Surg
- Mishandled Sharps
- Safety/Security
- Transfer - Internal or External
- Codes - Rapid Response, Blue, ...
- Confidentiality/PHI Breach/HIPA...
- Equipment/Supply/Devices
- OB/Nursery
- Skin integrity concern
- Transportation

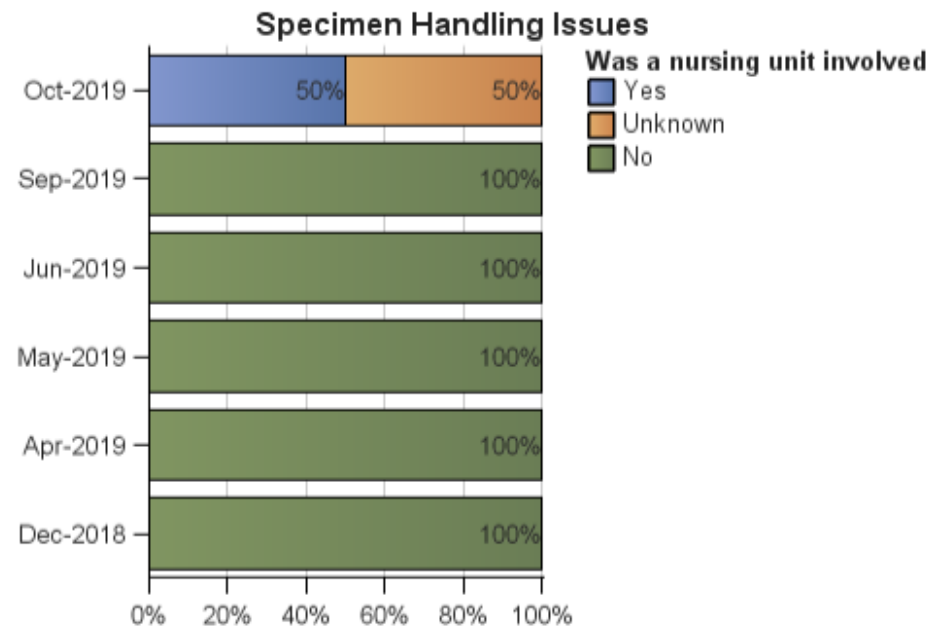
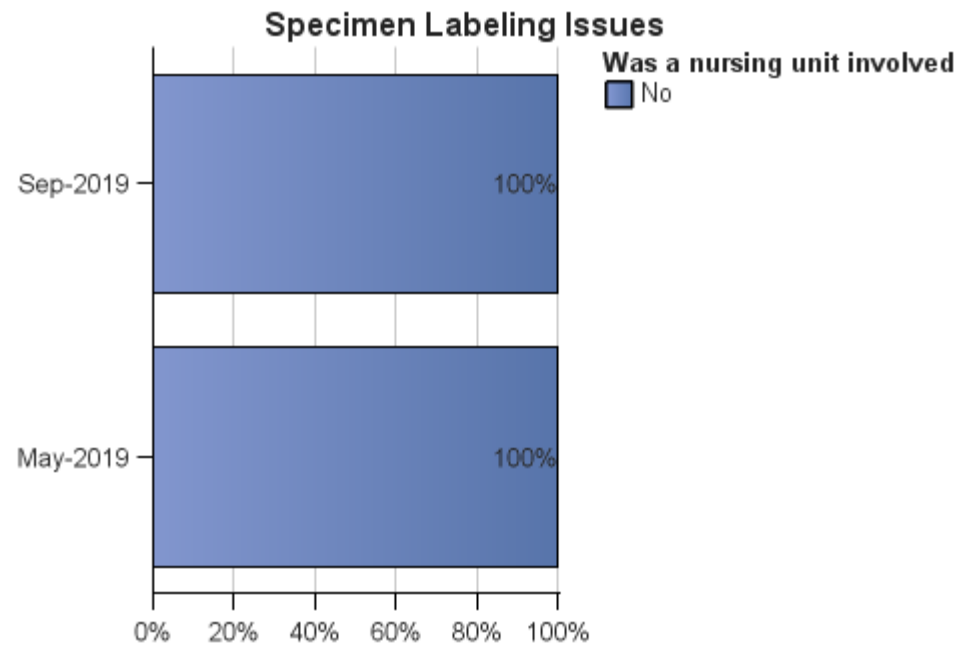
Data for chart on next page

| | Jul-2018 | Oct-2018 | Nov-2018 | Dec-2018 | Jan-2019 | Feb-2019 | Mar-2019 | Apr-2019 | May-2019 | Jun-2019 | Jul-2019 | Aug-2019 | Sep-2019 | Oct-2019 | Total |
|--|----------|----------|----------|----------|----------|----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|------------|
| AMA/Elopement/LWBS | | | | | | | 2 | 15 | 12 | 23 | 4 | 4 | 1 | 2 | 63 |
| Anesthesia | | | | | | | | | 2 | | | | | | 2 |
| Codes - Rapid Response, Blue, Deescalation | | | | | | 1 | 1 | 4 | 1 | | 1 | 4 | 2 | | 14 |
| Communication | | | | | | | | 8 | 4 | 5 | 4 | 10 | 3 | 6 | 40 |
| Complaints/review request | 1 | | | 1 | 1 | 1 | 4 | 7 | 16 | 15 | 11 | 8 | 12 | 11 | 88 |
| Confidentiality/PHI Breach/HIPAA violation | | | | | 1 | | | 7 | 7 | 11 | 11 | 5 | 6 | 8 | 56 |
| Critical Indicator | | | | | | | | | | 1 | | | | 4 | 5 |
| ED | | | | | | | | 3 | 3 | | 1 | | | | 7 |
| Equipment/Supply/Devices | | | | | | | | 1 | 2 | 3 | 3 | 1 | 3 | 7 | 20 |
| Falls/Slips | | 1 | | | | | | 3 | 6 | 1 | | 3 | 6 | 6 | 26 |
| IV issues/Blood transfusion issues | | | | | | | 1 | | 5 | | | 1 | 1 | 2 | 10 |
| Med Surg | | | | | | | | | 1 | 1 | | | | 1 | 3 |
| Medication Occurrence/Error | | | | | | | | 4 | 4 | | | | | | 8 |
| Mishandled Sharps | | | | | 1 | | | | 3 | 1 | 1 | 1 | 1 | 2 | 10 |
| OB/Nursery | | | | | | | | 2 | 2 | 2 | 1 | 1 | 2 | | 10 |
| Procedure/Test/Specimen problem | | | 1 | 1 | | | 4 | 9 | 16 | 15 | 9 | 6 | 13 | 16 | 90 |
| Safety/Security | | | | | | | | 4 | 7 | 3 | 2 | 2 | 3 | 1 | 22 |
| Skin integrity concern | | | | | | | | | | 2 | | | | | 2 |
| Surgery | | | | | | | 1 | 1 | 2 | 1 | | | | | 5 |
| Transfer - Internal or External | | | | | | | | 1 | | | 1 | 1 | | 1 | 4 |
| Transportation | | | | | | | | | | 1 | 1 | 1 | | | 3 |
| Workplace Violence | | | | | | | | 7 | | 2 | | | 7 | 1 | 17 |
| Total | 1 | 1 | 1 | 2 | 3 | 2 | 13 | 76 | 93 | 87 | 50 | 48 | 60 | 68 | 505 |

UORs Related to Lab

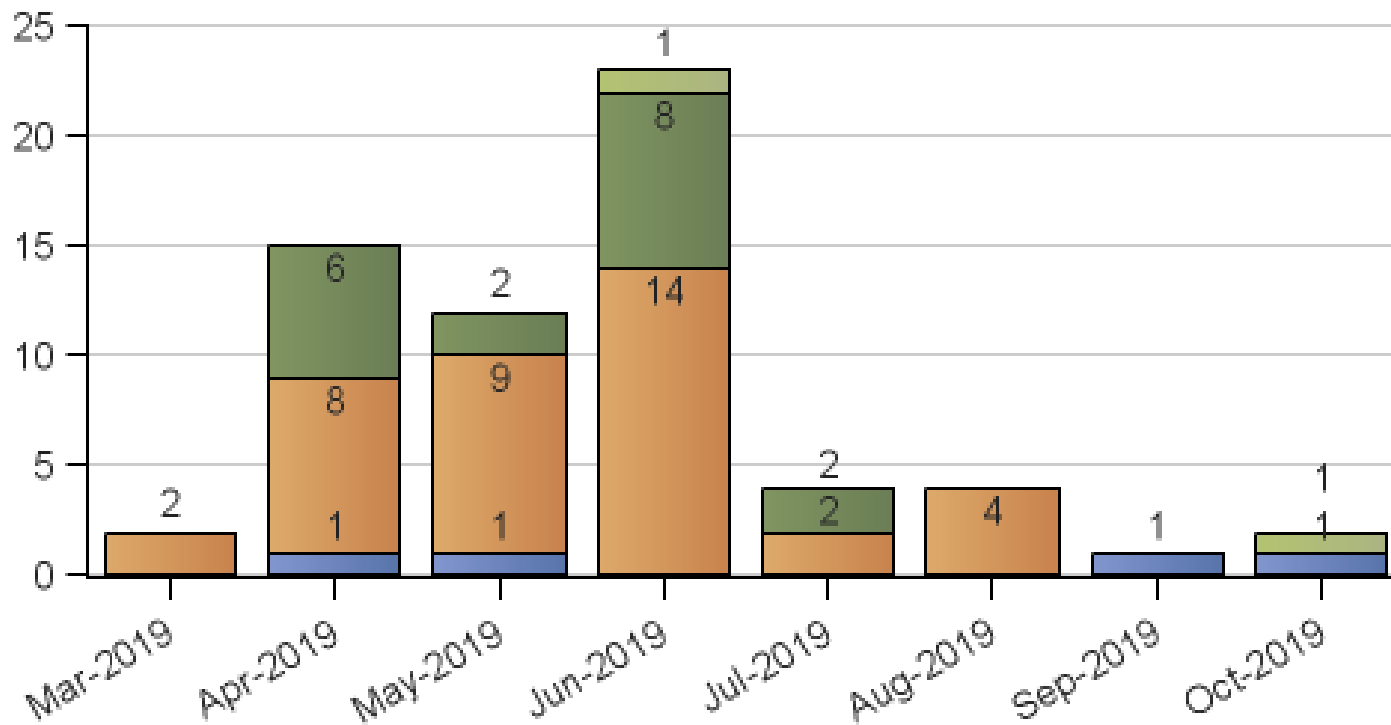


- Error reporting results
- Omitted a test or proc...
- Specimen Problems
- Other
- Delay due to Hospital/...
- Patient was not proper...
- Delay
- Performed wrong proc...
- Performed on wrong p...
- Order Issue
- Reaction to Contrast
- Consent issue
- Incorrect Diagnostic R...
- Unexpected complicati...



This area was a focus for the Professional Practice Council.

AMA / Elopement / LWBS



Emergency updated their critical indicators in July to no longer include Against Medical Advice.

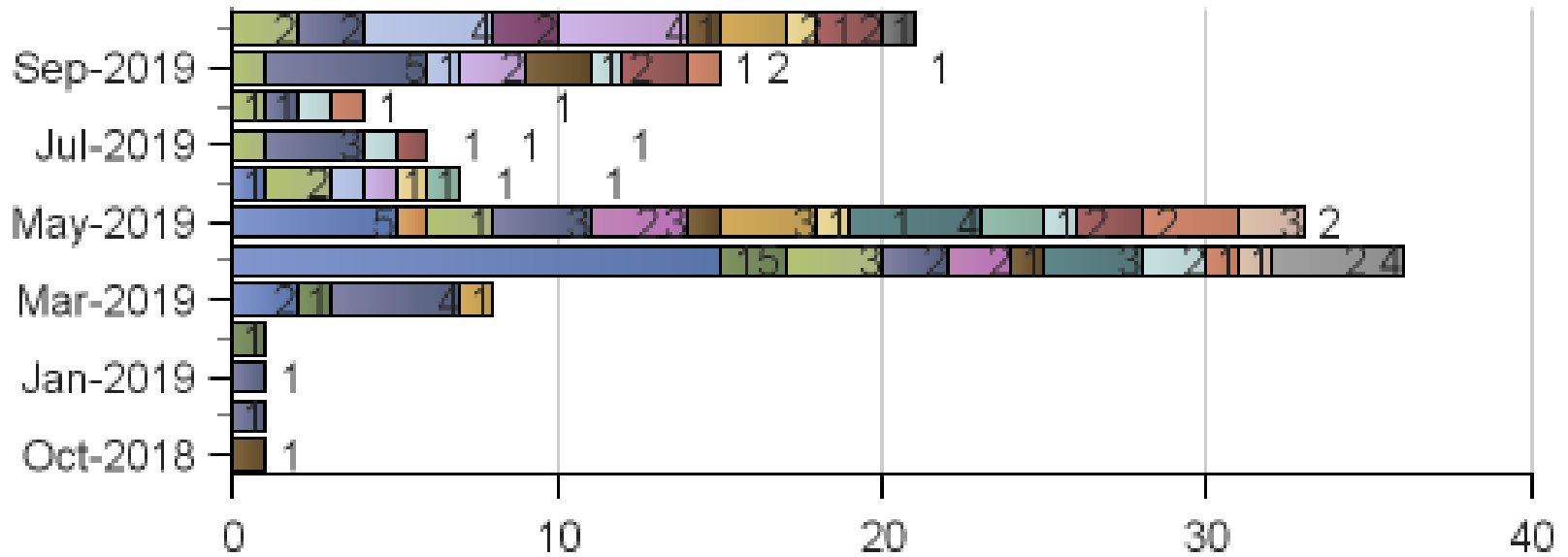
The drop off in reported "AMA" UORs is explained by this change.

AMA/Elopement/LWBS by Month and Location

| Item Count | | Apr-2019 | Aug-2019 | Jul-2019 | Jun-2019 | Mar-2019 | May-2019 | Oct-2019 | Sep-2019 | Total |
|-----------------------|--------------------------------|-----------|----------|----------|-----------|----------|-----------|----------|----------|-----------|
| | Left without being seen (LWBS) | 1 | | 2 | 7 | | 2 | | | 12 |
| | Against Medical Advice (AMA) | | 1 | 2 | 8 | | 2 | | | 13 |
| | Elopement | | | | | | | 1 | 1 | 2 |
| | Other | | | | | | | 1 | | 1 |
| ED | Against Medical Advice (AMA) | 8 | | | 8 | 2 | 7 | | | 25 |
| | Elopement | 1 | | | | | 1 | | | 2 |
| | Left without being seen (LWBS) | 5 | | | 2 | | | | | 7 |
| | Other | | | | 1 | | | | | 1 |
| Medical Surgical Unit | Against Medical Advice (AMA) | | 3 | | | | | | | 3 |
| HIM/Medical Records | Against Medical Advice (AMA) | | | | 1 | | | | | 1 |
| OB | Against Medical Advice (AMA) | | | | | | 1 | | | 1 |
| Total | | 15 | 4 | 4 | 27 | 2 | 13 | 2 | 1 | 68 |

Working with Complytrack to sort months/year in order.

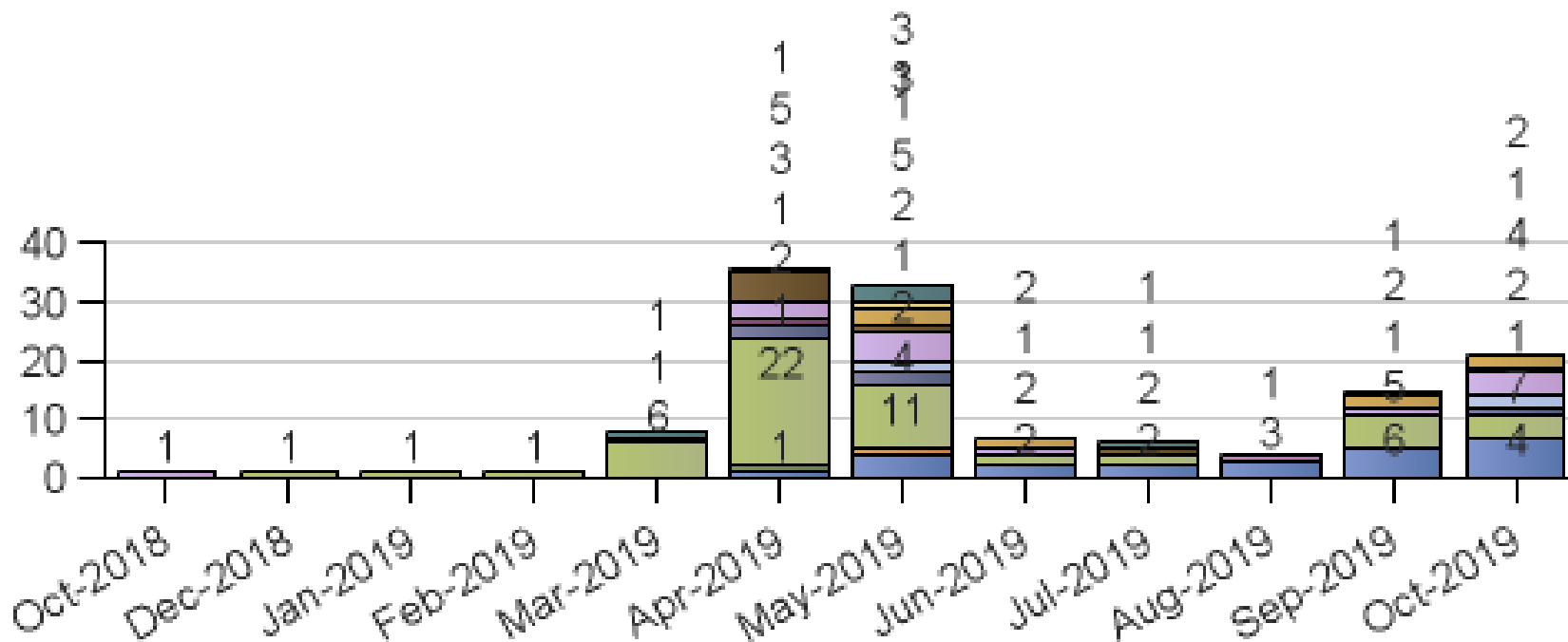
UORs Related to Nursing



- AMA/Elopement/LWBS
- Communication
- Critical Indicator
- Falls/Slips
- Medication Occurrence
- Procedure/Test/Speci...
- Anesthesia
- Complaints/review req...
- ED
- IV issues/Blood transf...
- Mishandled Sharps
- Safety/Security
- Codes - Rapid Respon...
- Confidentiality/PHI Bre...
- Equipment/Supply/Dev...
- Med Surg
- OB/Nursery
- Surgery

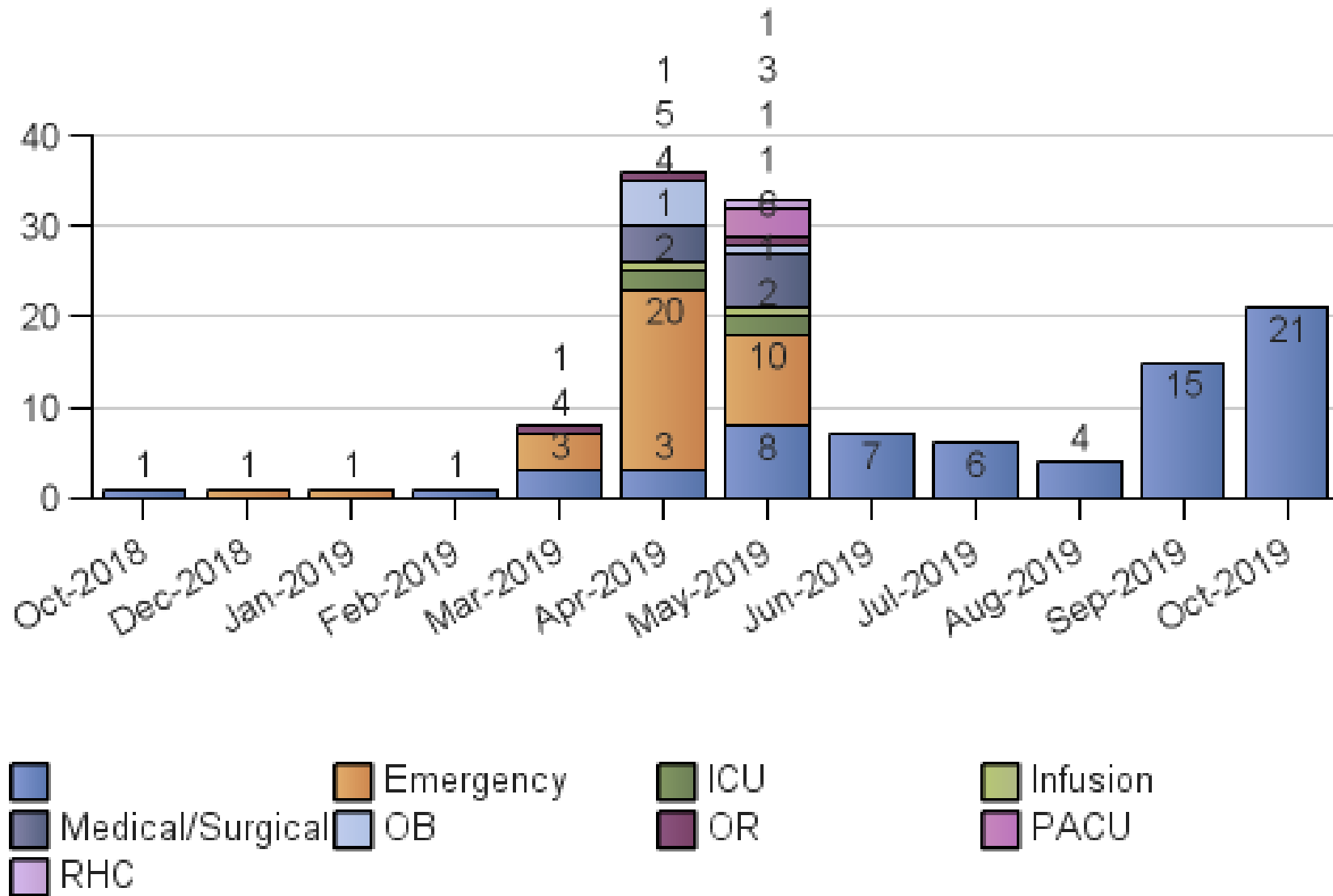
The question on the UOR form asking about whether nursing was involved was rephrased to more clearly state whether “Nursing Practice” may have had an effect on the UOR in late May, with input of some of our nursing team. This greatly reduced the “UORs related to nursing” and appears to be a much better reflection of whether nursing practice may need to be reviewed.

UORs Related to Nursing by Location



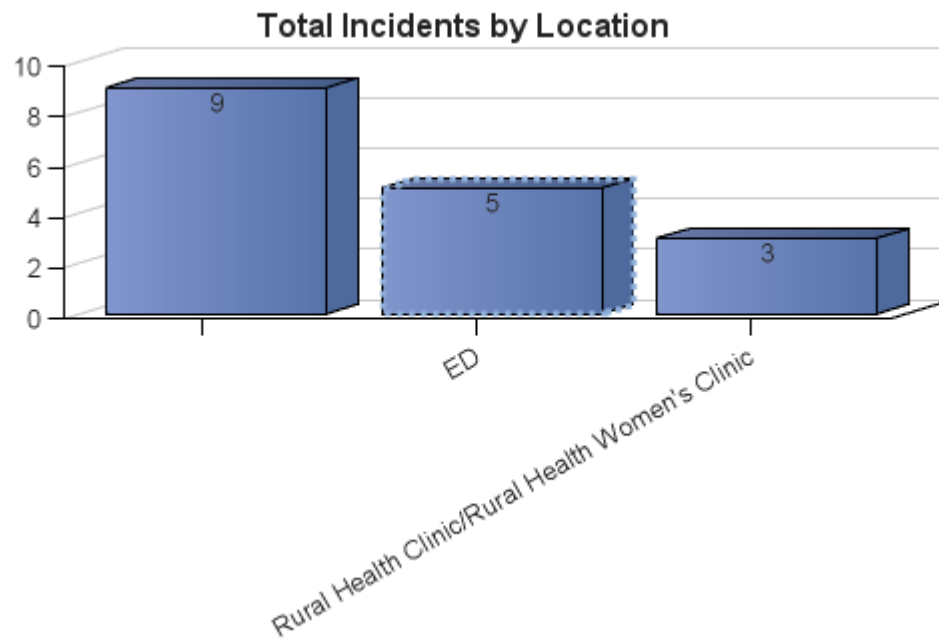
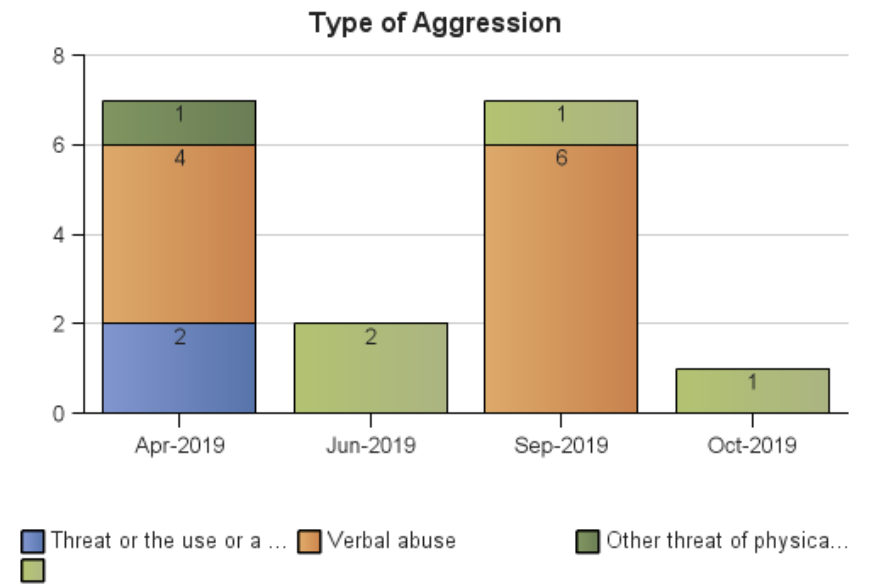
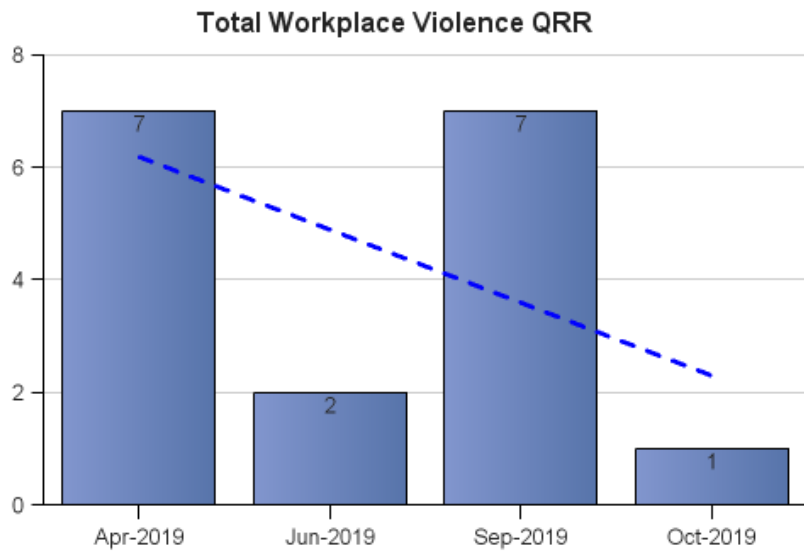
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UORs Related to Nursing by Nursing Unit Involved



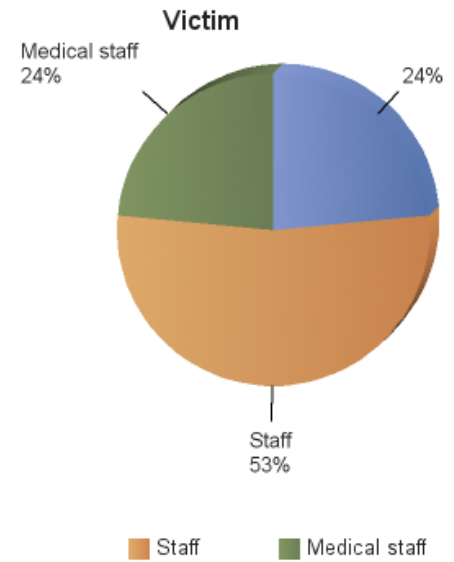
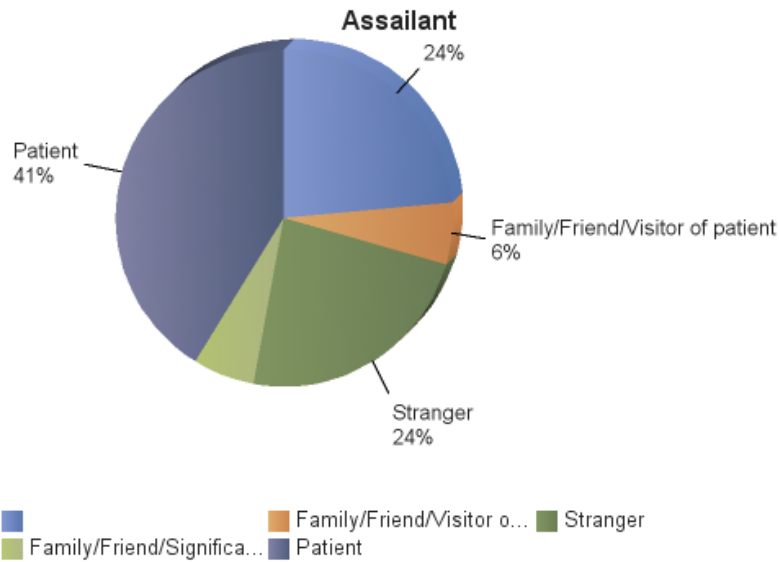
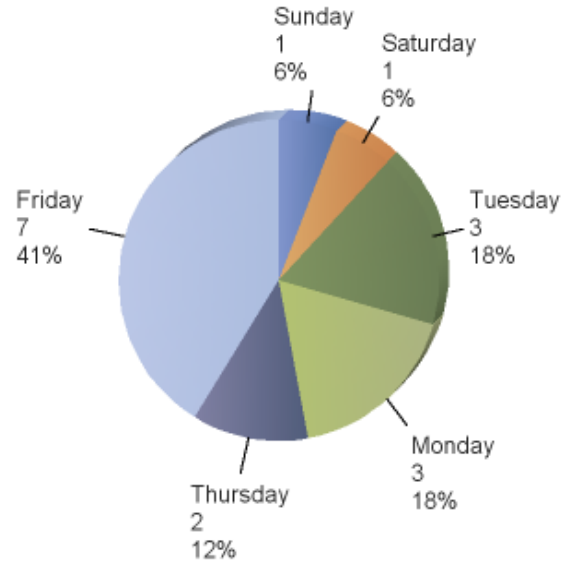
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We are working with Complytrack report writing experts to fix formatting and labeling issues, as seen in this graph.

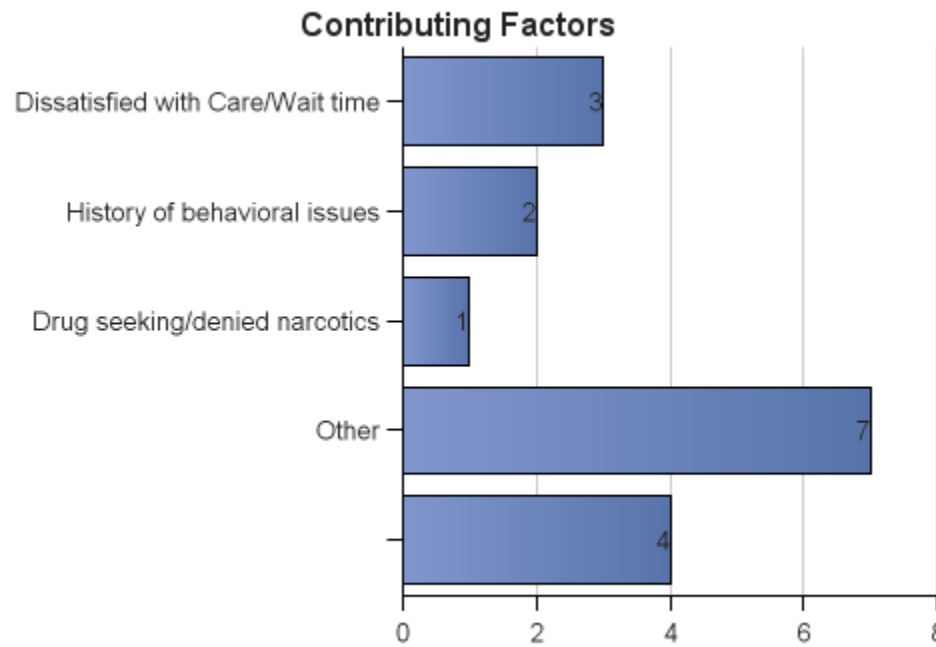
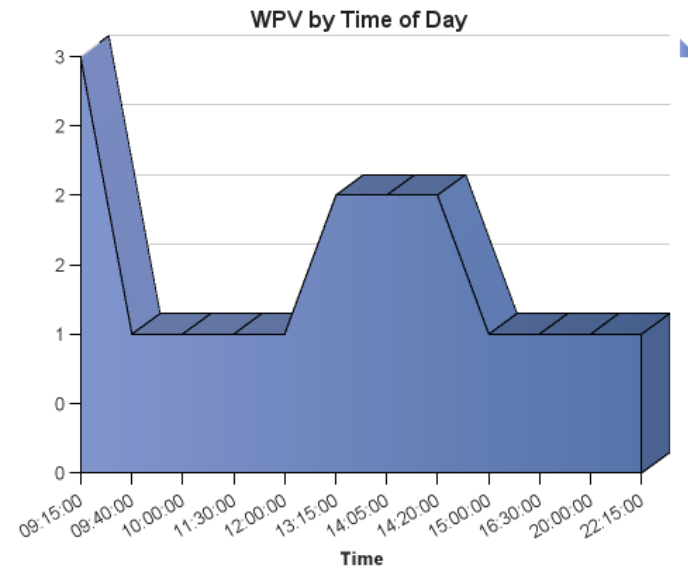
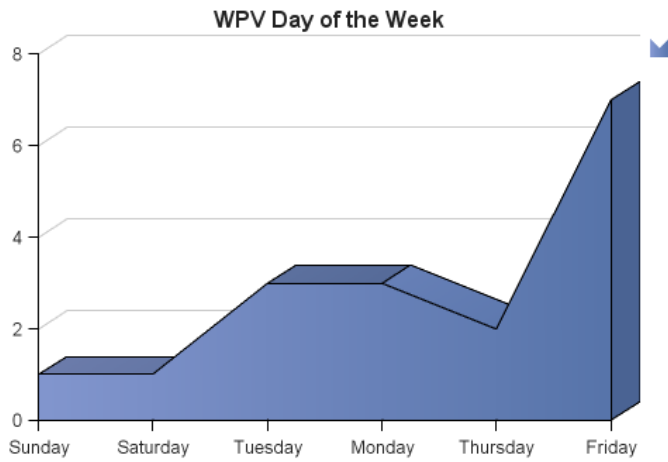


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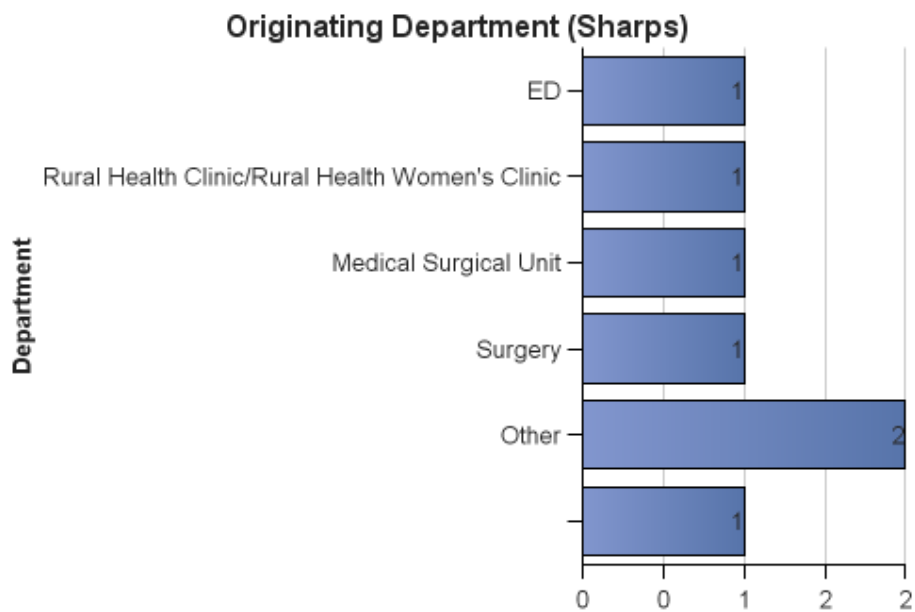
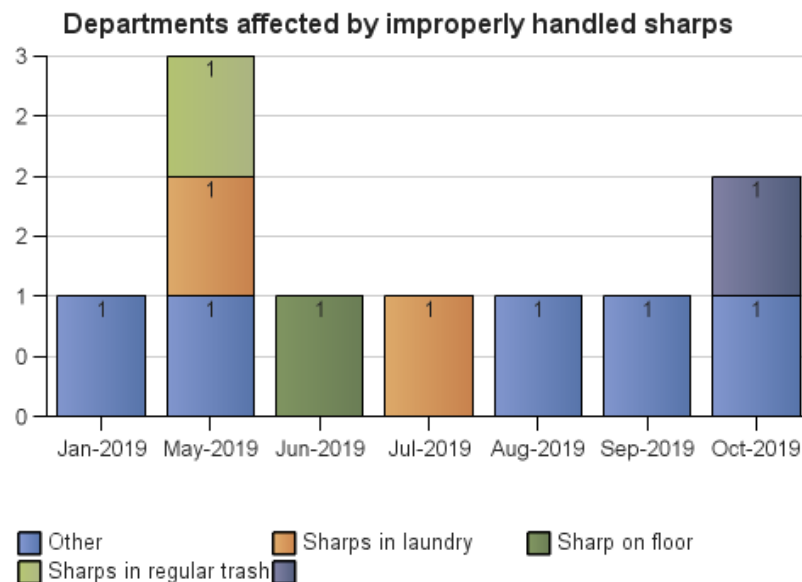
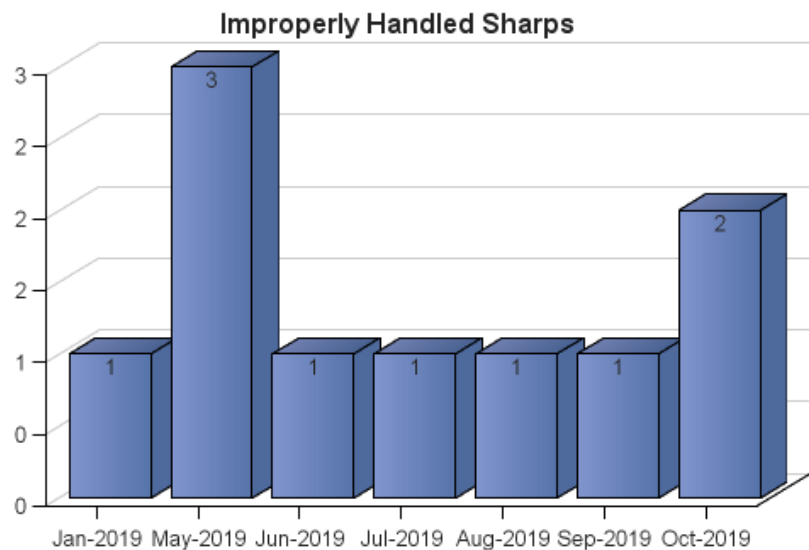
Total Incidents by Day of the Week



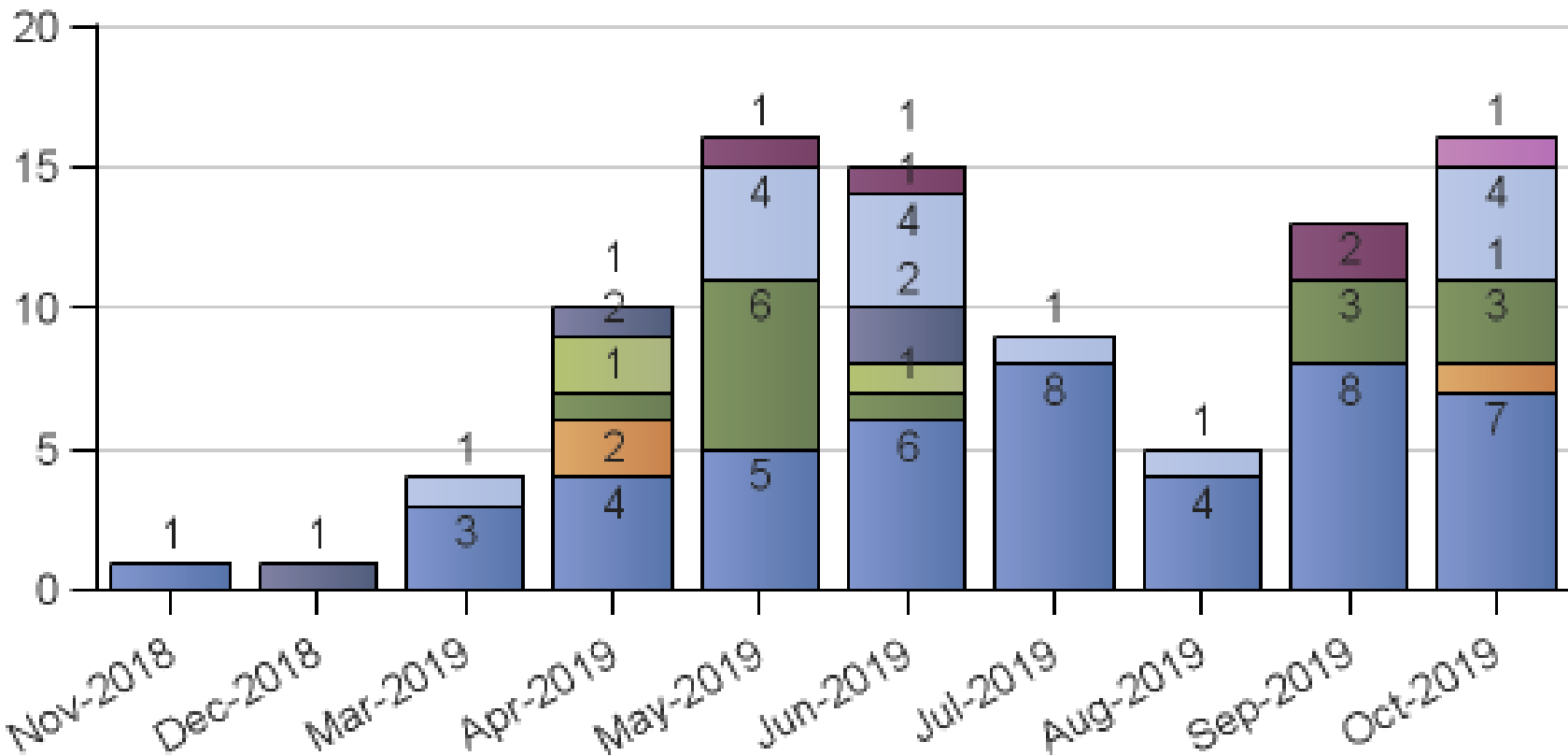
We are working with Complytrack report writing experts to fix formatting and labeling issues, as seen in this graph.



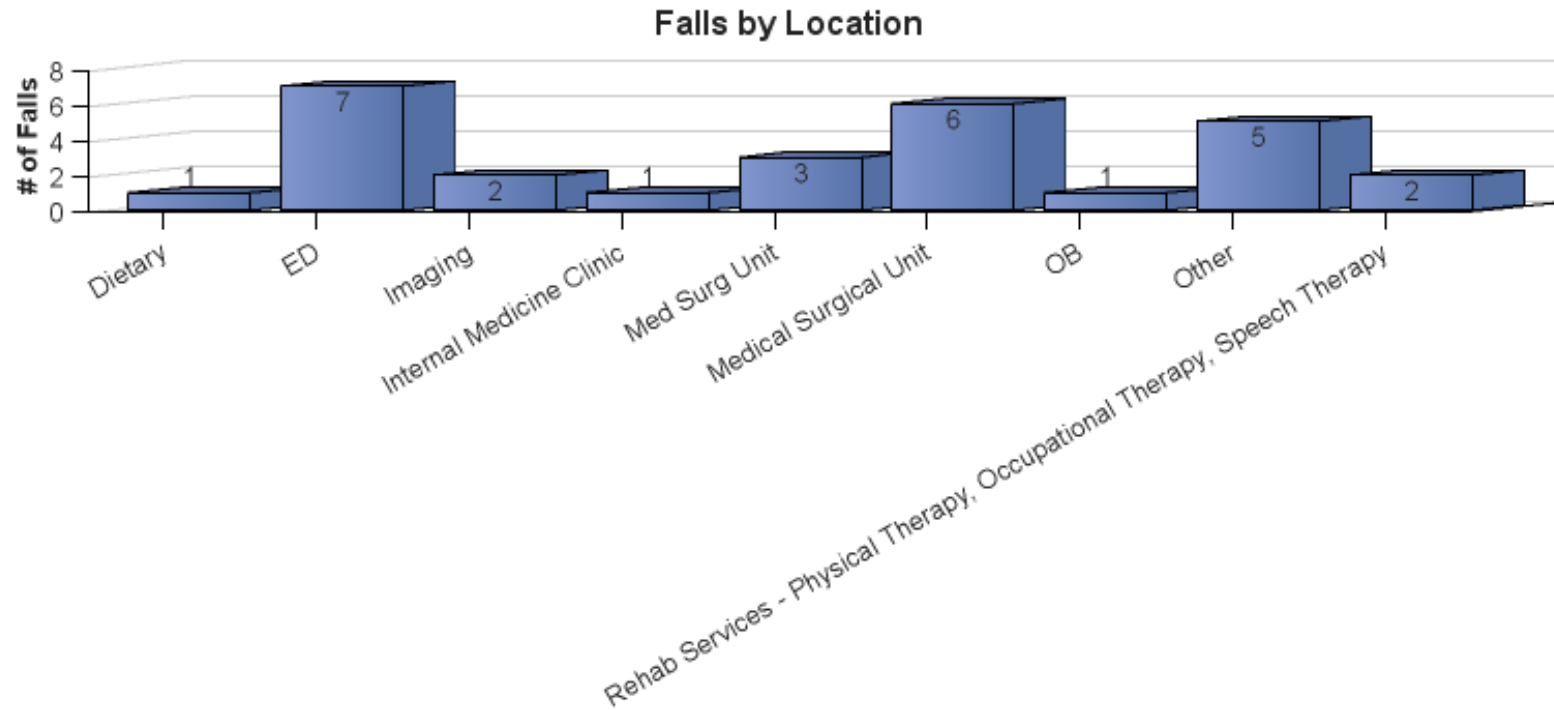
We are working with Complytrack report writing experts to fix formatting and labeling issues, as seen in this graph.



Specimen Issues

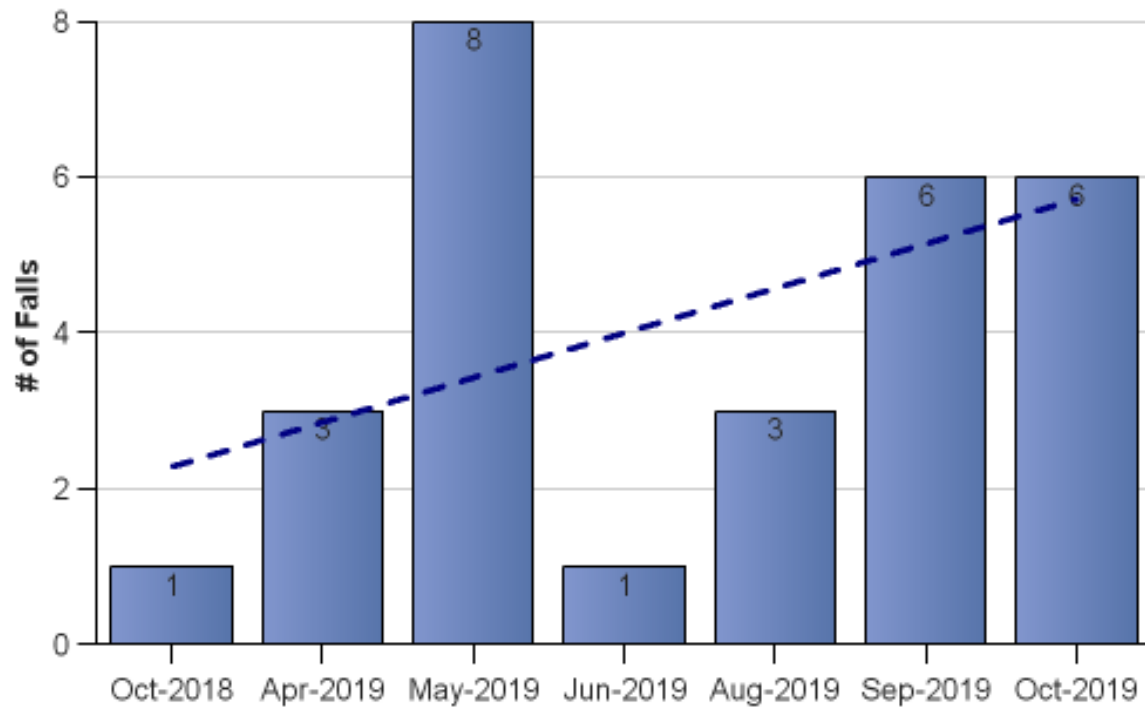


- Other
- Lost specimen
- Other
- Reference lab problem
- Wrong test ordered in ...
- Missed test
- Wrong specimen type ...
- Hemolyzed



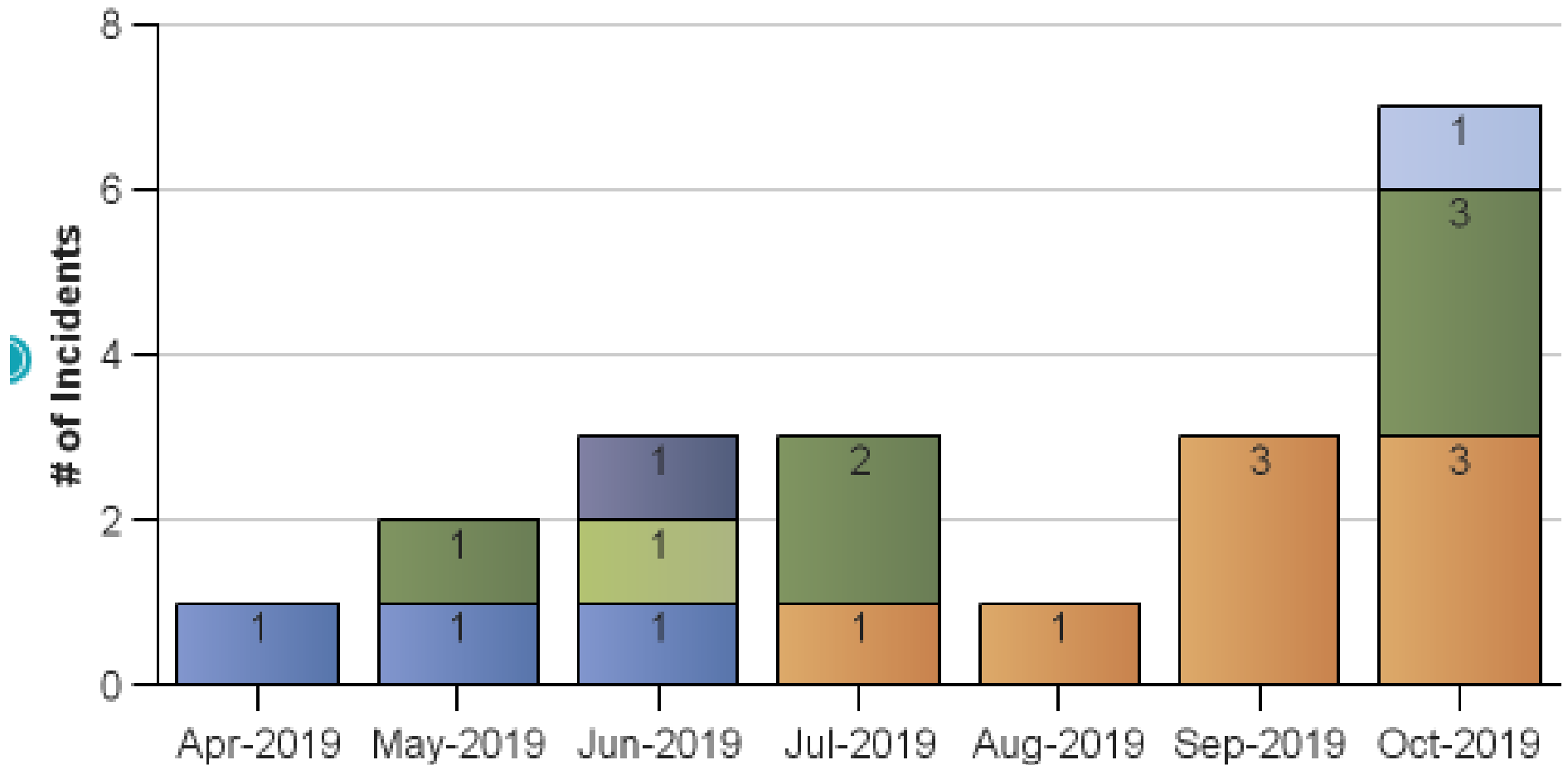
| | # of Falls | Falls/Slips | Total |
|---|------------|-------------|-----------|
| Dietary | | 1 | 1 |
| ED | | 7 | 7 |
| Imaging | | 2 | 2 |
| Internal Medicine Clinic | | 1 | 1 |
| Med Surg Unit | | 3 | 3 |
| Medical Surgical Unit | | 6 | 6 |
| OB | | 1 | 1 |
| Other | | 5 | 5 |
| Rehab Services - Physical Therapy, Occupational Therapy, Speech Therapy | | 2 | 2 |
| Total | | 28 | 28 |

Falls by Date

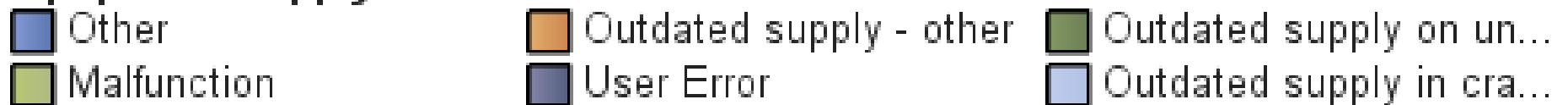


| # of Falls | Ambulating | Bathroom | Bed/Crib | Chair | Grounds/floor issues | Ice/weather related | Other | Stretcher/Table | Total |
|----------------|------------|----------|----------|----------|----------------------|---------------------|----------|-----------------|-----------|
| Not Identified | 2 | 1 | | | 2 | 1 | 3 | 1 | 10 |
| Confused | 1 | 1 | 1 | | | | | | 3 |
| Oriented | 5 | 1 | | 2 | | | 6 | 1 | 15 |
| Total | 8 | 3 | 1 | 2 | 2 | 1 | 9 | 2 | 28 |

Equipment/Supplies/Devices by Incident Type/Date

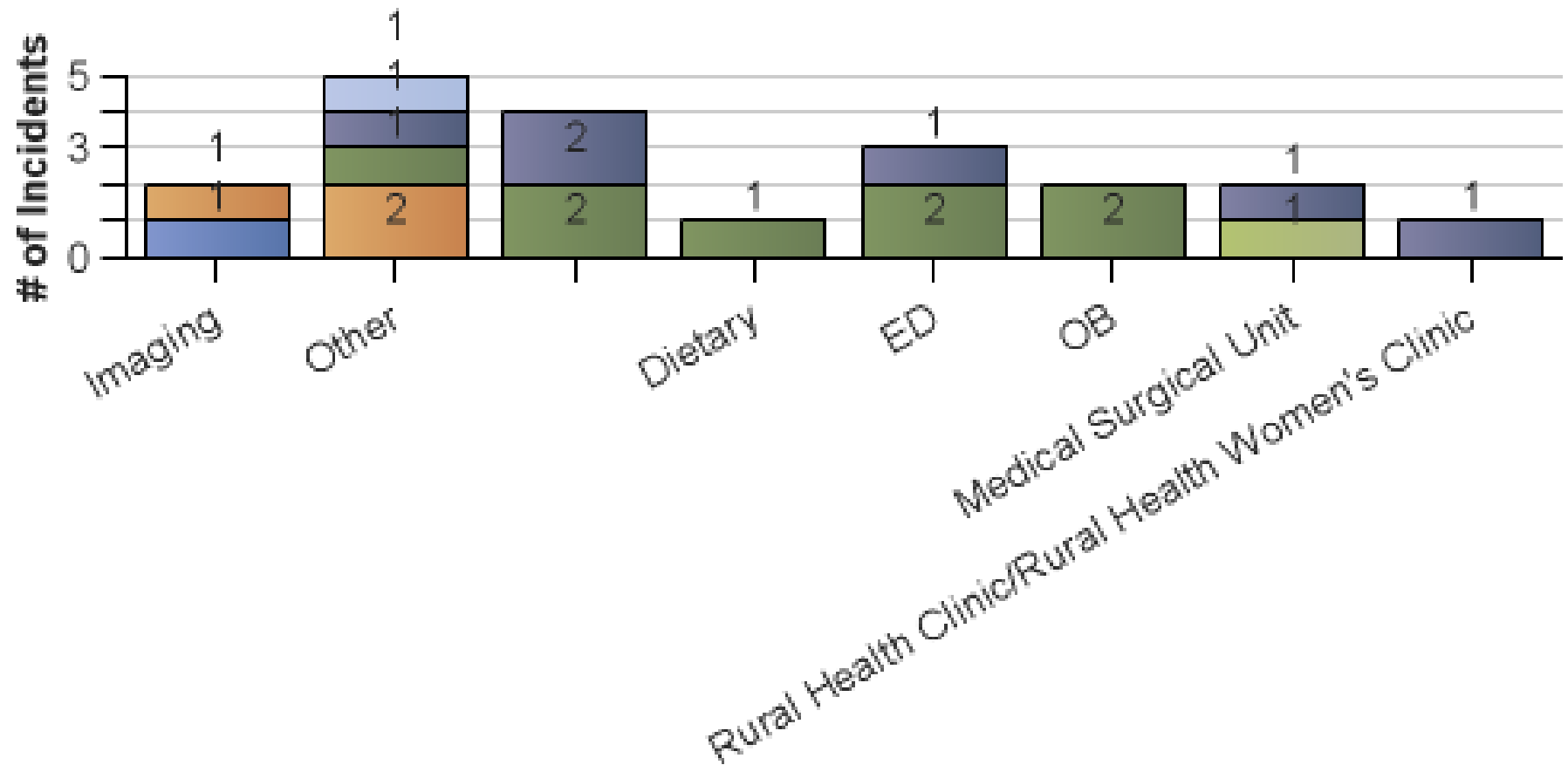


Equipment/Supply/Devices Problems



We are working with Complytrack report writing experts to fix formatting and labeling issues, as seen in this graph.

Equipment/Supplies/Devices by Incident Type/Location

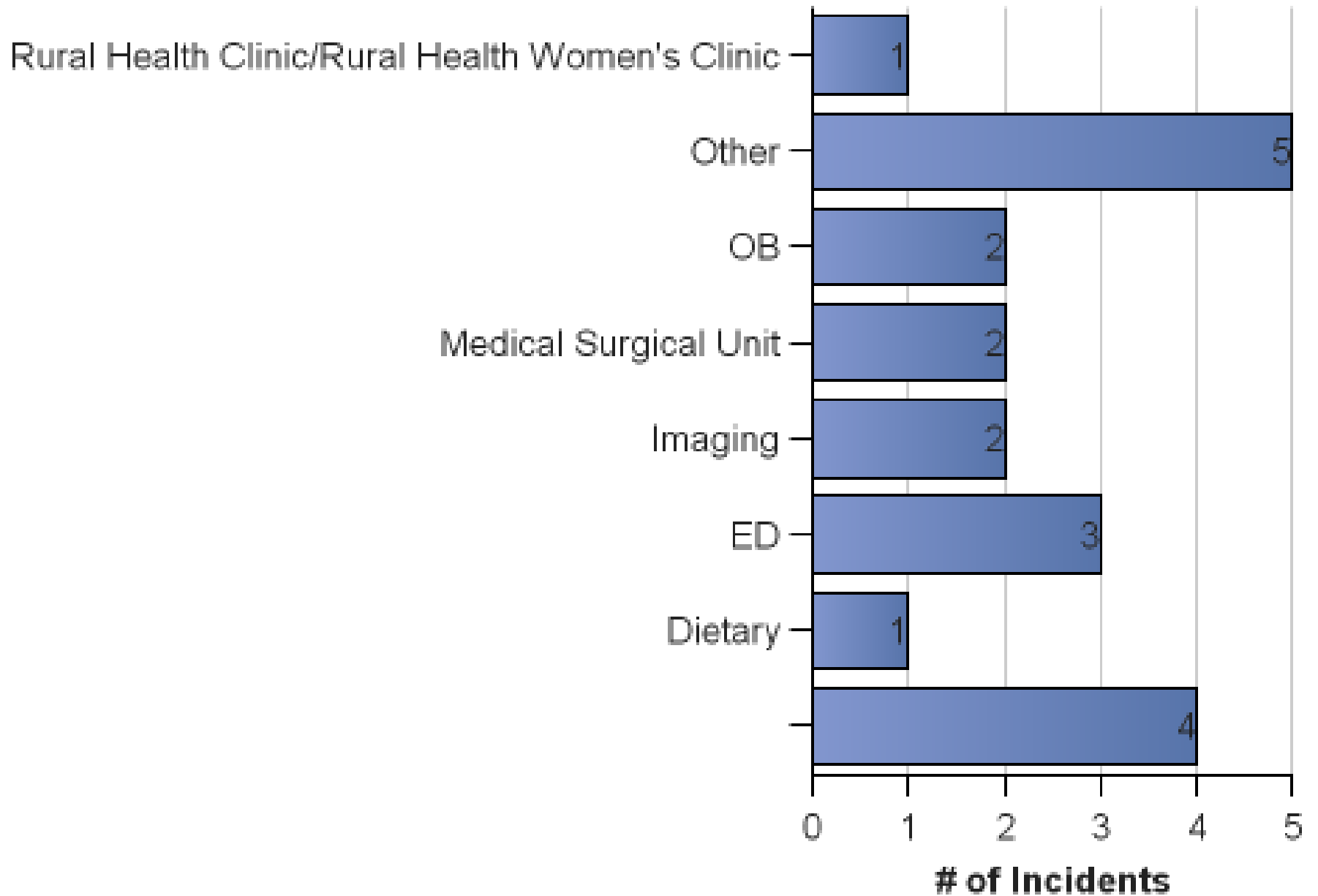


Equipment/Supply/Devices Problems

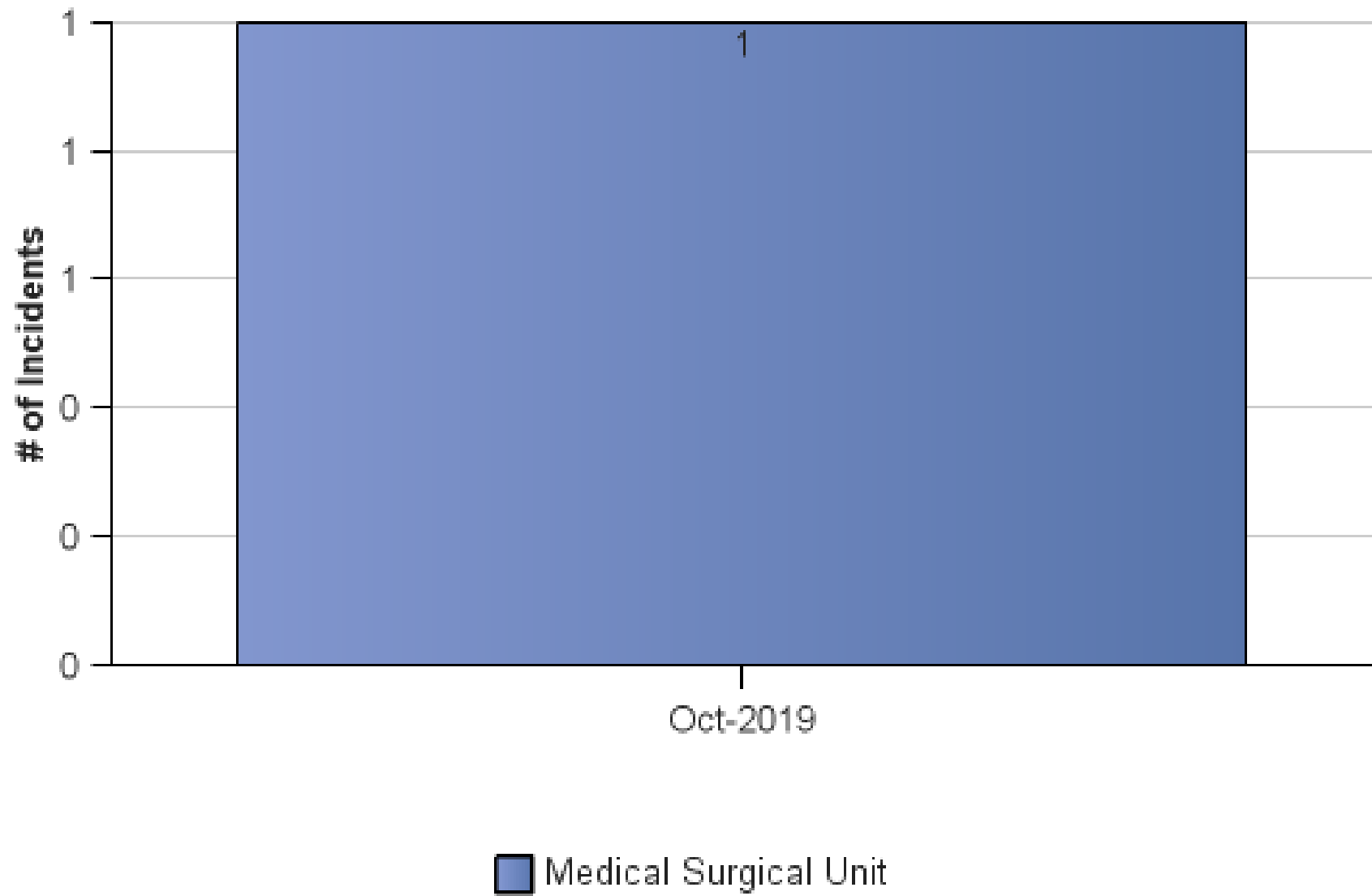
- Malfunction
- Other
- Outdated supply - other
- Outdated supply in cra...
- Outdated supply on un...
- User Error

We are working with Complytrack report writing experts to fix formatting and labeling issues, as seen in this graph.

Equipment/Supplies/Devices by Location

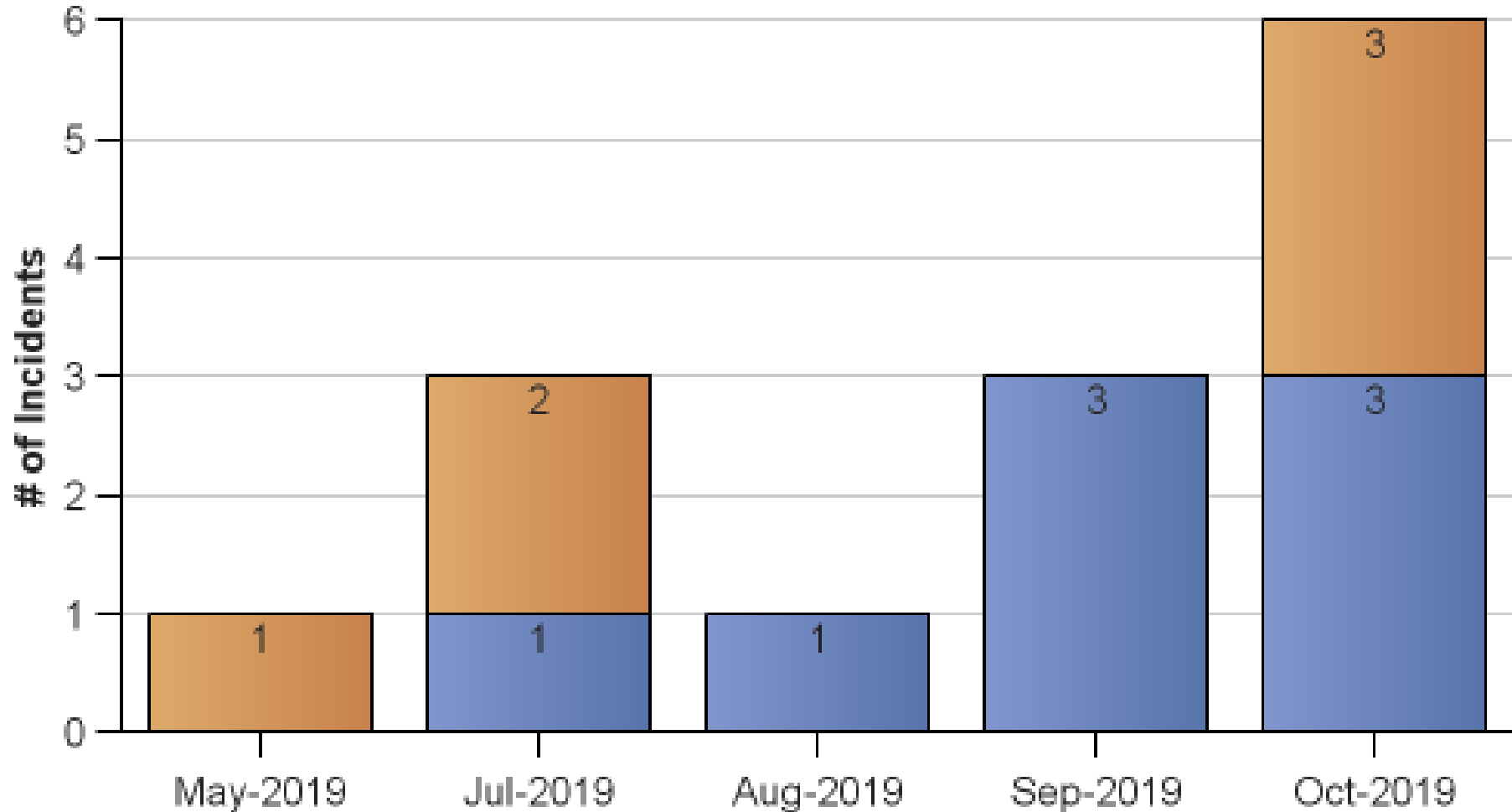


Outdates in Crash Cart



We monitor outdates in crash cart supplies as a regulatory/accreditation corrective action.

Outdates Other by Date



Equipment/Supply/Devices Problems

■ Outdated supply - other ■ Outdated supply on unit shelf

We monitor outdates in supplies as a regulatory/accreditation corrective action.

| Title | Status | Document Owner |
|---|----------|----------------|
| Accessibility & Labeling of Piped Med Gas System EC.02.05.09 EP11 | Approved | Webster, Danny |
| Areas Designated for Administration of General Anesthesia EC.02.05.01 EP25-26 | Approved | Webster, Danny |
| Automatic and Manual Transfer Switch Testing EC.02.05.07 EP 7 | Approved | Webster, Danny |
| Bulk Oxygen Systems EC.02.05.09 EP8-9 | Approved | Webster, Danny |
| Criteria for Alternate Operations of Utility Systems EC.02.05.01 EP 7 | Approved | Webster, Danny |
| Designing & Installing Utility Systems EC.02.05.01 EP1 | Approved | Webster, Danny |
| Emergency Clinical Interventions EC.02.05.01 EP12 | Approved | Webster, Danny |
| Emergency Power Generator Testing EC.02.05.07 EP 4-6 | Approved | Webster, Danny |
| Emergency Power Systems EC.02.05.01 EP 19 | Approved | Webster, Danny |
| Emergency Response Plan-HVAC Failure EC.02.05.01 EP 10d | Approved | Webster, Danny |
| Emergency Response Plan-Medical Gas Failure EC.02.05.01 EP 10e | Approved | Webster, Danny |
| Extension Cords EC.02.05.01 EP24 | Approved | Webster, Danny |
| Four-Hour Emergency Generator Test & Failures EC.02.05.07 EP 9-10 | Approved | Webster, Danny |
| Initial Testing of Utility Systems EC.02.05.05 EP 2 | Approved | Webster, Danny |
| Inspections, Testing, & Maintenance of New Utility Systems EC.02.05.01 EP6 | Approved | Webster, Danny |
| Installing & Maintaining Appropriate Pressure Relations in Critical Areas EC.02.05.01 EP 15 | Approved | Webster, Danny |
| Labeling for Emergency Shutdowns EC.02.05.01 EP 9 | Approved | Webster, Danny |
| Line Isolation Monitor Testing EC.02.05.05 EP 7 | Approved | Webster, Danny |
| Management of Gas Storage Locations EC.02.05.09 EP1-6 | Approved | Webster, Danny |
| Managing Biological Agents EC.02.05.01 EP 14a | Approved | Webster, Danny |
| Mapping the Distribution of Utilities EC.02.05.01 EP 17 | Approved | Webster, Danny |
| Medical Gas Storage Rooms EC.02.05.01 EP 18 | Approved | Webster, Danny |
| Medical/Compressed Gas Cylinders & Storage Rooms EC.02.05.01 EP18 & EC.02.05.09 EP12 | Approved | Webster, Danny |
| Meeting Requirements of NFPA 99-2012 Chapters 5 & 11 EC.02.05.09 EP14 | Approved | Webster, Danny |
| Meeting Requirements of NFPA 99-2012 Chapters 6 & 9 EC.02.05.05 EP8 | Approved | Webster, Danny |
| Operating Rooms EC.02.05.01 EP20 | Approved | Webster, Danny |
| Piped Medical Gas & Vacuum Systems Maintenance & Testing EC.02.05.09 EP7 | Approved | Webster, Danny |
| Policy on Transfilling EC.02.05.09 EP13 | Approved | Webster, Danny |
| Re-locatable Power Taps (RPTs)/Power Strips EC.02.05.01 EP23 | Approved | Webster, Danny |
| Repair & Maintenance Risk Management EC.02.05.05 EP 1 | Approved | Webster, Danny |
| Response to Utility System Disruptions EC.02.05.01 EP13 | Approved | Webster, Danny |
| Risk Assessment for Monitoring for Waterborne Organisms EC.02.05.01 EP14b | Approved | Webster, Danny |
| Testing Battery-powered Exit Signs & Egress Lights EC.02.05.07 EP 1-2 | Approved | Webster, Danny |

| | | |
|---|----------|----------------|
| Testing Diesel Fuel EC.02.05.07 EP8 | Approved | Webster, Danny |
| Testing for (SEPSS) Stored Emergency Power Supply System EC.02.05.07 EP 3 | Approved | Webster, Danny |
| Testing Purity, Pressure, Etc. of Piped Medical Gas EC.02.05.09 EP10 | Approved | Webster, Danny |
| Testing Utility Systems EC.02.05.05 EP 4-6 | Approved | Webster, Danny |
| Utility System Failure & Emergency Response EC.02.05.01 EP10-11 | Approved | Webster, Danny |
| Utility System Failure-Elevator EC.02.05.01 EP10c | Approved | Webster, Danny |
| Utility Systems Electrical and Generator Failure EC.02.05.01 EP10b | Approved | Webster, Danny |
| Utility Systems Inspecting, Testing & Maintenance EC.02.05.01 EP 5 | Approved | Webster, Danny |
| Utility Systems Inventory EC.02.05.01 EP 3-4 | Approved | Webster, Danny |
| Utility Systems Management Plan EC.01.01.01 EP 9 | Approved | Webster, Danny |
| Utility Systems Pneumatic Tube Failure EC.02.05.01 EP 10g | Approved | Webster, Danny |

Dietary Policies

For BOD Review November, 2019

| |
|--|
| Dietary Department Refrigerator and Freezer Temperature Alarms |
| Dietary Refrigerator/Freezer Temperature Monitoring and Documentation* |
| Discharge Planning for Homeless Patients |
| Dishes in Staff Break Room Areas |
| Evaluation and Assessment of Patients' Nutritional Needs |
| Meal Assembly, Delivery, and Dishwashing Methods for Patients* |
| Meals to Patients and Visitors Policy |
| Ordering Dietary Supplements |
| Patient Food from Non-Hospital Sources |
| PC - Calorie Count Snack and Nourishment Record Sheet |
| Refrigerator Monitoring and Documentation |
| Storage of Frozen Foods |
| Test Tray Temperature Taking* |

These three policies are in Draft

| |
|---|
| Dietary Department Refrigeration Monitoring |
| Dietary Orders |
| PC - DIETARY FOOD SUPPLEMENTS |

BOARD OF DIRECTORS POLICIES AND PROCEDURES

| | <u>NAME OF POLICY</u> | <u>DATE APPROVED</u> |
|----|--|----------------------|
| 1 | Appointments To The NIHD Board of Directors | May 16, 2018 |
| 2 | Attendance at Meetings | April 18, 2018 |
| 3 | Authority of the Chief Executive Officer for Contracts and Bidding | May 16, 2018 |
| 4 | Basis of Authority: Role of Directors | April 18, 2018 |
| 5 | Compensation of the Chief Executive Officer | May 16, 2018 |
| 6 | Election Procedures and Related Conduct | April 18, 2018 |
| 7 | NIHD Board Meeting Minutes | June 20, 2018 |
| 8 | Northern Inyo Healthcare District Board of Directors Conflicts of Interest | May 16, 2018 |
| 9 | NIHD Board of Directors Meetings/Brown Act Compliance | June 20, 2018 |
| 10 | Officers and Committees of the Board of Directors | May 16, 2018 |
| 11 | Public Records Requests | May 16, 2018 |
| 12 | Reimbursement of Expenses | April 18, 2018 |
| 13 | Requests For Public Funds, Community Grants, Sponsorships | May 16, 2018 |
| 14 | Suggested Guidance To Fill A Board Vacancy by Appointment | August 15, 2018 |
| 15 | Use by NIHD Directors of District Email Accounts | May 16, 2018 |
| 16 | Work Flow for Appointments to Fill Board Vacancy | August 15, 2018 |

Overview: Organizational billed charges were high in July and August with significant positive variances in pharmacy sales. The month of September is a different story with expected revenues from Inpatient but negative volumes from all outpatient sources and clinics. October improved from September.

| | <u>Charges</u> | <u>Budget</u> |
|-----------------|----------------|---------------|
| October, 2018 | 12,311,788 | 12,324,875 |
| November, 2018 | 12,965,830 | 13,205,209 |
| December, 2018 | 11,320,722 | 13,205,209 |
| January, 2019 | 13,649,585 | 13,645,381 |
| February, 2019 | 11,808,879 | 12,324,875 |
| March, 2019 | 12,927,842 | 13,645,381 |
| April, 2019 | 14,479,237 | 13,205,209 |
| May, 2019 | 13,190,872 | 13,645,381 |
| June, 2019 | 12,985,554 | 13,205,327 |
| July, 2019 | 14,142,468 | 13,645,381 |
| August, 2019 | 14,486,110 | 14,095,678 |
| September, 2019 | 12,636,290 | 13,640,980 |
| October, 2019 | 14,167,924 | 14,095,678 |

Gross Accounts Receivables in Athena continue to be unacceptably high at \$48,736,526; 113.2; Gross Days in AR. Remaining Gross Accounts Receivable in Paragon is \$2,442,653 and Centricity is \$381,131.

Salaries and Wages continued to be steady on a per day basis, even with the holiday in September.

| | <u>Salaries & Wages</u> | <u>Cost Per Day</u> |
|-----------------|-----------------------------|---------------------|
| January, 2019 | 2,550,818 | 82,284 |
| February, 2019 | 2,457,730 | 87,776 |
| March, 2019 | 2,674,515 | 86,275 |
| April, 2019 | 2,555,902 | 85,199 |
| May, 2019 | 2,616,111 | 84,391 |
| June, 2019 | 2,509,763 | 83,659 |
| July, 2019 | 2,585,146 | 83,392 |
| August, 2019 | 2,638,465 | 85,112 |
| September, 2019 | 2,530,883 | 84,363 |
| October, 2019 | 2,536,968 | 81,838 |

Audit Update: The audit was entering the final stages of completion when I asked Wipfli to post-poner the finishing process. An error of significant magnitude was discovered by the business office and charges previously posted in the past fiscal year were overstated by approximately \$1,450,000.

As of the writing of this report (November 8th), the report is awaiting the results of the Medicare cost report settlement estimate. The cost report is expected to have a significant impact on the annual results as a significant decrease in patient days and increased outpatient sales will push expenses into and out of the Medicare cost settlement by Medicare benefit category. The audit will be presented at the December Board of Directors meeting.

Submitted by John Tremble

Northern Inyo Healthcare District - Summary of Key Ratios

| Unit of Measure | 09/30/2019 | 08/31/2019 | 07/31/2019 | 06/30/2019 |
|----------------------------------|---------------|---------------|---------------|--------------------|
| Cash, CDs & LAIF Investments: | \$ 24,551,976 | \$ 24,237,671 | \$ 26,353,608 | \$ 27,264,480 |
| Days Cash on Hand | 105.00 | 103.65 | 112.70 | 116.60 |
| Athena Gross Accounts Receivable | \$ 48,766,032 | \$ 48,766,032 | \$ 44,505,205 | \$ 42,891,066 |
| Average Daily Revenue | \$ 430,894 | \$ 440,084 | \$ 432,425 | \$ 420,533 |
| Gross Days in AR | 113.17 | 110.81 | 102.92 | 101.99 |
| Acute Census Days | 211 | 191 | 240 | 2,803 |
| Swing Bed Census Days | 23 | 15 | 7 | 454 |
| Observation Days | 36 | 38 | 39 | 485 |
| Total Inpatient Utilization | 270 | 244 | 286 | 3,742 |
| Average Daily Inpatient Census | 8.71 | 7.87 | 9.23 | 10.25 |
| Average Acute Daily Charge | \$ 10,846.13 | \$ 10,281.36 | \$ 11,472.19 | \$ 10,982.78 |
| Adjusted Daily Census (with OP) | 38.54 | 42.55 | 41.54 | 38.29 |
| Emergency Room Visits | 605 | 876 | 881 | 9,153 |
| Operating Room Cases | 126 | 109 | 116 | 1,470 |
| RHC Visits | 2,439 | 2,377 | 2,675 | 29,446 |
| | | | | Fiscal 2019 |
| Inpatient Revenue | \$ 2,537,994 | \$ 2,117,960 | \$ 2,833,630 | \$ 35,770,899 |
| Outpatient Revenue | 9,608,636 | 11,774,827 | 10,843,405 | 110,939,678 |
| Clinic Revenue | 458,568 | 593,322 | 465,433 | 6,784,060 |
| Total Revenue | \$ 12,605,198 | \$ 14,486,109 | \$ 14,142,468 | \$ 153,494,636 |
| Revenue Per Day | \$ 420,173 | \$ 467,294 | \$ 456,209 | \$ 420,533 |
| % Change | -10.1% | 2.4% | 1.8% | |
| Salaries | \$ 2,422,139 | \$ 2,528,362 | \$ 2,476,554 | \$ 25,697,886 |
| PTO Expenses | 254,834 | 254,720 | 269,335 | 3,255,428 |
| Total Salaries Expense | \$ 2,676,974 | \$ 2,783,082 | \$ 2,745,889 | \$ 28,953,314 |
| Expense Per Day | \$ 89,232 | \$ 89,777 | \$ 88,577 | \$ 79,324 |
| % Change | -0.6% | 1.4% | 2.8% | |
| Operating Expenses | \$ 4,330,335 | \$ 3,930,250 | \$ 4,051,730 | \$ 49,294,043 |
| Operating Expenses Per Day | \$ 144,344 | \$ 126,782 | \$ 130,701 | \$ 135,052 |
| Capital Expenses | 590,014 | 589,257 | 560,212 | 7,103,119 |
| Capital Expenses Per Day | \$ 19,667 | \$ 19,008 | \$ 18,071 | \$ 19,461 |
| Total Expenses | \$ 7,597,323 | \$ 7,302,590 | \$ 7,357,830 | \$ 85,350,476 |
| Total Expenses Per Day | \$ 253,244 | \$ 235,567 | \$ 237,349 | \$ 233,837 |
| Gross Margin | \$ (522,456) | \$ 435,083 | \$ 522,819 | \$ 1,772,471 |
| Gross Margin Per Adjusted Day | \$ (451.86) | \$ 329.86 | \$ 406.01 | \$ 126.82 |

Northern Inyo Healthcare District
Income Statement Summary
As of September 30, 2019

| | Month To Date 09/30/2019 | Month To Date 08/31/2019 | Year To Date 09/30/2019 | Year To Date 09/30/2018 |
|--|-----------------------------|-----------------------------|----------------------------|----------------------------|
| Inpatient Revenue | 2,537,993.99 | 2,117,959.72 | 7,489,584.30 | 7,890,076.84 |
| Outpatient Revenue | 9,608,636.18 | 11,774,827.62 | 32,226,869.00 | 27,971,465.93 |
| Clinic (RHC) Revenue | 458,567.65 | 593,322.38 | 1,517,322.55 | 1,985,221.84 |
| Total Gross Patient Service Revenue | 12,605,197.82 | 14,486,109.72 | 41,233,775.85 | 37,846,764.61 |
| Deductions from Revenue | (6,351,719.70) | (7,476,280.76) | (20,832,380.45) | (19,179,284.12) |
| Other Patient Revenue | 1,413.03 | 15,737.20 | 40,583.52 | 0.00 |
| Total Net Patient Revenue | 6,254,891.15 | 7,025,566.16 | 20,441,978.92 | 18,667,480.49 |
| Income/Expense from Cost Reporting | 0.00 | 0.00 | 23,557.00 | 0.00 |
| Other Operating Revenue | 819,975.86 | 712,106.78 | 2,227,702.20 | 3,432,926.44 |
| Net Operating Revenue | \$ 7,074,867.01 | \$ 7,737,672.94 | \$ 22,693,238.12 | \$ 22,100,406.93 |
| Operating Expenses | | | | |
| Repairs and Maintenance | 36,601.00 | 1,015.47 | 43,431.51 | 211,583.46 |
| Leases and Rental Expenses | (43,380.73) | 35,738.70 | 32,952.12 | 216,129.71 |
| Salary & Wages | 2,422,139.49 | 2,528,361.72 | 7,427,055.07 | 6,887,438.92 |
| Benefits | 1,717,218.16 | 1,663,652.56 | 4,843,960.34 | 5,105,813.03 |
| Non-Benefit Expenses | 11,267.20 | 12,655.57 | 32,557.79 | 48,084.93 |
| Professional & Physician Fees | 911,259.91 | 713,993.23 | 2,433,490.60 | 3,552,221.70 |
| Supplies | 831,406.41 | 845,035.60 | 2,526,665.98 | 2,347,828.78 |
| Contract Labor & Services | 584,737.81 | 427,266.53 | 1,471,814.96 | 760,248.93 |
| Other Department Expenses | 98,807.70 | 84,739.89 | 293,601.62 | 258,781.39 |
| Hospital Insurance Expenses | 36,142.88 | 43,991.63 | 131,587.14 | 171,592.96 |
| Utilities | 141,102.76 | 143,921.47 | 435,476.99 | 448,978.46 |
| Depreciation and Amortization | 357,440.00 | 357,440.00 | 1,043,274.21 | 1,021,294.39 |
| Other Fees | 259,966.19 | 212,959.98 | 684,563.59 | 290,987.91 |
| Interest Expense - Operating | 232,614.05 | 231,817.31 | 696,248.67 | 708,875.85 |
| Total Operating Expenses | \$ 7,597,322.83 | \$ 7,302,589.66 | \$ 22,099,430.09 | \$ 22,029,860.42 |
| Total Net Operating Profit (Loss) | \$ (522,455.82) | \$ 435,083.28 | \$ 593,808.03 | \$ 70,546.51 |
| Non-Operating Revenue | | | | |
| Other Income | | | | |
| Tax Payer General Support | 48,743.07 | 48,743.07 | 146,229.21 | 146,229.21 |
| Bond/ Tax Payer Bond Support | 137,595.79 | 137,595.79 | 412,787.37 | 328,957.24 |
| Investment Income | 0.00 | 0.00 | 0.00 | 20.28 |
| Fin Chgs-Pt Ar - Int Incm-Jdgmnt | 0.00 | 0.00 | 0.00 | 92.26 |
| Fin Chgs-Pt Ar - Int Incm-Payors | 9.14 | 836.87 | 932.74 | 7,905.26 |
| Interest Income | 95,089.15 | 13,370.20 | 160,690.64 | 151,165.46 |
| Grant Revenue | 3,468.23 | 20,000.00 | 31,468.23 | 55,715.72 |
| Other Non-Operating Income | 1,596.00 | 1,596.00 | 3,192.00 | 9,324.00 |
| Net Medical Office Activity | (360,219.59) | (392,660.12) | (1,253,130.98) | (1,647,531.75) |
| 340b Net Activity | 29,848.79 | 51,343.60 | 131,327.07 | 6,841.24 |
| Donations | 0.00 | 0.00 | 44,060.00 | 0.00 |
| Rental Income | 4,881.41 | 2,730.00 | 12,492.82 | 7,389.06 |
| Gain - Investments - Other Income | 2,459.50 | 7,252.50 | 14,387.00 | 5,060.50 |
| Total Non-Operating Net Results | \$ (36,528.51) | \$ (109,192.09) | \$ (295,563.90) | \$ (928,831.52) |
| Non-Operating Expenses | 0.00 | 50,000.00 | 130,000.00 | 0.00 |
| Net Non-Operating Profit (Loss) | (36,528.51) | (159,192.09) | (425,563.90) | (928,831.52) |
| Net Income (Loss) | \$ (558,984.33) | \$ 275,891.19 | \$ 168,244.13 | \$ (858,285.01) |

Northern Inyo Healthcare District
Balance Sheet
As of September 30, 2019

Assets

Current Assets

| | |
|---|----------------------|
| Cash and Liquid Capital | \$ 5,533,724.55 |
| Short Term Investments | 16,969,123.24 |
| PMA Partnership | 679,758.00 |
| Accounts Receivable, Net of Allowance | |
| Accounts Receivable | 52,585,052.35 |
| Allowances against Receivables | (31,956,807.74) |
| NIA Accrued Allowances | (643,843.08) |
| Total Accounts Receivable, Net of Allowance | <u>19,984,401.53</u> |
| Other Receivables | 3,203,904.59 |
| Inventory | 2,022,786.71 |
| Prepaid Expenses | 1,907,224.57 |
| Total Current Assets | <u>50,300,923.19</u> |

Assets Limited as to Use

| | |
|--|----------------------|
| Internally Designated for Capital Acquisitions | 1,193,798.87 |
| Short Term - Restricted | 150,576.55 |
| Limited Use Assets | |
| LAIF - DC Pension Board Restricted | 804,601.26 |
| DB Pension | 13,632,410.00 |
| PEPRA | 5,338.00 |
| Total Limited Use Assets | <u>14,442,349.26</u> |
| Revenue Bonds Held by a Trustee | 3,307,345.36 |
| Total Assets Limited as to Use | <u>19,094,070.04</u> |

Long Term Assets

| | |
|---|----------------------|
| Long Term Investment | 2,049,127.76 |
| Fixed Assets, Net of Depreciation | |
| Fixed Assets | 127,168,522.92 |
| Accumulated Depreciation | 51,061,664.82 |
| Construction in Progress | 837,569.90 |
| Total Fixed Assets, Net of Depreciation | <u>76,944,428.00</u> |

Total Assets

\$ 148,388,548.99

Liabilities

Current Liabilities

| | |
|--------------------------------------|----------------------|
| Current Maturities of Long-Term Debt | \$ 2,311,088.92 |
| Accounts Payable | 6,576,020.30 |
| Accrued Payroll and Related | 7,887,510.53 |
| Accrued Interest and Sales Tax | 204,631.96 |
| Unearned Revenue | (1.65) |
| Due to 3rd Party Payors | 4,542,512.32 |
| Due to Specific Purpose Funds | (25,097.72) |
| Other Deferred Credits - Pension | 3,481,539.70 |
| Total Current Liabilities | <u>24,978,204.36</u> |

Long Term Liabilities

| | |
|---------------------------------------|----------------------|
| Long Term Debt | 39,253,947.15 |
| Bond Premium | 468,621.15 |
| Accreted Interest | 13,851,910.25 |
| Other Non-Current Liability - Pension | 32,705,323.00 |
| Total Long Term Liabilities | <u>86,279,801.55</u> |
| Suspense Liabilities | 192,611.13 |

Total Liabilities

\$ 111,450,617.04

Fund Balance

| | |
|----------------------------------|----------------------|
| Fund Balance - beginning of Year | \$ 36,619,131.27 |
| Temporarily Restricted | 150,576.55 |
| Net Income | 168,224.13 |
| Total Fund Balance | <u>36,937,931.95</u> |

Liabilities + Fund Balance

\$ 148,388,548.99