AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
June 17, 2020 at 5:30 p.m.
2957 Birch Street, Bishop, CA

Northern Inyo Healthcare District invites you to attend this Zoom meeting:

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

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

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: 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, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the agenda.

3. **New Business**:
   A. Requests for Proposals for Audit Services; Eide Bailly, BKD, Wipfli & MossAdams (*action item*)
   B. Request for Permanent Chief Medical Officer position at NIHD (*action item*)
   C. *Tuition Reimbursement* Policy and Procedure approval (*action item*)
   D. AED (Automated External Defibrillator) Purchase (*action item)*
   F. Return on Investment Analysis Committee Update *(information item)*
   G. Board Agenda Item Review and Approval Process *(action item)*
   H. CEO Signature Authority *(information item)*
   I. Request for Special Board Meeting Wednesday, June 24, 2020, 5:30pm. Fiscal Budget of 2020-2021 for Approval *(action item)*

J. Southern Inyo Healthcare District and Northern Inyo Healthcare District Pediatrics and Orthopedic Service Agreement *(information item)*

4. **Old Business**:

5. **Reports** (*information items*):
   A. Building separation construction project update

   B. Governance Consultant update

   C. Chief Executive Officer Search update

6. **Chief of Staff Report**: Stacey Brown MD
   A. Medical Staff Appointments (*action items)*

      1. Gregory Gaskin, MD (*emergency medicine)* – provisional active staff
      2. Timothy Brieske, MD *(family medicine) – provisional active staff*

   B. Telemedicine Staff Appointments - credentialing by proxy (*action item*)
   As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon Adventist Health's credentialing and privileging decisions.

      1. Armand Rostamian, MD (*cardiology*) – telemedicine staff
      2. Diana Havill, MD (*psychiatry*) – telemedicine staff

   C. Staff Category Change (*action item*)

      1. Ruhong Ma, DO (*internal medicine*) – change from locums to provisional active staff. Privileges valid through 12/31/2021.

   D. Resignations (*action items*)
      1. Peter Bloomfield, MD (*emergency medicine*) – active staff – effective 5/26/20

   E. Policies and Procedures (*action items*)
      1. *Pharmacy Downtime Procedure*
      2. *Opioid Sedation Scale*
      3. *Opioid Administration*
      4. *Pain Assessment and Documentation*
      5. *Scope of Service Acute/Subacute*
      6. *Telemetry Criteria Guideline*
      7. *MRI Safety*
      8. *Code Blue Procedure – Code Blue Team*
      9. *Cardiac Stress Test Protocol and Procedure*

   F. Annual Approvals (*action items*)
      1. Radiology Critical Indicators 2020

G. Internal Medicine Core Privilege Form update (*action item*)

Consent Agenda (action items)

7. Approval of minutes of the May 20 2020 regular meeting
8. Approval of minutes of the May 28 2020 special meeting
9. Compliance Department quarterly report
10. Policy and Procedure annual approvals

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11. **Reports from Board Members** (*information items*)
12. **Adjournment to Closed Session to/for**:
    A. Conference with Legal Counsel, anticipated litigation, significant exposure to litigation (*pursuant to Government code Section 54956.9(d)(2)*) 2 cases.

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

    C. Conference with Legal Counsel, anticipated litigation, significant exposure to litigation (pursuant to Government code Section 54956.9(d)(2)) Potential privacy breach, Jody DeSousa.
13. **Return to Open Session and Report of Any Action Taken** (*information item*).
14. **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.

June 4, 2020

Proposal for Audit Services

NORTHERN INYO HEALTHCARE DISTRICT

Submitted By:

Eide Bailly LLP
David Showalter, CPA
Partner

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Executive Summary

WE WANT TO WORK WITH YOU

Thank you for the opportunity to present this proposal to provide audit services for Northern Inyo Healthcare District ("the District"). We are truly excited about this opportunity to work together. Based on our discussion and understanding of your operations, our industry experience and additional resources we can offer, we believe Eide Bailly is the right firm for you as you navigate these challenging times. We've served healthcare clients for more than 50 years and are confident you will benefit from this experience.

Industry Experience. The healthcare industry is in a constant state of change, and, is particularly challenged during these unprecedented times. Our extensive healthcare industry knowledge and experience working with health systems, hospitals, and even health plans across the country bring the right skills for you. The partners selected for your engagement are leaders in the healthcare industry and will provide the knowledge and insight that the District deserves. In addition, managers and seniors have a very high concentration in the industry and have experience working with organizations similar to the District. We have a dedicated team of more than 200 healthcare professionals serving over 2,400 healthcare clients nationwide. During your engagement, we will work closely with your management team to identify issues and provide responsive solutions that are tailored to the District. We hope you have seen firsthand our industry resources available through our various webinars and other thought leadership communications regarding COVID-19, the CARES Act and related provider relief federal funding.

Why Eide Bailly. We've developed this proposal with the District in mind. You have our commitment that we will provide timely, personalized services for you. We pride ourselves on delivering honest and insightful advice beyond what is normally experienced in the public accounting industry. We make it a priority to always be accessible to our clients, which includes partner and manager involvement during all phases of the engagement, as well as throughout the year.

The following pages highlight our firm's strengths and demonstrate why Eide Bailly merits serious consideration. Know that you will be a highly valued client. Our people would be proud to work with Northern Inyo Healthcare District and build a trusting relationship with your team. Please contact me if you would like to discuss any aspect of this proposal.

Best regards,

David E. Showalter

David Showalter, CPA | Partner
916.999.8502 | dshowalter@eidebailly.com

1 EXPERIENCE

Our experienced professionals are committed to the industries we serve. We focus on training, and we like to think of ourselves as thought leaders.

2 PEOPLE

We're a team of collaborators and innovators. Our culture is the heart of our firm, and we're always working together to do things differently and better.

3 COMMUNICATIONS

Open, honest, frequent communication ensures that you're not in for any surprises. We'll stay in touch throughout the year, so you feel understood, connected and confident.

4 CORPORATE RESPONSIBILITY

We consider ourselves good corporate citizens—caring for our people, giving back to our communities, and taking care of our environment.

About Us

WHAT INSPIRES YOU, INSPIRES US

With more than 100 years of service, Eide Bailly focuses on what matters most to you. Our CPAs and business advisors deliver industry and subject matter expertise resourcefully, ensuring that we're providing clients with guidance that reflects their needs.

We pride ourselves on being leaders in the healthcare industry, with a strong focus on rural healthcare, and offering valuable perspectives beyond our core strength of accounting and tax compliance. We're here to help guide the strategy and operations of the District, and we'll make sure you feel connected and understand the process.

Our people are optimistic and good-natured—and we believe you'll enjoy working with us. Our service style is hands-on, and we're always looking for new ways to solve your problems or help you embrace opportunities.

Our Commitment to Clients

Our work with clients is more than an engagement. It's a relationship, built on value and trust—and results. When working with Eide Bailly, you will:

- Work with professionals who truly care about your business and will take the time to get to know you and your organization.
- Gain insight from our industry and service specialists to accomplish your objectives, address challenges and leverage new opportunities.
- Make better business decisions knowing you are guided by trusted advisors who care about your success.

AT A GLANCE

top 25 CPA firm in the nation

offices in 14 states

325+ partners

2,500+ staff

one Eide Bailly

Firm Experience

INSPIRED TO SERVE

Health Care Experience

Health care is Eide Bailly's leading industry, serving over 2,400 health care organizations throughout the nation. Over 200 professionals are dedicated to serving the health care industry, including specialists in assurance, third-party reimbursement, tax, financing, operational improvement, digital transformation, revenue cycle and other services.

Our client base includes organizations such as healthcare systems, community and critical access hospitals, rural health clinics, long-term care facilities, clinics and physician groups, home health agencies, independent living facilities and more.

We have significantly developed and expanded our health care practice to meet the changing needs of the industry. The health care practice has grown to be our largest industry group of the firm. As a result, we have welcomed a significant number of experienced professionals such as former chief financial officers, business office managers, compliance specialists, operational leaders, registered nurses and others with operating experience to work directly with our health care clients to improve overall efficiencies and profitability.

National Perspective

We will bring a valuable perspective to the District by bringing best practices to bear on the ever-changing environment you face in running of your organization. The broader the foundation of knowledge that you have to base your decisions on, the better those decisions will be. In addition, we will continue to keep in touch with you through a variety of means, including our quarterly healthcare newsletter as well as single-issue e-blasts and webinars to communicate timely information on late-breaking industry developments.

With healthcare as such a significant part of our firm's practice, we are able to invest in education, both internally and externally. This dedication to the industry helps our clients in practical ways every day. We stay current on regulatory and operational issues that affect our clients and deliver pertinent information to our clients on a timely basis. This enables our clients to focus more of their time on their mission rather than spending all of their time navigating the waters of regulatory compliance.

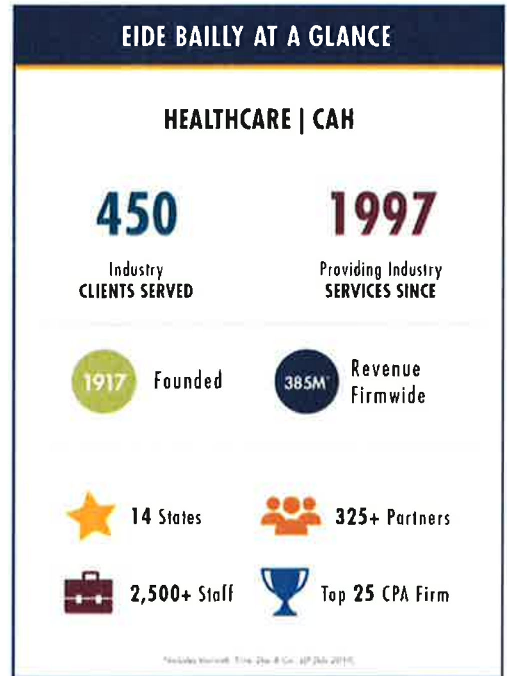
With a focus on being innovative and ensuring our clients' success, we continually invest in our firm's resources to provide our clients with strategic solutions. Specific services that we are working with our clients focus on CARES Act and Federal relief compliance, telehealth billing and revenue cycle, reimbursement, compliance and governance. Our clients are provided information key to stakeholders so that they can make changes when the issue is at hand.

Critical Access Hospital Experience

Since our involvement with the first Critical Access Hospital (CAH) conversion in the nation in 1998, Eide Bailly has assisted more than 450 CAHs with a wide array of services beyond the traditional core services of audit and cost reports, including financial feasibility studies, market analysis, ACO development, chargemaster reviews, revenue cycle and compliance reviews, and a variety other operational and performance improvement issues.

Eide Bailly believes that truly serving Critical Access Hospitals means a lot more than just completing the audit and preparing the cost reports. Our CAH clients range in size from $3 million to more than $80 million in net patient revenue. This broad range of CAH experience provides our professionals with a well-rounded understanding of the varying issues CAHs face. Our industry volume provides our staff members with significant experience working with CAHs.

Providing these services are part of a comprehensive approach we take to help our CAH clients fulfill their missions. We leverage our consulting and reimbursement experience to our clients' benefit during the course of providing these services in a number of ways, including identifying reimbursement improvement opportunities.



Critical Access Hospital and Rural Health Clinic Webinar Series

In addition to healthcare specific e-blasts, white papers and onsite discussions with your service team, Eide Bailly provides numerous opportunities for our clients to grow their knowledge of healthcare related topics, including emerging issues through various mediums. We also provide periodic webinars specific to CAH and rural health clinic topics, and the sessions are designed to address common issues faced by virtually every CAH. Prior year's topics have included:

- 340B: Current Issues, Audit Findings and Strategies.
- Staffing for Success.
- What Business Intelligence Can Do for Your Operations.
- 2019 Code Changes that Affect Critical Access Hospitals.
- Chargemaster, Pricing, Transparency: What Does this all Mean?
- Tax and Reimbursement Hot Topics: What you need to know for your Critical Access Hospital Medicare Cost Report.
- Revenue Cycle Focus.
- Provider Compensation Strategies in the Rural Health Clinic Setting.
- Rural Health Clinics 2019 Reimbursement Update.

Eide Bailly is one of only two CPA firms in the nation that is a corporate sponsor of the National Rural Health Association. We are truly committed to Rural Health and provide educational sessions on assurance, reimbursement and tax issues affecting rural hospitals through the NRHA as well as state hospital associations, state HFMA chapters and national HFMA and ACHE, and state rural health associations.

Rural Healthcare Experience

As a firm, we are Gold Sponsors of the National Rural Health Association (NRHA) and are active participants of Healthcare Financial Management Associations (HFMA) at the local and national level as well as State Hospital Associations.

At the national level, we are one of the few accounting firms in the country that is an active participant in the National Rural Policy Institute sponsored by the NRHA at the beginning of each calendar year. We take advantage of this opportunity to work with various state delegations and meet with their congressional representatives to discuss rural health concerns and to provide recommendations and needs for consideration by Congress in addressing the health needs in rural America.

One of our team members serves on the Policy Congress for NRHA, which is the body that determines the lobbying positions that NRHA will take before the administration and members of Congress. As a part of this process, our team member works with committees to advise Congress on the rural payment mechanisms and how they can change to include rural hospitals in the changing healthcare landscape under the Affordable Care Act. We are also a member of the NRHA Rural Hospital's Issues Group.

KEEP THE PULSE OF THE INDUSTRY

Commitment to the Healthcare Industry

PUTTING THE PIECES TOGETHER

Keeping Clients Informed

Because we are committed to the healthcare industry, we provide our professionals with specific, ongoing training related to relevant issues. This investment ensures our people stay current on the unique challenges and opportunities within the healthcare industry, so they are in the best position to help clients address these issues.

District personnel will be invited to trainings as part of our engagements. Eide Bailly offers a variety of healthcare related educational opportunities, including periodic email updates on emerging issues through our industry groups on topics such as regulatory changes, reimbursement, industry trends, etc. Additionally, there are numerous webinars provided specific to critical access hospitals, rural health clinics, accounting updates, and general business issues.

Eide Bailly *Insights*

Another source of added value that Eide Bailly brings to its clients is industry thought leadership communication. The *Insights* are a forum for ideas, a place to share leading best practices and a source of thought leadership as a catalyst to help our clients address difficult challenges and emerging issues. This thought leadership includes white papers, articles and other publications and webcasts focusing on financial reporting, audit and operational topics that are on demand for viewing at your convenience. Some of the recent *Insights* published are:

- The CARES Act Has Been Passed - What You Should Know.
- What You Need to Know About COVID-19 and Medical Procedure Codes.
- Accelerated Payments and File Extensions for Medicare Providers Due to COVID-19.
- Taxpayer Certainty and Disaster Relief Act of 2019.
- What is the Appropriate Use Criteria Program and Why it Matters?
- The New Year's Impact on CPT Codes.
- Critical Access Hospital Assessment and Business Intelligence.

Other Services We Provide

Eide Bailly is a full-service CPA firm performing traditional CPA firm services of attest (audits, reviews, compilations), tax, and cost report preparation. We also have management advisory services including forensics, cybersecurity, compliance and revenue cycle, digital transformation, vendor added reseller (VAR) sales of accounting software, internal audit and many other non-traditional services. Our core services offered include the following:

Audit and Assurance

- Audits.
- 401(k) and Employee Benefit Plan Audits.
- Agreed Upon Procedures.
- Single Audits.
- Internal Audits.

Consulting

- Population Health Management.
- Technology Consulting.
- Enterprise Risk Management.
- Strategic Financing Services.
- Forensic & Valuation.
- Transaction Services.
- Cybersecurity Consulting.
- Business intelligence.
- Compliance and Coding Reviews.
- 340b Compliance Reviews.
- Revenue Cycle.
- Strategic Reimbursement Services
- Contract reviews.
- Physician Compensation.
- Pricing Studies.
- ACO and Healthcare Operational Consulting.
- Rural Health Clinic Reimbursement Studies.
- Digital Transformation.
- Community Health Needs Assessment.
- Tax structure and analysis and tax regulation.
- Cybersecurity consulting

Connect with Us

Visit us at www.eidebailly.com to learn about the many services we offer, register for courses, sign up for our *Insights* Newsletter, read overviews from prior months and stay connected throughout the year.

Team Qualifications

AN EXPERIENCED FIRM

We're passionate about our work—and your success. We have selected professionals for your service team who are the right fit for your engagement, based on their knowledge and experience in the healthcare industry.

David Showalter will lead the engagement team and serve as the Audit Engagement Partner with **Mollee Key** serving as Audit Manager and **Tommy Bowen** as the Senior Associate. We have also included **Ralph Llewellyn**, a leader in our Healthcare Industry Group, serving as a Technical Review and Consulting Partner. These professionals bring strong credentials and a desire to work with the District. If awarded these engagements, these individuals will serve as your primary contacts. Additional resources will support the project team as necessary.

Because we are committed to the healthcare industry, we provide our professionals, as well as our clients, with specific, ongoing training related to new and common issues.

Staff Members

All of our seniors have more than two years of experience in public accounting and specialize in the healthcare industry. Once an agreeable timeline has been determined, we will assign talented staff members to your engagement.

SERVICE TEAM

We know the importance of a strong business relationship, so we keep staffing changes to a minimum year-to-year. Eide Bailly has a high retention rate, allowing us to provide stability. You'll find profiles for each team member in **Appendix A**. The following information will provide an overview of your service team:

David Showalter, CPA – ENGAGEMENT PARTNER

David Showalter will serve as the engagement partner and will direct the activities of the team, coordinating all services, and ensuring the timely delivery of quality of service. He has more than 20 years in public accounting with experience in the healthcare, governmental and not-for-profit industries throughout his career. David serves as the partner in-charge for Arrowhead Regional Medical Center, San Joaquin General Hospital, Gateways Hospital and Mental Health Center, and serves as the technical review partner for Ventura County Medical Center/Health System. David is a California Certified Public Accountant and is a Department Head for the firm's Northern California Offices.

Ralph Llewellyn, CPA – TECHNICAL REVIEW/CONSULTING PARTNER

Ralph will serve as the Technical Review/Consulting Partner. He has actively provided operational and reimbursement consulting services to CAH clients for several years. Ralph has over 20 years of experience, and as a former CFO of a rural hospital and long-term care provider in North Dakota, he identifies with the situations faced by the CFOs of CAHs and long-term care providers. He is the Partner-In-Charge of the Critical Access Hospital Market Segment for Eide Bailly and is a frequent speaker for the State and National organizations presenting on operational, reimbursement and strategic initiatives. Ralph s located in our Fargo, ND office.

Mollee Key, CPA – AUDIT MANAGER

Mollee will serve as the Manager overseeing the audit engagement. She will coordinate the activities of the engagement team with the staff assigned to the audit. She will work with Scott to make sure your needs are met during the audit, as well as throughout the year. The District will benefit from Mollee's expertise and experience. She has over 6 years of accounting experience providing audit and consulting services to a variety of clients, with a focus in healthcare facilities and nonprofit CAHs. Mollee has supervised hospital engagements ranging from CAHs from $20 million in revenue to over $80 million, as well as health systems with over $1 billion in revenue. She also brings health insurance experience to the engagement, experience in the development of models to assess and track PPP and federal relief funding and will be onsite during the audit engagement.

Tommy Bowen, CPA – SENIOR AUDITOR

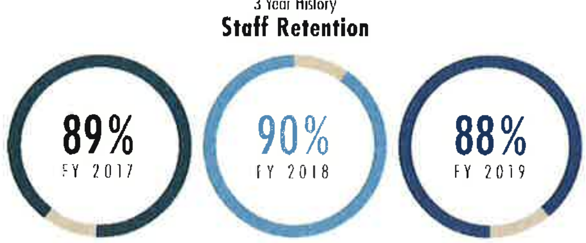
Tommy Bowen will serve as the in-charge and will be responsible for the daily audit work, supervision of staff and execution of audit plan for the District. He has more than 6 years in public accounting with experience in the healthcare industry throughout his career. His focus has been on performing audits of healthcare agencies, cities, counties, special districts and other local governmental entities. Tommy holds the Certified Public Accountant (CPA) designation and is located in our Sacramento, CA office.

Affirmative Action

Eide Bailly adheres to the principles of Affirmative Action through our daily human resources and business operations practices. All members of Eide Bailly operate within the Affirmative Action guidelines and value its objectives.

Staff Continuity

To help ensure a strong business relationship and to minimize disruptions, we keep staffing changes to a minimum. Compared to the national average, Eide Bailly experiences a high retention rate which translates to providing our clients with consistent service teams. We will strive for continuity of staff for your engagement. With this continuity comes quality, as team members' knowledge of your organization grows from year to year.



Should the need arise to change any of the key engagement personnel, we will notify you in writing and provide the qualifications of the proposed replacement. Upon your approval, new engagement personnel will join your service team.

Continuing Education

Because we are committed to the industries we serve, we provide our professionals with specific, ongoing training. This investment ensures our people stay current on the unique challenges and opportunities within the industry sectors so that they are in the best position to help clients address these issues.

Firmwide, our continuing professional education (CPE) program requires all professional staff obtain education that exceeds the requirements of the American Institute of Certified Public Accountants (AICPA). The firm places a strong emphasis on lifelong learning and recognizes the importance of developing our professionals to best serve our clients. In addition, we regularly share information among the audit teams in different offices to ensure we are providing clients with the latest thinking and best possible solutions.

In addition, for the past 27 years, we sponsor an annual healthcare retreat, bringing all of the industry partners, managers, and senior associates together to discuss the healthcare industry. The focus of this retreat, in addition to industry knowledge, is team building. As our healthcare practice functions in essence as its own office, this team building is vital to deliver quality service and to work across physical office locations with limited barriers. By expanding our knowledge of issues important to you, we are able to provide more in-depth, knowledgeable solutions to our clients.

Services

A CUSTOMIZED SERVICE APPROACH

Eide Bailly's service approach is customized to the healthcare sector and the financial issues most important to this industry. We do not take an approach used for other industries and make it "fit" for healthcare entities. We understand the unique nature of auditing healthcare organizations, particularly, CAHs and incorporate that into our approach.

Specific ways in which our audit approach will provide value to the District include the following:

- Staff, managers and partners who will be involved during fieldwork are experienced in working with healthcare entities. These individuals spend the vast majority of their time working with healthcare clients; they know what to look for and which financial issues and risk areas are of most importance.
- We build a high-level of partner and manager involvement into our audit services so that clients have access to our most experienced people.
- Collaborative, not combative, communication is a hallmark of our communication style. We do not "dictate" a response to our clients, but instead work to develop solutions that are acceptable to all parties.
- We focus on being proactive in communication so that management is able to use information in a timely manner. This approach makes the audit a better experience for everyone and avoids surprises. In our role as auditors, we are exposed to a significant amount of information regarding organizations' financial results and how they address different issues. That information will be regularly shared with management to provide them with a greater understanding of the approach taken by their peers, as well as the results achieved by them. We have also gathered a significant amount of industry data and have developed a database of information that can be used to benchmark your organization. We provide this information as a service to our clients.

- Timely does not mean "just in time." By focusing on planning and communicating with management throughout the audit, reimbursement and tax processes, we are able to create a better overall experience that goes beyond the delivery of the audit report by a certain deadline.
- We employ a "peer to peer" versus "teacher to student" relationship. We view our clients as peers. While this may seem like an obvious practice that should be found across the industry, our clients tell us that our relationship focus is different – and refreshing.

To ensure effective communication throughout the audit, we work with clients to establish communication protocols at the start of the engagement, which results in higher levels of client satisfaction. Our team will meet with members of management to determine the frequency and format of communication you would like so that we can provide the necessary information. We will also meet with members of the Board of Directors as necessary to discuss the audit process and identify any issues or concerns they may have; or issues we should be aware of when planning the audit.

We have found when we work with our clients, rather than for our clients, the professional services rendered take on a much higher value.

Audit Approach

Our audit approach is designed to collaborate with the District to achieve optimal value. The approach consists of certain major components: Planning and Pre-Work, Interim Work, Fieldwork, and Reporting. In particular, to ensure a smooth transition, we spend additional time in the first year prior to yearend to understand your business, financial statements and internal control processes, so that we can plan an effective and efficient first year audit. We have significant experience in obtaining new work and with CAHs, therefore, we believe we have created a smooth and effective process.

The objectives and timing of each component are described in the following:

Planning and Pre-Work

- Gain knowledge of organization and environment, including via review of predecessor workpapers.
- Perform analytical procedures to identify audit risk areas.
- Evaluate the nature of the operating environment (for example, changes in volume, degree of system and reporting centralization, sensitivity of processed data, the impact on critical business processes, potential financial impacts and economic and regulatory environment).
- Discussions with management and accounting staff, including the Board, to address any risks or concerns that they may have.
- Determine audit procedures by area, based on results of audit planning.
- Prepare listing of audit information requested from organization.
- Discuss and finalize the engagement timeline, audit approach and process.

Interim Work

- Review of interim financial information and reports to identify significant risks early.
- Review of significant estimate areas and consideration of underlying assumptions early in process in order to come to an agreement on methods, approach and positions.
- Documentation of internal control systems, including IT, and related changes from prior periods.
- Consideration of fraud, risk of noncompliance, illegal acts, abuse, etc.
- Assessment of audit risk and identification of potential audit issues.
- Preparation and communication of audit request lists and work papers.
- Discussions with management to determine internal controls, perform walk-throughs and discuss any potential audit issues.
- Determine audit procedures by area, based on results of audit planning and risk assessment.
- Review minutes, resolutions and ordinances.
- Review implementation of new accounting standards and impact on reporting.

Fieldwork

- Audit areas based on risk assessment.
- Obtain and prepare schedule and analyses supporting the financial information.
- Daily updates to management.
- Assess cost report estimate based upon preliminary cost report.
- Exit conference with management to discuss findings and results.

Reporting

- Review of the financial statements by the partner over the engagement.
- Review of financial statements by a partner not otherwise associated with the audit to obtain a "second opinion" on the completeness and adequacy of financial statement disclosures.
- Completion of management letters and review with management.
- Preparation of other communications to management and Board.
- Presentation to Finance Committee or Board at its regularly scheduled meeting.

Ongoing Communication

- Obtain interim financial statements throughout the year for review.
- Analyze significant changes and identify areas to further tailor our audit plans and to keep us up-to-date with continuing changes.
- Participate periodically at your Board meetings, and any other meetings, at the Board's request.

TENTATIVE SCHEDULE

Upon appointment as your auditor, we will discuss a proposed engagement schedule and work with you to ensure the timetable meets your needs and makes the most effective use of staff members' time.

The schedule below indicates the schedule we would expect on an ongoing basis; however, in the initial year, based upon our discussion, we would expect that reporting would occur in November/December. We understand from our discussions with you that this would meet your reporting requirements. In addition, we do expect that we would begin working with you in the summer to develop the approaches and initial estimates, however, we expect that we would need to work with you through year end to ensure that an appropriate estimate(s) is made for financial reporting in the initial year of the audit.

Audit Schedule

We will work closely with your team through the planning stages to clearly define expectations and the items required in order to facilitate an efficient audit which will enable us to meet your deadline. The following table identifies the overall timing and structure of our audit for ongoing years and the timing of each section. *See discussion above for initial year timing considerations.*

Audit Timeline

Activity	Timing									
	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb
Planning/Pre-Work										
Interim										
Fieldwork										
Reporting										
Ongoing Communication										

SMOOTH TRANSITION

Our goal is to make the transition as smooth as possible. We will manage the transition to minimize time demands on your employees and ensure a timely first year audit in accordance with professional standards.

We are experienced in transitioning many clients from predecessor professional service providers. In each case, we worked closely with client personnel and accomplished the transition with minimal disruption of client activities. The following are some of the critical activities we perform to make the transitions successful.

- Spend more time in the planning stages of the audit to understand accounting and operational processes.
- Identify any issues during the planning stage and have them resolved before starting the audit.
- Review current auditor's workpapers to help us understand what the District provided regarding schedules and other documentation. We will modify our requests to match what the District has seen in the past.
- Partners and managers spend more time in the field so when issues are identified they are resolved in the field and not at the end of the audit.
- Continue ongoing communications with management during the audit process and throughout the year.
- **Meet your deadlines and expectations!**

Cost Proposal

VALUE FOR YOUR FEES

We propose the following fees based on our understanding of the scope of work and the level of involvement of the District' staff:

Engagement Services and Fees

Professional Services	2020	2021	2022	2023	2024
Financial Statement Audit	$33,000	$33,000	$40,000	$44,000	$44,000

Fees in subsequent years will be adjusted based upon inflation and subject to any significant changes in your business or new accounting standards that apply. Our fees also assume the District will draft all financial statements and related notes to the financial statements.

Out-of-Pocket Fees

In addition to the professional fees listed above, you will be billed for actual out-of-pocket expenses such as travel time, mileage, lodging and meals. While we look forward to future onsite and face-to-face discussions with you regarding your business and operations, and believe there is value to such dialogue, given our ability to use technology and remote capabilities, we can certainly discuss options to reduce such costs.

Billing Policy Regarding Telephone Inquiries

We know clients appreciate access to all of their service team members. We embrace this opportunity for constant communication and will ensure our team members are available when you have questions and issues. This service is included in the scope of the engagement. If a particular issue surfaces that falls outside the scope of this engagement, we'll bring it to your attention and obtain approval before proceeding.

References

SIMILAR CLIENTS AND SERVICES

We recently asked our clients what they value most about their relationship with our firm. Industry knowledge, attentive service, genuine advice, and friendly people were just a few of the responses we received. Our clients are truly the best critics of our service.

We encourage you to contact our clients to learn about their Eide Bailly experiences.

Similar Clients

Schoolcraft Memorial Hospital
Boyd Chappell
Chief Financial Officer
906.341.3233
bchappell@scmh.org

Arrowhead Regional Medical Center
Arvind Oswal
Chief Financial Officer
909.580.6170
oswala@armc.sbcounty.gov

Tomah Memorial Hospital
Joseph Zeps
Chief Financial Officer
608.377.8681
jzeps@tomahhealth.org

Dickinson County Healthcare System
Debra Hanson
Controller
906.776.5518
debra.hanson@dchs.org

Additional Resources

LET US HELP YOU WITH MORE

We understand working with experienced professionals that understand healthcare is important to you. Our diverse team of consultants serves as an ongoing resource to our audit professionals and is always available to answer questions related to operations, reimbursement, contractual arrangements, billing, and a variety of other items.

By seeking professionals with a wide range of backgrounds, including management, risk and governance, controls, compliance, strategy, operations, nursing, financing, revenue cycle and coding, health information management, and reimbursement, we can provide answers to most questions our clients may have or can direct them to other external resources. This team of healthcare consulting professionals serves not only as a direct resource to our clients, but as support to the professionals serving you.

Our consultants continually conduct training sessions with our compliance group to share their knowledge. This allows our compliance group to keep current on reimbursement and other healthcare industry changes. During the delivery of services, we will frequently be asked about, or will notice during the course of our documentation review, issues in areas such as billing, coding, operations, information technology, compliance or compensation. Our extended service team is always available to provide clear answers and direction in a timely fashion.

The consulting team works with you and our other service teams to provide a seamless delivery of services. The District may elect to utilize the depth of resources available to them through our wide variety of financial and other consulting services. However, regardless of whether or not the District chooses to utilize these services, our industry knowledge will be leveraged into each service we provide.

As previously noted, we also provide monthly email updates on fast emerging issues through our industry groups on topics such as regulatory changes, reimbursement, industry trends, etc. We publish e-blasts on an as-needed basis to keep our clients, prospects and business friends informed on the current news. These e-blasts are provided free of charge.

Strategic Reimbursement Services

Eide Bailly has a dedicated team of professionals versed in the area of third-party reimbursement. The team specializes in the area of Medicare and Medicaid Regulations and their reimbursement impact. We specifically have deep experience in areas such as IME/GME, upper payment limit programs, Medicare bad debts capture and reporting, wage index, and provider-based reimbursement impacts. The team provides cost reporting services to over 500 clients nationwide, includes a dedicated group with extensive PPS consulting experience and has great depth in the area of Strategic Reimbursement and getting the most out of your reimbursement. This team has grown in a very complex environment and is well suited to meet the challenges as the healthcare payment structure changes.

CAH Cost Report Model

We understand the reimbursement issues faced by the District. We also recognize the importance of our CAH clients to be able to reasonably estimate the settlement amount from Medicare for the current cost reporting period throughout the year. In response, we have developed a Critical Access Hospital Reimbursement Model (CAH Model) to assist our clients with this estimate. The CAH Model may eliminate the need and investment in Interim cost reports.

- Industry-leading Microsoft Office Excel-based spreadsheet that is customized to your unique operations.
- Provides accurate interim financial information.
- Designed to flex accordingly when you experience a significant swing in cost or volume.
- Updated regularly to reflect changes in regulations as well as to incorporate client suggestions.

Eide Bailly's CAH Model is customized to a hospital's unique operations. Data to be used includes information from previously filed cost reports and current year data. The CAH Model estimates settlements using a CAH's current volumes and costs. Since the tool uses current year-to-date operations (ongoing basis), it is designed to flex accordingly when a CAH experiences a significant swing in volume or costs during the current year.

Clients appreciate the minimal time it takes to update the model monthly. The monthly trial balance is imported into the model, monthly statistics are entered, and in seconds, clients can see what their financial position is relative to Medicare. The CAH model is a powerful tool that provides clients with the Medicare data that they need when they need it.

It should be noted that laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. While the CAH Model does not guarantee perfect results, our clients utilizing the CAH Model have been able to generate reliable financial information. This enables them to more effectively manage their operations and reflect the estimate for third-party payor settlements to be included in the monthly financial statements for internal reporting.

Operational Process Improvement Services

Eide Bailly has worked with many healthcare facilities in assessing operations. This work includes establishing department productivity benchmarks, assessing process and work flow issues, and service line analysis. As a result, our clients manage staffing levels more effectively, eliminate inefficient work, and provide service level profitably reports to leadership. Proper revenue and expense (fixed and variable) mapping, contractual allocation, and overhead cost allocation are all part of the service level report. Our goal is to help our clients become effective ('doing the right things') and efficient ('doing things right') in their day-to-day operations.

Strategic Financing

We have a dedicated team of professionals providing strategic financing services to healthcare clients nationwide, including forecasted financial statements, board education, and debt capacity studies. In addition, we have assisted clients in departmental budget processes, development and training, physician supply and demand modeling, market demand studies, and other strategic financial planning and analysis scenario and sensitivity projections. Eide Bailly has conducted numerous financial forecasts annually ranging in size from under $10 million to over $100 million for healthcare organizations looking into expansions, renovations, or replacement projects.

Chargemaster Review

For over 20 years, our team has provided onsite hospital chargemaster reviews that are designed to assist providers in meeting the billing requirements of Medicare, Medicaid and commercial payers. These reviews consist of more than a review of current procedural terminology (CPT) codes, revenue codes and charge descriptions. Our review process not only provides recommendations to correct billing and reimbursement issues but focuses on educating your staff regarding the underlying theory of billing that is necessary to help maintain chargemaster compliance after our review.

A perfect chargemaster is not enough if your team is not properly capturing charges for the services rendered. Our chargemaster review process includes the review of a sample of patient claims and charts depending on the services provided and size of the facility to determine the adequacy of the charge capture process. Our findings are included in our reports with recommendations on how to better capture the charges related to services rendered.

The Advisory Board Company

The Advisory Board is an important resource for healthcare entities searching for ideas and benchmarks to help improve their operations. Eide Bailly is a member of and sponsors this important thought leadership organization. We are one of the few accounting firms with this level of involvement and access to this resource. Our firm works with and utilizes the Advisory Board expert researchers and seasoned consultants to help identify cutting edge solutions to the toughest challenges that hospitals face. Since we are one of the few accounting firms who have this level of involvement in this important resource, we are well positioned to share this valuable industry thought leadership with you.

Information System Review Experience

Compliance with HIPPA, HITECH and the sheer reputation risk present with the storage of patient and member information is a constant challenge for any integrated health delivery organization. Preventative controls are the first step toward a secure environment and an understanding of the IT system safeguards has become a more important aspect of the audit.

Although incidence response is a prospective risk, the prevalence of breaches is requiring this to become a significant focus of the approach, given the timing it takes to become aware of a breach, identify the records affected and control a response. These plans are quickly becoming the most effective way to mitigate the financial impact of a breach.

We annually complete an evaluation of the information technology general controls within the District's IT environment in conjunction with the audit, as well as any key controls in areas where system related controls are critical to the financial reporting process. The purpose of this evaluation is to conduct a risk assessment of the controls within the District's IT environment as related to financial statement reporting.

Relevant Information to the District

The IT General Controls Review includes a review of IT Controls in the following categories:

- IT Governance – Policies and Standards.
- Change and Confirmation Management.
- Fault Tolerance, Incidence Response Plan and Data Recovery (Business Continuity and Data Recovery).
- Network Administration and Monitoring, including Logging and Intrusion Detection.
- Logical Access and Audit Controls.
- Physical Security and Environmental Controls.
- Technology Service Provider.
- Management Monitoring and Remediation of Results of Recent Penetration Tests.
- Software Development Life Cycle

The IT General Controls Review will be planned to occur prior to year-end. During this phase, a detailed list of the IT controls and test procedures will be reviewed, updated and agreed upon with the District in advance of work commencing. A series of test procedures will take place based on the control being reviewed, including a combination of observation, verification, interviews and walk through tests. We will then analyze controls through year-end to determine the extent, if any, of additional testing. While this analysis may not identify all controls and defenses against cyber-attacks, cyber security is considered when reviewing the design and operational effectiveness of IT internal controls.

Client experience has shown that we have been successful in ensuring we focus our tests to those IT controls that meet the objective as it relates to financial reporting, which minimizes disruption of your team.

System Implementation

We understand the District will be implementing a new Electronic Health Record (EHR) system during the term of the agreement. While a post-implementation review of the system is not required, we believe Eide Bailly is highly qualified to assist and review the implementation of the new system. The majority of our healthcare clients have recently implemented new EHR systems, including Cerner, EPIC, Cerner, and Nextgen. We have performed procedures to ensure the systems were qualifying systems and performed procedures to test implementation and conversion of data.

The following audit strategy used when clients implement new financial or billing systems is a two-fold strategy:

1) Eide Bailly will determine that the District appropriately tested and validated post-implementation to ensure that the controls operate as intended and support financial reporting requirements, and that the information produced by the system is complete; accurate, and valid. The business process owners, third-parties (as appropriate), and IT stakeholders should formally sign-off on the outcome of the testing process as set out in the testing plan.

2) Eide Bailly will perform interviews, reviews of information and sample testing related to the implementation to gain comfort with the new financial system.

For the first process, Eide Bailly will verify:

- that the data from the legacy system was migrated accurately and completely to the new system by examining the methodology of the migration procedures for reasonableness, including interview of key finance and IT personnel.
- that the District conducted testing to determine that the new system is accurately and completely capturing data feeds from the subsystems, as necessary.
- depending on the type of modules that will be used, ensure that the District has determined that the proper system parameters and automated controls have been set up and are functioning as expected.
- that the District has determined that the new system is accurately and completely reporting data for financial (including GAAP and Statutory) and managerial reporting purposes.
- that the District has set up the system so that there is proper segregation of duties.
- that there is proper logical security over the system, including user access administration.
- that key system calculations and reports were tested during the user acceptance phase of implementation.
- that there was IT staff training conducted related to the maintenance and support of the new system.

For the second process, Eide Bailly will interview key personnel, examine controls and selectively test:

- the reconciliation of data between the legacy system and the new system.
- the system's accuracy and completeness in capturing data feeds from the subsystems, when necessary.
- the segregation of duties that exist on the new system.
- the methods for granting and controlling privileges including role-based access controls, and
- the management of superuser rights, logs and audit trails.

Eide Bailly will then determine that the District has set up appropriate job scheduling and batch processing, that sufficient change controls are in place, that IT staff has implemented sufficient backup and disaster recovery procedures and that the Accounting staff has been adequately trained on the new system and that a level of reference documentation exists to support the efficient use of the system.

As part of any audit, Eide Bailly is required to understand how the system collects and processes data as well as the controls implemented within the system. We will obtain an understanding of how the District uses each module of the system to collect, process and transmit information to the appropriate employees, as well as an understanding of the controls in place over input and access to data and controls over changes to the data files and the particular features of the software.

Cybersecurity

Our professionals have deep IT backgrounds, specializing in a broad range of security services and allowing us to tailor solutions to your needs. We work with every level of your organization—your boards and executives, technical IT admins and general users—to provide insight and guidance so you can feel confident your data is protected.

IT Consulting

Business planning and technology strategy go hand-in-hand, like having a good offense and defense. You can't win the game without planning for both. Whether you want a better way to power your decision making, a simpler way to run your organization, or you just want to see a return on your technology, a solid strategy always comes first. Our business consultants will help you define your goals and business needs so that your technology game plan keeps you winning.

Internal Audit

Our internal audit professionals bring strong process, procedure, internal control and risk management experience to your organization. We bridge these skills with specialized insight related to risk and compliance and specific industry knowledge to help your organization reduce risk and improve operational efficiency.

Forensic Accounting

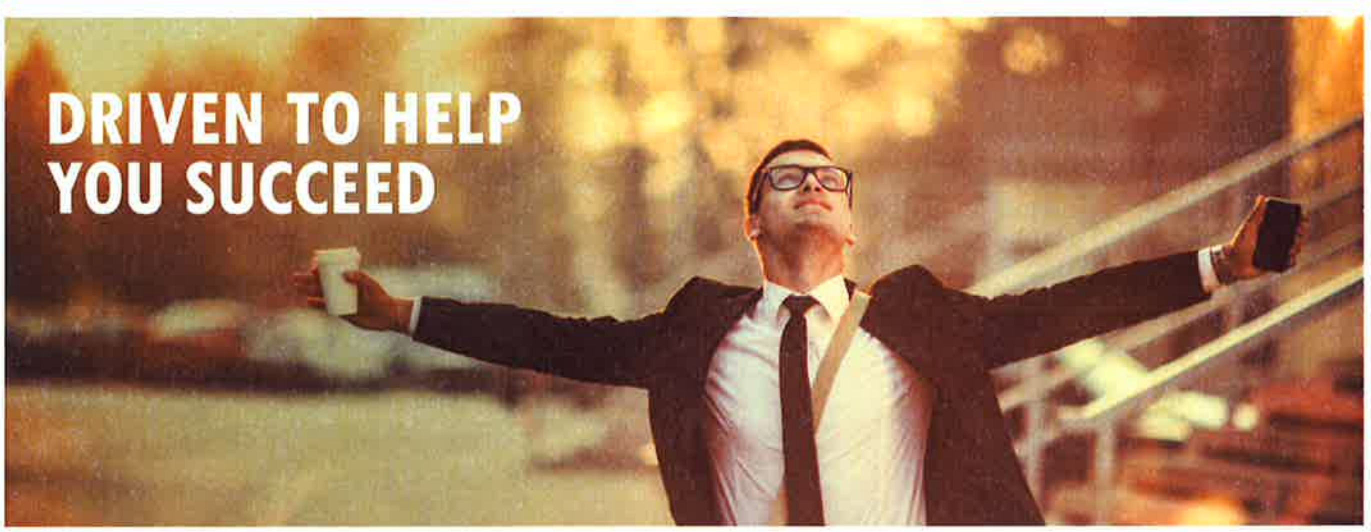
We have seasoned professional with years of relevant investigative experience. Our forensic accountants are experienced in assisting with internal, civil, criminal and insurance recovery investigations related to allegations of theft, fraud and accounting irregularities. The forensic methodologies and technology used by our team of specialists help get to the facts of these situations and are court proven. We understand the urgency of resolving these types of matters and take pride in delivering a quality work product in an efficient and timely matter.

National Tax Office

Eide Bailly's National Tax Office serves as a resource for clients to help analyze complex tax issues related to business decisions. Our professionals are committed to helping clients stay informed about tax news, developments and trends through various specialty areas, including accounting methods and periods, cost segregation studies, state and local taxation, international tax, tax exempt organizations, tax controversy, research and development tax incentives and tax legislation. We draw on professionals who specialize in keeping abreast of legislative actions, share updates regarding tax news, developments and trends; and have the vision to continually develop and offer services that bring value and meet our clients' changing needs. The National Tax Office regularly publishes tax update e-newsletters, insights and hosts relevant workshops and webinars to keep our clients aware of emerging issues.

State and Local Tax (SALT)

Eide Bailly offers a variety of SALT services to help your organization get into and remain in compliance. Our consulting services include registration assistance, where we can complete or review state and local tax forms, as well as respond to state inquiries and notices or assist in preparing a response. Our professionals conduct state and local tax research for clients and provide training on these tax matters. Other key SALT areas include income taxes; franchise, gross receipts and net worth taxes; sales and use taxes; credits and incentives; employment taxes; abandoned and unclaimed property; and property taxes.



Why Choose Eide Bailly

WE WANT TO WORK WITH YOU

Work isn't just work. We see it as a chance to help you solve problems, achieve goals and pursue passions.

We can connect you with the knowledge, resources and solutions that help bring confidence to your business decisions. **We want to work with you!**

If you have questions or would like additional information, don't hesitate to contact us. We want to make sure you have everything you need to make your decision.

David Showalter, CPA
Partner
916.999.8502
dshowalter@eidebailly.com

What inspires you, inspires us.

We're driven to help clients take on the now and the next with inspired ideas, solutions and results. We look forward to working with you.

Appendix A – Team Profiles

TEAM PROFILES

DAVID SHOWALTER, CPA

Partner

INSPIRATION: I truly enjoy serving my clients and assisting them with complex accounting and financial reporting issues. What really excites me is developing long-term business relationships with my clients and building on that trust and relational experience to continuously provide the highest level of service.

916.999.8502 | dshowalter@eidebailly.com

David has focused his practice on conducting audits and advisory services for state, regional and local governments, including health care providers. He is responsible for the oversight of audit and advisory engagements and also, as appropriate, for the recommendation of internal control structures and best practices.

The healthcare industry is one that continues to grow rapidly within California, and the regulatory environment continues to provide our clients with challenges in meeting the needs of the public while adhering to the reporting and compliance requirements that come with receiving federal and state dollars. The hospitals and healthcare facilities that David works with include both nonprofit organizations as well as governmental healthcare facilities.

David provides annual training to firm staff through in-house continuing professional education to ensure consistency and knowledge are not just at the partner level but also with the entire team providing services to our clients. He also provides annual audit and accounting updates for many of his governmental clients and industry groups.

David's clients trust his level and depth of knowledge of the reporting and compliance requirements under generally accepted accounting principles, including changes promulgated through the Governmental Accounting Standards Board (GASB), Financial Accounting Standards Board (FASB), Generally Accepted Government Auditing Standards and the Federal Uniform Guidance. With David's experience working with a variety of governmental, healthcare and not-for-profit entities, he provides a unique perspective to his clients and in the evaluation of their financial reporting, internal controls and governance.

Client Work

More than 19 years conducting audits of governmental and not-for-profit entities.

Serves on the CalCPA Governmental Accounting & Auditing Committee.

Served on a consultative group for the Governmental Accounting Standards Board (GASB).

Memberships

American Institute of Certified Public Accountants

California Society of Certified Public Accountants

Designation/Licensures

Certified Public Accountant

Education

Bachelor of Science, Business Administration, Accounting – California State University, San Bernardino

RALPH J. LLEWELLYN, CPA

Partner-in-Charge of Critical Access Hospitals

INSPIRATION: I enjoy providing innovative solutions to the challenges in today's health care environment.

701.239.8594 | rllewellyn@eidebailly.com

Ralph conducts operational assessments to assist providers in enhancing financial and operational performance, including financial strategies for financial turnaround of healthcare facilities. He provides chargemaster/cost report audits and redesign projects, and he conducts reimbursement enhancement studies for healthcare providers. He assists providers in developing physician compensation agreements.

Clients can expect creative solutions to the challenges they encounter in the healthcare environment. Ralph has a passion for rural healthcare and its providers and is not afraid to pull up his sleeves and get in the trenches with clients.

Having had an interest in the magical arts from childhood, Ralph's first job was behind the counter at a local magic shop. Thinking outside the box, he funded much of his college education performing his magical skills on stage. Years later, he still entertains friends and family with magic. Ralph also brews his own beers (he loves a good India Pale Ale) and gets his exercise on the golf course.

Client Work

Developed a strategy to turn around a facility that was hemorrhaging financially. The facility is now financially sound.

Assisted a hospital and independent clinic in a rural area come together under a single operation. Individually, they were performing poorly and not meeting the needs of the community. Now together, they are building a model that will meet the needs of the community and will deliver better financial results.

Developed a new physician compensation model to better incentive physicians to improve overall productivity. The net result was a physician group that acknowledged they had too many providers on staff, supported a reduction in total physician staffing, and improved their individual productivity and compensation.

Memberships

North Dakota Healthcare Financial Management Association, Past President

American Institute of Certified Public Accountants

Designation/Licensures

Certified Public Accountant

Current nursing home administrator licensure in North Dakota

Certified Healthcare Financial Professional

Education

Master of Business Administration – University of North Dakota, Grand Forks

Bachelor of Science, Accounting – Minot State University, North Dakota

Bachelor of Arts, Business Administration – Minot State University, North Dakota

Community

Frequent presenter and lecturer on healthcare topics at state and national conferences

Roger Maris Celebrity Golf Tournament, Committee Member

MOLLEE KEY, CPA

Audit Manager

612.253.6679 | mkey@eidebailly.com

Mollee supports the healthcare, health insurance and nonprofit organizations in audit and assurance services. She provides knowledge and experience in appropriate application of accounting pronouncements applicable to healthcare organizations.

Client Work

Leads audit engagement teams for healthcare organizations, including planning, performing, supervising and reviewing engagements, and communicates audit results through reports and presentations to management, audit committees and boards.

Provides oversight for numerous statutory insurance audits as well as other compliance work for insurance companies.

Knowledgeable in both U.S. Generally Accepted Accounting Principles and Statutory Accounting Principles.

Plans and performs Uniform Guidance (formerly A-133) audits to healthcare and nonprofit organizations which receive federal funds.

Assesses accounts receivable and third-party reserve models and has worked with CAHs in the development of realization model analysis approaches. Has extensive experience in the preparation of financial statements, including the implementation of new standards.

Reviewed, tested and provided recommendations on Internal Control improvements and efficiencies.

Researched issues and developed disclosures related to hospital disclosures.

Memberships

American Institute of Certified Public Accountants

Minnesota Society of Certified Public Accountants

Healthcare Financial Management Association

Designations/Licensures

Certified Public Accountant

Education

Bachelor of Science, Accounting and Business Administration – Winona State University, Minn.

TOMMY BOWEN, CPA

Senior Associate

INSPIRATION: "I find great pleasure in providing exceptional audit services to my clients. I strive to provide value and quality to assist my clients in achieving financial reporting and operational excellence."

916.999.8514 | tbowen@eidebailly.com

Tommy has several years of experience in audit and assurance including servicing a variety of governmental agencies, from cities and counties to various districts and agencies.

When you work with Tommy, you can expect professional and quality work. He caters to all his clients' needs by understanding their businesses and key risks.

Outside of work, Tommy enjoys unplugging from systems - spending quality time with his family and being outdoors.

Client Work

Provides value to organizations by working through their transaction cycle processes and organizational design to identify risks and recommend best practice solutions.

Memberships

American Institute of Certified Public Accountants

California Society of Certified Public Accountants

National Eagle Scout Association

Designation/Licensures

Certified Public Accountant

Education

Master of Science Business Administration, Accountancy – Sacramento State University

Master of Science Business Administration, Taxation – Sacramento State University

Bachelor of Arts, Liberal Studies – Cal Poly, San Luis Obispo

Appendix B — Peer Review

PEER REVIEW

Report on the Firm's System of Quality Control

December 28, 2017

To the Partners of Eide Bailly LLP and the
National Peer Review Committee

We have reviewed the system of quality control for the accounting and auditing practice of Eide Bailly LLP (the firm) applicable to engagements not subject to PCAOB permanent inspection in effect for the year ended July 31, 2017. Our peer review was conducted in accordance with the Standards for Performing and Reporting on Peer Reviews established by the Peer Review Board of the American Institute of Certified Public Accountants (Standards).

A summary of the nature, objectives, scope, limitations of, and the procedures performed in a System Review as described in the Standards may be found at www.aicpa.org/prsummary. The summary also includes an explanation of how engagements identified as not performed or reported in conformity with applicable professional standards, if any, are evaluated by a peer reviewer to determine a peer review rating.

Firm's Responsibility

The firm is responsible for designing a system of quality control and complying with it to provide the firm with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. The firm is also responsible for evaluating actions to promptly remediate engagements deemed as not performed or reported in conformity with professional standards, when appropriate, and for remediating weaknesses in its system of quality control, if any.

Peer Reviewer's Responsibility

Our responsibility is to express an opinion on the design of the system of quality control and the firm's compliance therewith based on our review.

Required Selections and Considerations

Engagements selected for review included engagements performed under *Government Auditing Standards*, including compliance audits under the Single Audit Act; audits of employee benefit plans, audits performed under FDICIA, and examinations of service organizations [SOC 1 and SOC 2 engagements].

As a part of our peer review, we considered reviews by regulatory entities as communicated by the firm, if applicable, in determining the nature and extent of our procedures.

Opinion

In our opinion, the system of quality control for the accounting and auditing practice of Eide Bailly LLP applicable to engagements not subject to PCAOB permanent inspection in effect for the year ended July 31, 2017, has been suitably designed and complied with to provide the firm with reasonable assurance of performing and reporting in conformity with applicable professional standards in all material respects. Firms can receive a rating of *pass, pass with deficiency(ies)* or *fail*. Eide Bailly LLP has received a peer review rating of *pass*.

Cherry Bekaert LLP

Cherry Bekaert LLP

Caring for our external and internal clients with a passion to go the extra mile.

Respecting our peers and their individual contributions.

Conducting ourselves with the highest level of integrity at all times.

Trusting and supporting one another.

Being accountable for the overall success of the Firm,
not just individual or office success.

Stretching ourselves to be innovative and creative, while managing the related risks.

Recognizing the importance of maintaining a balance between work and home life.

Promoting positive working relationships.

And, most of all, enjoying our jobs ... and having fun!

What inspires you, inspires us.
eidebailly.com

111 S. Tejon Street, Suite 800 | Colorado Springs, CO 80903-2286
719.471.4290 | Fax 719.632.8087 | bkd.com

June 5, 2020

Ms. Genifer Owens
Controller
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93515

Dear Ms. Owens:

While Northern Inyo Healthcare District (the District) focuses on fulfilling the mission and vision of your organization, you recognize the importance of receiving quality professional services from a reputable CPA and advisory firm. You need accessible advisors who can provide proactive, tailored guidance, as well as the experience and resources you require. We believe BKD CPAs & Advisors is that firm.

Our advisors have a broad range of knowledge gained from working with thousands of health care providers nationwide. Working with BKD could mean forging a strong working relationship with a business advisor and team backed by a firmwide network of industry-focused thought leaders. We understand the financial demands rural health care providers face. BKD also is involved with national and state industry associations, as well as helping develop industry accounting and auditing standards. We frequently present at national, regional and local conferences, as well as participate on industry committees that help shape the accounting and regulatory requirements for health care providers and government organizations. We can provide the District a fresh look at your compliance with regulations, and our experience allows us to offer best practices, suggestions and tailored industry insights throughout the year.

Staying up-to-date with complex reporting requirements and changing accounting standards can prove challenging. At BKD, our team is armed with knowledge and insight to share best practices, ideas and specific recommendations that can help you maintain strong financial operations.

We believe our proposal will help you select our firm for timely, efficient and objective services delivered by experienced professionals. I will call you soon to answer questions you may have about this proposal, or you may reach me at 719.471.4290 or by email at tjrivera@bkd.com.

Sincerely,

Tammy J. Rivera, CPA
Partner
719.471.4290
tjrivera@bkd.com

Executive Summary

Payment reform. New regulations. Potential cuts in Medicare and Medicaid. The health care industry is becoming more unpredictable, while the need for better and more specialized care shows no sign of slowing down. Add monitoring your financial position and tax compliance, and your to-do list becomes that much longer. For Northern Inyo Healthcare District (the District) the reality is that all of these items need your attention. Choosing one over the other isn't an option, because they all affect your viability. BKD CPAs & Advisors is here to help. We're known for excellence among health care providers, and our numbers support this reputation. Health care providers nationwide depend on us to provide professional services efficiently.

Here's what you can expect from working with us:

- Advisors committed to connecting you to the tools and services you need to thrive
- A national network of advisors that includes clinical and nonclinical professionals, allowing for a well-rounded approach to your concerns
- Insight as you evaluate the new payment models shaping your industry
- Cost-effective professional services to help you demonstrate transparency and sound fiscal stewardship
- A high-quality audit approach supported by specialized IT and other resources
- Professionals who can help you understand and adapt to changing technologies
- Access to data analytics professionals who can help you sort through and translate the volumes of data you generate daily
- Strategies to help you improve operational efficiency and better mitigate risk
- An engagement staffing philosophy that prioritizes partner involvement and industry experience
- A smooth transition process focused on limiting disruption to your operations
- Experienced professionals who can work with the District to identify areas you believe may warrant a fresh look
- A consistent team of responsive professionals backed by the resources of a reputable national firm

Navigating Challenges Related to COVID-19

While no industry has been untouched by the outbreak of COVID-19, health care providers have been affected like no other. As you contend with a radically altered operating environment and evolving regulations, BKD is committed to helping the District stay informed and proactive. Our industry thought leaders have been monitoring events as they progress and evaluating strategies that could help our clients weather them more successfully. We can provide assistance with areas such as:

- Monitoring legislative changes
- Identifying strategies to improve cash margins and cash flow
- Evaluating IT considerations for a more substantially remote workforce
- Risk mitigation including navigating business interruption claims and assessing financing options
- Interpreting 1135 waivers and evaluating their potential effects on your operations
- Assessing whether you are following best practices to safeguard telehealth patient privacy and document visits appropriately, if applicable

We understand you are going to be facing unprecedented challenges for an indefinite period of time. As you encounter new questions, please know your trusted advisors at BKD are prepared to help. In addition, we invite you to visit **bkd.com/covid-19** for additional information as this crisis continues to evolve.

Service Description

The District has requested information and a fee quote for the following professional services:

- Financial Statement Audit in Accordance with *Government Auditing Standards* & Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (the Uniform Guidance)

Your Investment

BKD knows our clients do not like fee surprises. Neither do we. Our goal is to be candid and timely, and we want to answer your questions about fees upfront. We determine our fees by evaluating a number of variables: the complexity of the work, the project's scope, the time we will spend and the level of professional staff needed.

Proposed Fees

Northern Inyo Healthcare District	
For the Year Ending June 30	**2020**
Financial Statement Audit	$75,000 – $85,000
Audit of Federal Funds in Accordance with Uniform Guidance (per Major Program) **	$ 5,000 – $10,000

**The Provider Relief Funds received under the CARES Act will be subject to single audit requirements. It is subject to the audit requirements of the Uniform Guidance. While a CFDA number has been assigned, the compliance supplement is not yet available, therefore a cost estimate is difficult to determine at this time and could change based on final issued audit requirements. This audit requirement will only be applicable for the years in which you have $750,000 or more of federal expenditures.

In addition, you will be billed travel costs and an administrative fee of 4 percent to cover items such as copies, postage and other delivery charges, supplies, technology-related costs, such as computer processing, software licensing, research and library databases, and similar expense items. Our fees may increase if our duties or responsibilities change because of new rules, regulations and accounting or auditing standards. We will consult with you should this happen.

Our estimate of fees does not include any time that may be required to address a restatement of the previously audited financial statements. Accordingly, any such work will be billed based on our hourly rates, which we can provide upon request.

Your BKD Engagement Team

The most critical factor in providing you with high-quality service is choosing your engagement team. We take team selection seriously and have the appropriate team of advisors to meet your needs.

Tammy J. Rivera, CPA – Lead Healthcare Partner (for audit and/or tax services)

Jami L. Johnson, CPA – Audit Director

Lindie Eads, CPA – Senior Manager

Additional Resources

Rob MaCoy, CPA – Accounting and Auditing Director

Lea Geiser Hayler, CPA – Assistant Accounting and Auditing Director

Sherry Witzman – Reimbursement Director

Why Choose BKD

Delivering Value

It is important to monitor expenditures and receive exceptional value for your investments. However, informed consumers understand value is about more than just price. Value from a professional CPA and advisory firm is about the quality of the work and the merit of the advice. Expect BKD's work to be accurate and insightful. We stand behind it. Our Public Company Accounting Oversight Board (PCAOB) inspections and American Institute of CPAs (AICPA) peer reviews demonstrate the firm's record of excellence.

As evidenced by our inclusion in the **INSIDE Public Accounting** Best of the Best Firms list for the last nine years (as of August 2019), we also offer long-term consistency, exceptional performance and a national network of support and resources. BKD is large enough to help you address a variety of financial issues. At the same time, we pride ourselves on hard work and low overhead, which keep our fees competitive. With our reputation, size, service and experience, you can consider us a good value.

Thought Leadership

BKD advisors are serious about reinforcing their positions as thought leaders in the industries they serve. To help keep you informed about emerging issues in your industry, as well as changes in regulations and accounting and tax methods, we provide **BKD Thoughtware®** webinars, seminars, tailored training sessions, podcasts and articles. Many of these are eligible for continuing professional education (CPE) credit.

Unmatched Client Service®

You want trusted advisors who will deliver exceptional client service, focus on your needs and take the time to address your unique challenges. BKD understands. We take our commitment so seriously, we penned five standards of Unmatched Client Service and supporting guidelines in **The BKD Experience: Unmatched Client Service**, a book that articulates the firm's philosophy and sets expectations for serving clients. Those five standards are Integrity First, True Expertise, Professional Demeanor, Responsive Reliability and Principled Innovation.

Critical Access Hospital Experience

Through our work with critical access hospitals (CAH) nationwide, we have gained the expertise the District needs to help you remain compliant and receive appropriate reimbursement. We help our CAH clients evaluate cost report alternatives, monitor interim payment rates, plan strategically and thoughtfully consider other issues important to their success.

In addition, through our involvement in the National Rural Health Association (NRHA) and similar associations, we provide technical support to the advocacy efforts that help develop and improve the CAH program. Members of BKD National Health Care Group also have presented on CAH reimbursement and other issues at national, regional and state association meetings, including:

- American Health Lawyers Association Institute on Medicare and Medicaid Payment Issues
- Healthcare Financial Management Association Annual National Institute
- NRHA Annual CAH Conference
- Annual Western Region Flex Conference

Uniform Guidance Audit and Compliance Experience

BKD performs hundreds of Single Audits annually, focusing on two objectives: first, an audit of your financial statements and reporting on the Schedule of Expenditures of Federal Awards (SEFA) in accordance with *Government Auditing Standards*, and second, a compliance audit for federal awards expended during the fiscal year in accordance with the Uniform Guidance.

Approximately one-third of our not-for-profit and governmental clients receive federal funding. Our extensive experience with compliance testing in accordance with the Office of Management and Budget (OMB) requirements can help provide SHP with a Single Audit performed properly and submitted on time.

Our Approach

During our audit procedures of federal award programs, we do not simply look for findings to report. We look for opportunities to advise you of more efficient ways to comply with federal regulations to reduce the risks of sanctions or reduced funding. BKD has developed contacts at federal agencies and has been able to work cooperatively with these agencies to help clients resolve or avoid issues.

Entities subject to the Uniform Guidance and *Government Auditing Standards* will benefit from BKD's specially designed audit programs, checklists and database of federal audit programs.

Training Requirements for Single Auditors

The District can have confidence in BKD auditors' experience in testing federal funding subject to the Uniform Guidance. Our audit professionals are required to receive at least 120 hours of CPE every three years, and for auditors involved with audits performed under *Government Auditing Standards*, this education includes the hours required to comply with *Government Auditing Standards* **Yellow Book** guidance. Staff members attend a series of core audit and accounting courses over the first four years of their careers. Staff subsequently receive additional training on accounting and auditing for the not-for-profit and governmental environment.

Legislative Updates, Straight From the Source

You've likely been hearing it for years—how important it is to keep up with the frequent changes in the health care industry. Your accounting firm's commitment to monitoring this evolving landscape and proactively updating you should be among your minimum requirements at this point. That said, the District deserves more, which is why we've taken it a step further. Nationally recognized attorney and former judge Travis Lucas—a respected name in Washington, D.C.—is sharing his more than 25 years of legal expertise, congressional relationships and knowledge of the legislative process with BKD and our clients.

This direct connection to Capitol Hill means the District has the ability to ask specific questions of key D.C. decision makers. It also means our professionals are aware of new mandates as they occur and can help you summarize and apply their effects to your organization sooner rather than later. Consider this partnership one more way you can confidently move forward with BKD supporting you along the way.

Commitment to Integrity & Excellence

Integrity First: our client service standards start with it. We believe integrity trumps economics every time. As the business environment evolves and new challenges arise, this commitment will remain the foundation of all that we do. In addition, excellence is one of our firm's core values, and we will never apologize for having high standards in our service to clients. BKD's commitment to audit quality means the District is getting what you pay for—an audit performed by a firm with a track record of high quality, as demonstrated by our American Institute of CPAs (AICPA) peer reviews and PCAOB inspections.

In 2018, we published our first annual audit quality report, **The Importance of Quality: Our Commitment to Integrity & Excellence**, a current copy of which is included in the Appendix. This report provides further insight on our efforts to maintain quality, including:

Audit requirements

Technical ability and leading the process

Using technology to advance our capability

Security and infrastructure

Delivering and monitoring quality results

We invite you to read the current version of our quality report and learn more about our commitment to improving the quality of our work. Our quality report can be found at **bkd.com**.

A Smooth Transition

Our BKD Smooth Transition™ process places a great deal of emphasis on becoming familiar with the District's team quickly, with little disruption to day-to-day operations. We plan to work with you to develop a tailored transition plan that meets your timing requirements and incorporates the areas you believe may warrant a fresh look. As a result, potential concerns can be identified and resolved efficiently.

Generally, our approach includes the following components:

- Meet with your key management team to further develop rapport and gather initial information about your business structure
- Become acquainted with your staff to address questions about the transition process to help them understand our approach
- Review the prior auditor's workpapers to enhance our understanding of your specific accounting and auditing issues, as well as your operations
- Schedule an early planning session with appropriate personnel to obtain their input in developing an efficient and tailored service approach
- Discuss the level of assistance your staff can provide
- Develop appropriate timetables for performing our services, reviewing and approving our deliverables, meeting with the audit committee

BKDconnect Client Sites

As previously discussed, BKDconnect Client Sites is an innovative client portal designed to help address the challenges financial engagements present and conveniently connect you with BKD advisors. Prior to the start of your engagement, BKD will post our questionnaires and other related documents on a BKDconnect Client Sites website, specifically prepared for the District, where requests can be reviewed and completed.

BKDconnect Client Sites can make it easier to:

- View and manage information about your engagement or project
- Share documents and files with your BKD advisors and project teams
- Organize documents and files for retrieval
- Assign tasks to your team and receive requests for information from BKD
- Track the progress of tasks toward completion
- Access our award-winning, industry-specific articles, webinars, videos and more

BKDconnect Client Sites can help improve communication, save time, limit disruptions, including duplicate requests for information, and keep you connected with BKD advisors.

Our acceptance of this engagement is subject to completion of our normal client acceptance procedures. Upon acceptance, the actual terms of our engagement will be documented in a separate letter to be signed by you and us. All information contained within this proposal is proprietary and confidential. The information provided in this proposal is intended for informational purposes only and may not be copied, used or modified, in whole or in part, without BKD's prior written approval. All information in this proposal is as of May 31, 2019, unless otherwise noted.

505 Fourteenth Street
Fifth Floor
Oakland, CA 94612-1912

510 768 0066
wipfli.com

June 5, 2020

Kelli Davis
Interim CEO
Northern Inyo Healthcare District
Bishop, California
Via email

Dear Kelli,

Attached please find our engagement letters for both the audit and cost report work for fiscal year ended, June 30, 2020.

Pursuant to Vinay's request, I am also including, in the table below, the engagement quote for the next five years, including the current year's engagement. This quote includes both the financial statement audit and cost report services. We certainly understand that the District is experiencing financial difficulty during these unprecedented times. As a result, we are offering you a discount off prior year's fee for the next two years, and then for years three through five, we will adjust upwards based on a normal annual fee increase.

We propose the following:

June 30,	2020	2021	2022	2023	2024
Audit of the Northern Inyo Healthcare District	$ 42,000	$ 42,000	$ 44,000	$46,000	$ 48,000
Preparation of the Medicare cost reports	10,000	10,000	10,500	11,000	11,600
Preparation of the Medi-Cal cost reports	2,000	2,000	2,100	2,200	2,300
Total audit professional fees	$ 54,000	$ 54,000	$ 56,600	$ 59,200	$ 61,900
Out-of-pocket and processing expenses (estimated)	5,000	5,000	5,000	5,000	5,000
Two (2) complimenatry registrations to the Wipfli RHC/CAH Conference	Included	Included	Included	Included	Included
Routine telephone calls throughout the year	Included	Included	Included	Included	Included
Management report	Included	Included	Included	Included	Included
Presentation to the Board of Directors (in person)	Included	Included	Included	Included	Included
Total audit, cost report, and related fees	$59,000	$59,000	$ 61,600	$ 64,200	$66,900

The fees described above include all current accounting pronouncements as promulgated by the *Governmental Accounting Standards Board*. In addition, the federal government has recently listed the HHS Provider Relief Fund in the System for Award Management (SAM) assistance listings and assigned Catalog of Federal Domestic Assistance (CFDA) number 93.498 to the program. In this listing it is reported that *Title 2 Code of Federal Regulations Subtitle A Chapter II Part 200* (Uniform Guidance) will apply to this program, including Subpart F (Audit Requirements). What this means is that if the District receives federal awards exceeding $750,000 (combined all direct and indirect awards), a Single Audit may be required for 2020 and perhaps 2021, depending on the timing of the expenditures.

A Single Audit includes auditing both the financial statements of the organization under audit as well as auditing the organization's compliance with major federal programs. At this time, the *2020 Compliance Supplement* has not been published by the Office of Management and Budget (OMB). *The Compliance Supplement* typically defines the areas of compliance the oversight agency considers direct and material to a federal program and may indicate specific audit procedures. As we do not yet know the extent of procedures that will need to be performed if a Single Audit is required, our proposal does not include fees for performing a Single Audit. If you require a fee quote for Single Audit procedures, we would be happy to provide an estimate based upon the many other Single Audits that Wipfli performs and could adjust that estimate as more information becomes known.

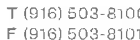
We look forward to our continued relationship with Northern Inyo Healthcare District as we navigate the many changes in the healthcare industry, perhaps under a "new normal."

With warm regards,

Jeffrey M. Johnson, CPA
Partner – Wipfli Healthcare Practice

cc: Vinay Behl, Interim CFO

Enclosures



T (916) 503-8100
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2882 Prospect Park Drive
Suite 300
Rancho Cordova, CA 95670

May 26, 2020

Mr. Vinay N S Behl, Chief Financial Officer
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

Re: Audit and Nonattest Services

Dear Mr. Behl:

Thank you for the opportunity to provide services to Northern Inyo HealthCare District. This engagement letter ("Engagement Letter") and the attached Professional Services Agreement, which is incorporated by this reference, confirm our acceptance and understanding of the terms and objectives of our engagement, and limitations of the services that Moss Adams LLP ("Moss Adams," "we," "us," and "our") will provide to Northern Inyo HealthCare District ("you," "your," and "District").

Scope of Services – Audit

You have requested that we audit the District's financial statements, which comprise the statements of net position, net position of pension trust fund – plan and net position of pension trust fund – PEPRA plan as of June 30, 2020, and the related statements of revenues, expenses, and changes in net position, changes in net position of pension trust fund – plan, changes in net position of pension trust fund – PEPRA plan and cash flows for the year then ended, and the related notes to the financial statements. We will also report on whether the combining statements of net position and revenues, expenses and changes in net position of the district and component units, presented as supplementary information, are fairly stated, in all material respects, in relation to the financial statements as a whole. We have not been engaged to report on whether management's discussion and analysis and supplemental pension information, presented as required supplementary information, are fairly stated, in all material respects, in relation to the financial statements as a whole.

Accounting standards generally accepted in the United States of America provide for certain required supplementary information ("RSI"), such as management's discussion and analysis, to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. As part of our engagement, we will apply certain limited procedures to the District's RSI in accordance with auditing standards generally accepted in the United States of America. We will not express an opinion or provide assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide assurance. The following RSI will be subjected to certain limited procedures, but will not be audited:

1) Management's discussion and analysis
2) Supplemental pension information

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Assurance, tax, and consulting offered through Moss Adams LLP. Investment advisory services offered through Moss Adams Wealth Advisors LLC. Investment banking offered through Moss Adams Capital LLC.

Scope of Services and Limitations – Nonattest

We will provide the District with the following nonattest services:

1) Assist you in drafting the financial statements and related footnotes as of and for the year ended June 30, 2020.

Our professional standards require that we remain independent with respect to our attest clients, including those situations where we also provide nonattest services such as those identified in the preceding paragraphs. As a result, District management must accept the responsibilities set forth below related to this engagement:

- Assume all management responsibilities.
- Oversee the service by designating an individual, preferably within senior management, who possesses skill, knowledge, and/or experience to oversee our nonattest services. The individual is not required to possess the expertise to perform or reperform the services.
- Evaluate the adequacy and results of the nonattest services performed.
- Accept responsibility for the results of the nonattest services performed.

It is our understanding that you have been designated by the District to oversee the nonattest services and that in the opinion of the District are qualified to oversee our nonattest services as outlined above. If any issues or concerns in this area arise during the course of our engagement, we will discuss them with you prior to continuing with the engagement.

Timing

Brian Conner is responsible for supervising the engagement and authorizing the signing of the report. We expect to begin our audit in June 2020, and issue our report no later than October 31, 2020. As we reach the conclusion of the audit, we will coordinate with you the date the audited financial statements will be available for issuance. You understand that (1) you will be required to consider subsequent events through the date the financial statements are available for issuance, (2) you will disclose in the notes to the financial statements the date through which subsequent events have been considered, and (3) the subsequent event date disclosed in the footnotes will not be earlier than the date of the management representation letter and the date of the report of independent auditors.

Our scheduling depends on your completion of the year-end closing and adjusting process prior to our arrival to begin the fieldwork. We may experience delays in completing our services due to your staff's unavailability or delays in your closing and adjusting process. You understand our fees are subject to adjustment if we experience these delays in completing our services.

Fees

We have agreed to the following payment schedule for the services based on a total fee estimate of $45,000. We have also included estimated fees for 2021 – 2024 engagements. You will also be billed for expenses.

Service Description	2020 Estimated Fees	2021 Estimated Fees	2022 Estimated Fees	2023 Estimated Fees	2024 Estimated Fees
1st invoice to be sent upon commencement of planning	$-	$16,500	$20,000	$20,000	$20,000
2nd invoice to be sent prior commencement of fieldwork	-	33,000	40,000	40,000	40,000
3rd invoice to be sent with draft of financial statements	20,000	5,500	5,000	5,000	5,000
Final invoice – due after completion	25,000	-	-	-	-
Total	$45,000	$55,000	$65,000	$65,000	$65,000

Our invoices are due upon receipt. In addition to fees, we will charge you for expenses. Our invoices include a flat expense charge, calculated as five percent (5%) of fees, to cover expenses such as copying costs, postage, administrative billable time, report processing fees, filing fees, and technology expenses. Travel expenses and client meals/entertainment expenses will be billed separately and are not included in the 5% charge.

Our ability to provide services in accordance with our estimated fees depends on the quality, timeliness, and accuracy of the District's records, and, for example, the number of general ledger adjustments required as a result of our work. To assist you in this process, we will provide you with a Client Audit Preparation Schedule that identifies the key work you will need to perform in preparation for the audit. We will also need your accounting staff to be readily available during the engagement to respond in a timely manner to our requests. Lack of preparation, poor records, general ledger adjustments, and/or untimely assistance will result in an increase of our fees.

Reporting

We will issue a written report upon completion of our audit of the District's financial statements. Our report will be addressed to the Board of Directors of the District. We cannot provide assurance that an unmodified opinion will be expressed. Circumstances may arise in which it is necessary for us to modify our opinion, add an emphasis-of-matter or other-matter paragraph(s), or withdraw from the engagement. Our services will be concluded upon delivery to you of our report on your financial statements for the year ended June 30, 2020.

DRAFT

We appreciate the opportunity to be of service to you. If you agree with the terms of our engagement as set forth in the Agreement, please sign the enclosed copy of this letter and return it to us with the Professional Services Agreement.

Very truly yours,

Brian Conner, Partner for
Moss Adams LLP

Enclosures

Accepted and Agreed:

This Engagement Letter and the attached Professional Services Agreement set forth the entire understanding of Northern Inyo HealthCare District with respect to this engagement and the services to be provided by Moss Adams LLP:

Signature:______________________________

Print Name:____________________________

Title:_________________________________

Date:_________________________________

Client: #37163
v. 03/26/2020

DRAFT

PROFESSIONAL SERVICES AGREEMENT
Audit and Nonattest Services

This Professional Services Agreement (the "PSA") together with the Engagement Letter, which is hereby incorporated by reference, represents the entire agreement (the "Agreement") relating to services that Moss Adams will provide to the District. Any undefined terms in this PSA shall have the same meaning as set forth in the Engagement Letter.

Objective of the Audit

The objective of our audit is the expression of an opinion on the financial statements. We will conduct our audit in accordance with auditing standards generally accepted in the United States of America (U.S. GAAS). It will include tests of your accounting records and other procedures we consider necessary to enable us to express such an opinion. If our opinion is other than unmodified, we will discuss the reasons with you in advance. If, for any reason, we are unable to complete the audit or are unable to form or have not formed an opinion, we may decline to express an opinion or to issue a report as a result of this engagement.

Procedures and Limitations

Our procedures may include tests of documentary evidence supporting the transactions recorded in the accounts, tests of the physical existence of inventories, and direct confirmation of certain receivables and certain other assets, liabilities and transaction details by correspondence with selected customers, creditors, and financial institutions. We may also request written representations from your attorneys as part of the engagement, and they may bill you for responding to this inquiry. At the conclusion of our audit, we will require certain written representations from management about the financial statements and related matters. Management's failure to provide representations to our satisfaction will preclude us from issuing our report.

An audit includes examining evidence, on a test basis, supporting the amounts and disclosures in the financial statements. Therefore, our audit will involve judgment about the number of transactions to be examined and the areas to be tested. Also, we will plan and perform the audit to obtain reasonable, rather than absolute, assurance about whether the financial statements are free from material misstatement. Such material misstatements may include errors, fraudulent financial reporting, misappropriation of assets, or noncompliance with the provisions of laws or regulations that are attributable to the entity or to acts by management or employees acting on behalf of the entity that may have a direct financial statement impact. Because of the inherent limitations of an audit, together with the inherent limitations of internal control, an unavoidable risk exists that some material misstatements and noncompliance may not be detected, even though the audit is properly planned and performed in accordance with U.S. GAAS. An audit is not designed to detect immaterial misstatements or noncompliance with the provisions of laws or regulations that do not have a direct and material effect on the financial statements. However, we will inform you of any material errors, fraudulent financial reporting, misappropriation of assets, and noncompliance with the provisions of laws or regulations that come to our attention, unless clearly inconsequential. Our responsibility as auditors is limited to the period covered by our audit and does not extend to any time period for which we are not engaged as auditors.

Our audit will include obtaining an understanding of the District and its environment, including its internal control sufficient to assess the risks of material misstatements of the financial statements whether due to error or fraud and to design the nature, timing, and extent of further audit procedures to be performed. An audit is not designed to provide assurance on internal control or to identify deficiencies in the design or operation of internal control. However, if, during the audit, we become aware of any matters involving internal control or its operation that we consider to be significant deficiencies under standards established by the American Institute of Certified Public Accountants, we will communicate them in writing to management and those charged with governance. We will also identify if we consider any significant deficiency, or combination of significant deficiencies, to be a material weakness.

We may assist management in the preparation of the District's financial statements. Regardless of any assistance we may render, all information included in the financial statements remains the representation of management. We may issue a preliminary draft of the financial statements to you for your review. Any preliminary draft financial statements should not be relied upon, reproduced, or otherwise distributed without the written permission of Moss Adams.

Management's Responsibility for Financial Statements

As a condition of our engagement, management acknowledges and understands that management is responsible for the preparation and fair presentation of the financial statements in accordance with accounting principles generally accepted in the United States of America. We may advise management about appropriate accounting principles and their application and may assist in the preparation of your financial statements, but management remains responsible for the financial statements. Management also acknowledges and understands that management is responsible for the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to error or fraud. This responsibility includes the maintenance of adequate records, the selection and application of accounting principles, and the safeguarding of assets. You are responsible for informing us about all known or suspected fraud affecting the District involving: (a) management, (b) employees who have significant roles in internal control, and (c) others where the fraud could have a material effect on

the financial statements. You are responsible for informing us of your knowledge of any allegations of fraud or suspected fraud affecting the District received in communications from employees, former employees, regulators or others. Management is responsible for adjusting the financial statements to correct material misstatements and for confirming to us in the management representation letter that the effects of any uncorrected misstatements aggregated by us during the current engagement and pertaining to the latest period presented are immaterial, both individually and in the aggregate, to the financial statements as a whole. Management is also responsible for identifying and ensuring that the District complies with applicable laws and regulations.

Management is responsible for making all financial records and related information available to us and for the accuracy and completeness of that information. Management agrees that as a condition of our engagement, management will provide us with:

- access to all information of which management is aware that is relevant to the preparation and fair presentation of the financial statements, such as records, documentation, and other matters;
- additional information that we may request from management for the purpose of the audit; and
- unrestricted access to persons within the District from whom we determine it necessary to obtain audit evidence.

Dissemination of Financial Statements

Our report on the financial statements must be associated only with the financial statements that were the subject of our engagement. You may make copies of our report, but only if the entire financial statements (including related footnotes and supplementary information, as appropriate) are reproduced and distributed with our report. You agree not to reproduce or associate our report with any other financial statements, or portions thereof, that are not the subject of this engagement.

Offering of Securities

This Agreement does not contemplate Moss Adams providing any services in connection with the offering of securities, whether registered or exempt from registration, and Moss Adams will charge additional fees to provide any such services. You agree not to incorporate or reference our report in a private placement or other offering of your equity or debt securities without our express written permission. You further agree we are under no obligation to reissue our report or provide written permission for the use of our report at a later date in connection with an offering of securities, the issuance of debt instruments, or for any other circumstance. We will determine, at our sole discretion, whether we will reissue our report or provide written permission for the use of our report only after we have conducted any procedures we deem necessary in the circumstances. You agree to provide us with adequate time to review documents where (a) our report is requested to be reissued, (b) our report is included in the offering document or referred to therein, or (c) reference to our firm is expected to be made. If we decide to reissue our report or provide written permission to the use of our report, you agree that Moss Adams will be included on each distribution of draft offering materials and we will receive a complete set of final documents. If we decide not to reissue our report or withhold our written permission to use our report, you may be required to engage another firm to audit periods covered by our audit reports, and that firm will likely bill you for its services. While the successor auditor may request access to our engagement documentation for those periods, we are under no obligation to permit such access.

Changes in Professional or Accounting Standards

To the extent that future federal, state, or professional rule-making activities require modification of our audit approach, procedures, scope of work, etc., we will advise you of such changes and the impact on our fee estimate. If we are unable to agree on the additional fees, if any, that may be required to implement any new accounting and auditing standards that are required to be adopted and applied as part of our engagement, we may terminate this Agreement as provided herein, regardless of the stage of completion.

Representations of Management

During the course of our engagement, we may request information and explanations from management regarding, among other matters, the District's operations, internal control, future plans, specific transactions, and accounting systems and procedures. At the conclusion of our engagement, we will require, as a precondition to the issuance of our report, that management provide us with a written representation letter confirming some or all of the representations made during the engagement. The procedures that we will perform in our engagement will be heavily influenced by the representations that we receive from management. Accordingly, false representations could cause us to expend unnecessary efforts or could cause a material error or fraud to go undetected by our procedures. In view of the foregoing, you agree that we will not be responsible for any misstatements in the District's financial statements that we fail to detect as a result of false or misleading representations, whether oral or written, that are made to us by the District's management. While we may assist management in the preparation of the representation letter, it is management's responsibility to carefully review and understand the representations made therein.

In addition, because our failure to detect material misstatements could cause others relying upon our audit report to incur damages, the District further agrees to indemnify and hold us harmless from any liability and all costs (including legal fees) that we may incur in connection with claims based upon our failure to detect material misstatements in the District's financial statements resulting in whole or in part from knowingly false or misleading representations made to us by any member of the District's management.

Fees and Expenses

The District acknowledges that the following circumstances will result in an increase of our fees:

- Failure to prepare for the audit as evidenced by accounts and records that have not been subject to normal year-end closing and reconciliation procedures;
- Failure to complete the audit preparation work by the applicable due dates;
- Significant unanticipated transactions, audit issues, or other such circumstances;
- Delays causing scheduling changes or disruption of fieldwork;
- After audit or post fieldwork circumstances requiring revisions to work previously completed or delays in resolution of issues that extend the period of time necessary to complete the audit;
- Issues with the prior audit firm, prior year account balances or report disclosures that impact the current year engagement; and
- An excessive number of audit adjustments.

We will endeavor to advise you in the event these circumstances occur, however we may be unable to determine the impact on the estimated fee until the conclusion of the engagement. We will bill any additional amounts based on the experience of the individuals involved and the amount of work performed.

Billings are due upon presentation and become delinquent if not paid within 30 days of the invoice date. Any past due fee under this Agreement shall bear interest at the highest rate allowed by law on any unpaid balance. In addition to fees, you may be billed for expenses and any applicable sales and gross receipts tax. Direct expenses may be charged based on out-of-pocket expenditures, per diem allotments, and mileage reimbursements, depending on the nature of the expense. Indirect expenses, such as processing time and technology expenses, may be passed through at our estimated cost and may be billed as a flat charge or a percentage of fees. If we elect to suspend our engagement for nonpayment, we may not resume our work until the account is paid in full. If we elect to terminate our services for nonpayment, or as otherwise provided in this Agreement, our engagement will be deemed to have been completed upon written notification of termination, even if we have not completed our work. You will be obligated to compensate us for fees earned for services rendered and to reimburse us for expenses. You acknowledge and agree that in the event we stop work or terminate this Agreement as a result of your failure to pay on a timely basis for services rendered by Moss Adams as provided in this Agreement, or if we terminate this Agreement for any other reason, we shall not be liable to you for any damages that occur as a result of our ceasing to render services.

Limitation on Liability

IN NO EVENT WILL EITHER PARTY BE LIABLE TO THE OTHER FOR ANY SPECIAL, INDIRECT, INCIDENTAL, OR CONSEQUENTIAL DAMAGES IN CONNECTION WITH OR OTHERWISE ARISING OUT OF THIS AGREEMENT, EVEN IF ADVISED OF THE POSSIBILITY OF SUCH DAMAGES. IN NO EVENT SHALL EITHER PARTY BE LIABLE FOR EXEMPLARY OR PUNITIVE DAMAGES ARISING OUT OF OR RELATED TO THIS AGREEMENT.

Subpoena or Other Release of Documents

As a result of our services to you, we may be required or requested to provide information or documents to you or a third-party in connection with governmental regulations or activities, or a legal, arbitration or administrative proceeding (including a grand jury investigation), in which we are not a party. You may, within the time permitted for our firm to respond to any request, initiate such legal action as you deem appropriate to protect information from discovery. If you take no action within the time permitted for us to respond or if your action does not result in a judicial order protecting us from supplying requested information, we will construe your inaction or failure as consent to comply with the request. Our efforts in complying with such requests or demands will be deemed a part of this engagement and we shall be entitled to additional compensation for our time and reimbursement for our out-of-pocket expenditures (including legal fees) in complying with such request or demand.

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Document Retention Policy

At the conclusion of this engagement, we will return to you all original records you supplied to us. Your District records are the primary records for your operations and comprise the backup and support for the results of this engagement. Our records and files, including our engagement documentation whether kept on paper or electronic media, are our property and are not a substitute for your own records. Our firm policy calls for us to destroy our engagement files and all pertinent engagement documentation after a retention period of seven years (or longer, if required by law or regulation), after which time these items will no longer be available. We are under no obligation to notify you regarding the destruction of our records. We reserve the right to modify the retention period without notifying you. Catastrophic events or physical deterioration may result in our firm's records being unavailable before the expiration of the above retention period.

Except as set forth above, you agree that Moss Adams may destroy paper originals and copies of any documents, including, without limitation, correspondence, agreements, and representation letters, and retain only digital images thereof.

Use of Electronic Communication

In the interest of facilitating our services to you, we may communicate by facsimile transmission or send electronic mail over the Internet. Such communications may include information that is confidential. We employ measures in the use of electronic communications designed to provide reasonable assurance that data security is maintained. While we will use our best efforts to keep such communications secure in accordance with our obligations under applicable laws and professional standards, you recognize and accept we have no control over the unauthorized interception of these communications once they have been sent. Unless you issue specific instructions to do otherwise, we will assume you consent to our use of electronic communications to your representatives and other use of these electronic devices during the term of this Agreement as we deem appropriate.

Use of Third-Party Service Providers

We may use third-party service providers in serving you. In such circumstances, if we need to share confidential information with these service providers, we will require that they maintain the confidentiality of your information.

Enforceability

In the event that any portion of this Agreement is deemed invalid or unenforceable, said finding shall not operate to invalidate the remainder of this Agreement.

Entire Agreement

This Professional Services Agreement and Engagement Letter constitute the entire agreement and understanding between Moss Adams and the District. The District agrees that in entering into this Agreement it is not relying and has not relied upon any oral or other representations, promise or statement made by anyone which is not set forth herein.

In the event the parties fail to enter into a new Agreement for each subsequent calendar year in which Moss Adams provides services to the District, the terms and conditions of this PSA shall continue in force until such time as the parties execute a new written Agreement or terminate their relationship, whichever occurs first.

Use of Moss Adams' Name

The District may not use any of Moss Adams' name, trademarks, service marks or logo in connection with the services contemplated by this Agreement or otherwise without the prior written permission of Moss Adams, which permission may be withheld for any or no reason and may be subject to certain conditions.

Use of Nonlicensed Personnel

Certain engagement personnel who are not licensed as certified public accountants may provide services during this engagement.

Dispute Resolution Procedure, Venue and Limitation Period

This Agreement shall be governed by the laws of the state of Washington, without giving effect to any conflicts of laws principles. If a dispute arises out of or relates to the engagement described herein, and if the dispute cannot be settled through negotiations, the parties agree first to try in good faith to settle the dispute by mediation using an agreed upon mediator. If the parties are unable to agree on a mediator, the parties shall petition the state court that would have jurisdiction over this matter if litigation were to ensue and request the appointment of a mediator, and such appointment shall be binding on the parties. Each party shall be responsible for its own mediation expenses, and shall share equally in the mediator's fees and expenses.

If the claim or dispute cannot be settled through mediation, each party hereby irrevocably (a) consents to the exclusive jurisdiction and venue of the appropriate state or federal court located in King County, state of Washington, in connection with any dispute hereunder or the enforcement of any right or obligation hereunder, and (b) WAIVES ITS RIGHT TO A

DRAFT

JURY TRIAL. EACH PARTY FURTHER AGREES THAT ANY SUIT ARISING OUT OF OR RELATED TO THIS AGREEMENT MUST BE FILED WITHIN ONE (1) YEAR AFTER THE CAUSE OF ACTION ARISES.

Termination

This Agreement may be terminated by either party, with or without cause, upon ten (10) days' written notice. In such event, we will stop providing services hereunder except on work, mutually agreed upon in writing, necessary to carry out such termination. In the event of termination: (a) you shall pay us for services provided and expenses incurred through the effective date of termination, (b) we will provide you with all finished reports that we have prepared pursuant to this Agreement, (c) neither party shall be liable to the other for any damages that occur as a result of our ceasing to render services, and (d) we will require any new accounting firm that you may retain to execute access letters satisfactory to Moss Adams prior to reviewing our files.

Hiring of Employees

Any offer of employment to members of the audit team prior to issuance of our report may impair our independence, and as a result, may result in our inability to complete the engagement and issue a report.

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

Date: June 10, 2020

Title: **REQUEST FOR PERMANENT CHIEF MEDICAL OFFICER FOR NIHD**

Synopsis: Historically, NIHD has not had a Chief Medical Officer (CMO) or the role has been held by the Chief Executive Officer (CEO) who functioned as CMO. Having a Chief Medical Officer (CMO) who is an active member of the Medical Staff, whose role is to actively engage, align and act as a liaison between the medical staff and administration at NIHD is essential for effective partnerships, collaboration and decision-making. It is being requested that NIHD have a permanent CMO role that is separate and distinct from the CEO role to ensure a balance between medical oversight, the provision of quality care and the creation and fulfillment of operational goals and objectives.

It is recommended that the Board of Directors approve having a permanent CMO as a key member of the Executive Team on June 17, 2020 at the regularly scheduled monthly Board of Directors' meeting.

Prepared by: ______________________
Kelli Davis
Interim CEO

Reviewed by: ______________________
Tracy Aspel, CNO
Will Timbers, MD, Interim CMO

Approved by: ______________________
Kelli Davis, Interim CEO
Tracy Aspel, CNO
Will Timbers, MD, Interim CMO

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Acceptance: 5/25/2020 Submitted by: ______________________
Kelli Davis, Interim CEO

Northern Inyo Healthcare District
Job Description
Human Resources Department

Position Title: Chief Medical Officer

Job Summary:	The Chief Medical Officer (CMO) is a key member of the executive team and an active member of the Medical Staff whose primary role is to engage, align and act as a liaison between the medical staff and administration at the Northern Inyo Healthcare District (District). The CMO provides medical oversight, expertise and leadership to assist the Medical Staff and District Administration. The CMO has responsibilities to patients for the provision of quality care, and has responsibility for resource utilization across all departments and service line development. As a member of District leadership the CMO provides clinical expertise and leadership in the design and implementation of new clinical projects and innovations within the District. The CMO works closely with the Chief of Staff and other physician leaders, including Department Medical Directors, Medical Staff Committee Chairs, and Administrative Directors to create and fulfill operational goals and objectives. The CMO must be responsive to the concerns and needs of Medical Staff practitioners and is expected to foster and contribute to a close and mutually beneficial relationship between the Medical Staff and District leadership. The CMO maintains the highest degree of confidentiality in all areas involving patients and their related District business. Conducts District business in an ethical and lawful manner, and is willing to report any knowledge of real or potential fraud or abuse according to the NIHD Compliance Code of Conduct and abides by the NIHD Personnel and Payroll Policies and Procedures as well as Medical Staff By-laws. Additionally, CMO will attend Medical Executive Committee meetings, District Board meetings including Strategic planning sessions, provide medical perspective to strategic and operational planning and goal setting and in partnership with the Medical Staff Chief of Staff will ensure continuity of information flow between Medical Staff and District leadership.
Job Relationships:	Directly responsible to the Chief Executive Officer. Provides supervision and leadership to District departments as assigned. Works closely with District & Medical Staff leadership and is available to all employees and Medical Staff members.
Job Responsibilities:	• Serves as a member of the District Executive Team (C-Suite) • Leads and manages Department heads assigned to report to the CMO. • Liaison between Medical Staff and District including communication of District issues, new items of business and strategic direction/progress to the Medical Staff • Liaison with Chief of Staff when CEO is not available to meet with the Chief of Staff • Keep abreast of emerging models in health care delivery; identify and define new and innovative strategies to achieve business goals and objectives. • Identify opportunities to collaborate and develop clinical integration opportunities to achieve affordable outcomes (ie Accountable care Organizations, Value-Based Purchasing). • Promote collaboration between District and other community providers • Sets operational and financial goals/objectives in collaboration with the Department heads assigned to report to the CMO. • Performs leadership and management duties, specific projects and studies as assigned by the CEO in addition to regular duties. • Investigates assigned irregularities and identified District policy violations, when necessary takes corrective action. • Serves as District leadership representative at Medical Staff meetings • Develops and interprets District policies, objectives and operational procedures • Support assigned Directors/Managers and service areas to allow them to succeed • Routinely reviews and proposes changes/improvements to existing District policies and procedures • Serves as chairperson of various District committees as assigned by the CEO • Attends and participates in District Board meetings. • Participates in evaluating, selecting and integrating health care technology and information management systems that support patient care needs and efficient utilization of hospital resources. • Interfaces with regulatory bodies when necessary (such as TJC, CDPH, OSHPD…). • Acts as interim Director/Manager of any Department assigned to the CMO in the absence of the Department's regular Director/Manager or while a management vacancy exists. • Champion for Electronic Health Record and related initiatives • Works with Medical Directors in developing performance standards and monitoring process improvements • Participates with District Board in development of strategic plan • Works with Executive Team for implementation of strategic plan in alignment with District Mission, Vision & Values • Partner with Chief of Staff in recruitment and retention of practitioners • Develop and enforce contractual relationships with District practitioners

Position Title: Chief Medical Officer

	• Meet and work with Medical Directors in a regular and structured manner • Participate in assigned District and Medical Staff committees
Qualifications:	**Required** • A current unrestricted license to practice medicine in the State of California. • Currently an active member of the District Medical Staff or become an active member of the District Medical Staff within six months of hire. • A Bachelor's degree from an accredited college/university. • MBA, MHA or MPH or attain such degree within 24 months of hire or five to seven years of progressively more administrative experience in a healthcare environment, including experience in a compliance program. • Minimum seven years of clinical experience at a Critical Access Hospital or similar healthcare system **Expectations of employee** • Adheres to District Policy and Procedures • Acts as a role model within and outside the District • Performs duties as workload necessitates • Maintains a positive and respectful attitude • Communicates regularly with CEO about District issues related to areas of responsibility • Demonstrates flexible and efficient time management and ability to prioritize workload • Consistently reports to work on time prepared to perform duties of position • Works as a practicing clinician within the District **Competencies – Skills, Knowledge, Attributes** • Active Listening - Ability to actively attend to, convey, and understand the comments and questions of others. • Adaptability - Ability to adapt to change in the workplace. • Business Acumen - Ability to grasp and understand business concepts and issues. • Change Management - Ability to encourage others to seek opportunities for different and innovative approaches to addressing problems and opportunities. • Coaching and Development - Ability to provide guidance and feedback to help others strengthen specific knowledge/skill areas. • Communication, Oral and Written - Ability to communicate effectively with others using the spoken word and to communicate in writing clearly and concisely. • Conflict Resolution - Ability to deal with others in an antagonistic situation. • Decision Making - Ability to make critical decisions while following company procedures. • Delegating Responsibility - Ability to allocate authority and/or task responsibility to appropriate people. • Honesty / Integrity - Ability to be truthful and be seen as credible in the workplace. • Interpersonal - Ability to get along well with a variety of personalities and individuals. • Leadership - Ability to influence others to perform their jobs effectively and to be responsible for making decisions. • Negotiation Skills - Ability to reach outcomes that gain the support and acceptance of all parties. • Resource Management (People & Equipment) - Ability to obtain and appropriate the proper usage of equipment, facilities, materials, as well as personnel. • Working Under Pressure - Ability to complete assigned tasks under stressful situations.
Physical and Environmental Requirements:	To perform this job successfully, an individual must be able to perform each essential duty satisfactorily. Reasonable accommodations may be made to enable qualified individuals with disabilities to perform the essential functions. While performing the duties of this job, the employee is occasionally required to stand; walk; sit; use hands to finger, handle, or feel objects, tools or controls; reach with hands and arms; climb stairs; balance; stoop, kneel, crouch or crawl; talk or hear; taste or smell. The employee must occasionally lift and/or move up to 25 pounds. Specific vision abilities required by the job include close vision, distance vision, color vision, peripheral vision, depth perception, and the ability to adjust focus. Ability to wear Personal Protective Equipment (PPE) - as required in case of disaster. Typically in office environment in a controlled atmosphere building. See attached.

Position Title: Chief Medical Officer

Signatures

District management has reviewed this job description to ensure that essential functions and basic duties have been included. It is intended to provide guidelines for job expectations and the employee's ability to perform the position described. It is not intended to be construed as an exhaustive list of all functions, responsibilities, skills and abilities. Additional functions and requirements may be assigned by management as deemed appropriate.

This document does not represent a contract of employment, and hospital management reserves the right to change this job description and/or assign tasks for the employee to perform, as may be deemed appropriate. This job description has been approved by all levels of management:

Chief Executive Officer – print name/signature_______________________________________Date:__________

Employee signature below constitutes employee's understanding of the requirements, essential functions and duties of the position.

By signature I acknowledge that: 1) I have read this job description and I accept the responsibilities and authorities of this position; 2) I realize that there will be some meetings and in-services which I may be required to attend; 3) I understand how I will be compensated and that the position that I have accepted is Salaried/Exempt position; 4) I understand that my evaluation will be based on this job description; 5) this job description may be revised with my knowledge, as necessary, and I will receive any revised copies; 6) I have received a copy of this job description.

Employee – print name/signature_______________________________________Date:__________

Approved by CEO ______________________ Date: __________

Northern Inyo Healthcare District
Job Description
Human Resources Department

Position Title: Chief Medical Officer

Please check one box below in Section I and Section II that apply to this job description. Comments can be made in Section III.

Physical Requirements

C = Constant (76-100%) F = Frequent (51-75%) O = Occasional (26-50%) S = Seldom (1-25%) N = Never (0%),	E = Essential – Regardless of frequency, this activity is indispensable. M = Marginal – This activity is useful and helpful but not absolutely essential.

	Section I					**Section II**		**Section III**
	C	**F**	**O**	**S**	**N**	E	**M**	**Comments:**
Basic Skills:								
Reading			✓			✓		
Writing			✓			✓		
Math			✓			✓		
Talking			✓			✓		
Hearing			✓			✓		
Physical Demands:								
Sitting			✓			✓		
Standing			✓			✓		
Walking			✓			✓		
Stooping			✓			✓		
Crawling				✓			✓	
Climbing			✓				✓	
Reaching Overhead			✓				✓	
Crouching			✓				✓	
Kneeling			✓				✓	
Balancing				✓			✓	
Pushing or pulling			✓			✓		
Lifting or carrying			✓			✓		
Lifting or carrying (up to 10 lbs.)			✓			✓		
Lifting or carrying (up to 25 lbs.)			✓			✓		
Lifting or carrying (up to 50 lbs.)					✓		✓	
Lifting or carrying (up to 75 lbs.)					✓		✓	
Lifting or carrying (up to 100 lbs.)					✓		✓	
Lifting or carrying (over 100 lbs.)					✓		✓	
Moving patients				✓		✓		
Repetitive motions			✓			✓		
Environmental Requirements:								
Exposure to periods of stress			✓			✓		
Exposure to static electricity and electric amperes capable of doing bodily harm				✓			✓	
Exposure to blood, blood products, tissues, bodily fluids and excretions, as well as patients in infectious states				✓			✓	
Other:								

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Benefits - TUITION REIMBURSEMENT*	
Scope: District Wide	Manual: Human Resources - Employee Handbook
Source: Interim CEO	Effective Date: 1/14/15

PURPOSE:

To encourage employees to pursue higher education.

POLICY:

It is the policy of Northern Inyo Healthcare District (NIHD) to provide reimbursement to support educational growth. The reimbursement is limited to employees currently receiving benefits for the hours worked, in a pro-rated amount, based upon position status.

Reimbursement is for course fees and textbooks for education and development obtained from university courses and technical college courses for requests that have been pre-approved by Senior Management.

PROCEDURE:

Eligibility requirements

1. Employee must have successfully completed their introductory period.
2. Employee's performance must be at least satisfactory, meeting all expectations and not be in the progressive disciplinary process.
3. The paperwork must be submitted to Senior Management for approval prior to the start of the course.
4. The course must be directly related to the employee's position and be job-related.
5. The course must be through an accredited educational institution (university, technical college, or extension facility).
6. A passing grade of "C" or better, or a completion certificate, is required prior to reimbursement.

Reimbursement Criteria

1. Pre-approved university courses or technical college courses and associated textbooks are covered at a maximum of $1,000 per fiscal year for employees in positions that are 1.0 Full Time Equivalent (FTE), 80 hours/pay period. Funding is pro-rated based upon the employees FTE status. Example: 0.75 FTE staff, 60 hours/pay period, receive a maximum of $750 per fiscal year.
2. It is not the intent of this program to underwrite the pursuit of a technical school or college degree; however, if certain courses in the degree curriculum meet the above guidelines, they may be submitted for consideration.
3. Termination of employment (actual date of termination) for any reason prior to the completion of the class and submittal of the letter grade completion certificate will make the employee ineligible for this reimbursement.

Approval Procedure

1. Prior to enrollment, employees will need to complete the appropriate form, give it to their supervisor for approval, then their supervisor will send the form to Senior Management for consideration. The

Title: Benefits - TUITION REIMBURSEMENT*	
Scope: District Wide	Manual: Human Resources - Employee Handbook
Source: Interim CEO	Effective Date: 1/14/15

employee will be notified by Human Relations whether the request is approved or denied. Pre-approval from Senior Management is required for reimbursement.

2. If the request is approved, the employee will receive two copies of the approved form. When the course is completed, the employee will send one copy along with their class grade or completion certificate and a verified statement of tuition costs or adequate receipts to Human Relations for reimbursement of up to the maximum amount defined under Reimbursement Criteria.
3. Initial approval of a course of study does not obligate NIHD to approve future courses in that course of study. Approvals are only valid for the specific course and quarter/semester requested. Payment of courses at a higher institution rate does not obligate Northern Inyo Hospital to continue payment at that higher rate.

Additional Information

1. Employees may not apply for the tuition reimbursement for courses previously taken, or courses currently in progress. Pre-approval of Senior Management is required.
2. Unless directed and approved by NIHD, an employee's regular work schedule will not be altered to allow time off the job for participation in courses. Employee's time to participate in courses is not paid time unless approved PTO is used.
3. It is expected that employees who use this program will select courses locally if available and then pursue courses at a reasonable cost so that the most education and credits can be obtained for the reimbursement dollars provided.
4. Employees applying for any other educational assistance through any sources such as Free Application for Federal Student Aid (FAFSA) need to be aware that there may be notification requirements and/or tax considerations. It is advisable to consult your educational assistance program and a tax professional for such information.

FORMS:

TUITION ASSISTANCE REQUEST FORM

Approval	**Date**
Senior Leadership	1/13/2020
Board of Directors	01/14/2015; 07/15/2015
Last Board of Directors Review	

Developed: 09/2014
Revised: 07/15/2015, 1/2020ta
Reviewed:

Attachment A

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

Date: 6/5/2020

Title: **PURCHASE OF AUTOMATED EXTERNAL DEFIBRILLATORS (AED)**

Presenter(s): Tracy Aspel
Chief Nursing Officer

Synopsis: The NIHD Resuscitation Committee has recommended the purchase of 2 AED units for district properties that currently do NOT have these important safety devices on premise. One would be placed into the Birch Street property and the other in the Joseph House.

Prepared by: Tracy Aspel CNO
Name
Title

Reviewed by: ____________________
Name
Title

Approved by: Tracy Aspel CNO
Name
Title

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Acceptance: ________ Submitted by: ____________________
Chief Officer

Northern Inyo Hospital Board of Directors

Action Item Request 6/17/2020

Purchase of Automated External Defibrillators (AED)

Rationale: At the Resuscitation Committee meeting on 6/3/2020, it was unanimously approved by the committee to recommend the addition of AED safety device to the Birch Street property and the Joseph House. These two properties are owned and operated by Northern Inyo Hospital and currently are lacking AEDs. As a healthcare facility, it is prudent to have AEDs available in all of our properties for the safety of all persons who are on the NIHD properties.

Expected Costs: The costs will include the devices, mounting boxes, defibrillation pads, additional batteries, Clinical Engineer safety assessment and maintenance mounting to the walls. Estimated purchase cost is approximately $2,600 each.

Management of Equipment: Plan to check the AED at each location has been established by Clinical Engineering Manager. The Environmental Care Safety Specialist will be accountable to perform the routine check of the AEDs.

Request: I respectfully request the NIHD Board of Directors approve the purchase of two (2) Automated External Defibrillators.

Thanks,

Tracy Aspel, BSN, RN

Chief Nursing Officer

Tracy Aspel

From: Tracy Aspel
Sent: Thursday, June 04, 2020 8:18 AM
To: Vinay Behl
Subject: RE: AED for Birch Street Building

Thanks!

Tracy

From: Vinay Behl
Sent: Wednesday, June 03, 2020 7:43 PM
To: Tracy Aspel <Tracy.Aspel@nih.org>; Genifer Owens <Genifer.Owens@nih.org>
Subject: Re: AED for Birch Street Building

Tracy
My recommendation is to proceed with purchase as this is a risk issue. It will be capital purchase.
Thanks
Vinay

From: Tracy Aspel
Sent: Wednesday, June 3, 2020 6:44:30 PM
To: Vinay Behl; Genifer Owens
Subject: FW: AED for Birch Street Building

Vinay and Gen,
So it begins....
Today at the Resuscitation Committee it was brought up that the Birch Street Building (which contains the board room) does not have an AED. Below you will see my questions of Scott Stoner. I was hoping that this would be operational, rather than capital. Per Scott, he thinks this will meet the threshold for capital.
We have done without an AED in this building for years, but this is a risk.
What are your thoughts?
Respectfully,
Tracy

From: Scott Stoner
Sent: Wednesday, June 03, 2020 12:00 PM
To: Tracy Aspel <Tracy.Aspel@nih.org>
Subject: RE: AED for Birch Street Building

I have requested and will update you when I know more.

From: Tracy Aspel
Sent: Wednesday, June 03, 2020 11:42 AM
To: Scott Stoner <Scott.Stoner@nih.org>
Subject: RE: AED for Birch Street Building

Yes please, a quote would be good.

Tracy

From: Scott Stoner
Sent: Wednesday, June 03, 2020 11:08 AM
To: Tracy Aspel <Tracy.Aspel@nih.org>
Cc: Gina Riesche <Gina.Riesche@nih.org>
Subject: RE: AED for Birch Street Building

Quick search online shows they are $2500-$3000. I am not sure what our actual cost is, but I would say it is capital. If you need a formal quote I can reach out to purchasing if you would like.

From: Tracy Aspel
Sent: Wednesday, June 03, 2020 10:46 AM
To: Scott Stoner <Scott.Stoner@nih.org>
Cc: Gina Riesche <Gina.Riesche@nih.org>
Subject: AED for Birch Street Building

Scott,
How much does an AED cost? I am trying to determine if this would be capital.
Thanks,

Tracy Aspel, BSN, RN
Chief Nursing Officer
Northern Inyo Healthcare District
150 Pioneer Ln
Bishop, CA 93514
760-873-5811
Extension #2139

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Tracy Aspel

From: Scott Stoner
Sent: Thursday, June 04, 2020 4:39 PM
To: Tracy Aspel
Subject: RE: AED for Birch Street Building

Follow Up Flag: Follow up
Flag Status: Flagged

Tracy,

Steve has been all over this today with no luck. The best we can give you is that they will run around $2600 each.

He is struggling to get a quote, but I know you need something for tomorrow. We will keep trying, but this is the best we have right now.

From: Tracy Aspel
Sent: Wednesday, June 3, 2020 6:39 PM
To: Scott Stoner
Subject: RE: AED for Birch Street Building

Thanks Scott!

Tracy

From: Scott Stoner
Sent: Wednesday, June 03, 2020 12:00 PM
To: Tracy Aspel <Tracy.Aspel@nih.org>
Subject: RE: AED for Birch Street Building

I have requested and will update you when I know more.

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Subject: RE: AED for Birch Street Building

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Cc: Gina Riesche <Gina.Riesche@nih.org>
Subject: AED for Birch Street Building

Scott,
How much does an AED cost? I am trying to determine if this would be capital.
Thanks,

Tracy Aspel, BSN, RN
Chief Nursing Officer
Northern Inyo Healthcare District
150 Pioneer Ln
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NORTHERN INYO HEALTHCARE DISTRICT
RECOMMENDATION TO THE BOARD OF DIRECTORS
FOR ACTION

Date: June 10, 2020

Title: **NIHD SUBMISSION OF MATERIALS TO THE NIHD BOARD OF DIRECTORS POLICY AND PROCEDURE**

Synopsis: In order to maintain transparency, consistency, and uniformity of the materials presented to the Northern Inyo Healthcare District (NIHD) Board of Directors, formal procedures through this policy have been established for submission of document(s) to ensure full vetting by key District stakeholders has occurred prior to the material(s) being submitted for Board of Directors' review and or action.

It is recommended that the Board of Directors approve this policy and procedure on June 17, 2020 at the regularly scheduled monthly Board of Directors' meeting.

Prepared by: KELLI DAVIS, INTERIM CEO
Name
Title

Reviewed by: CEO (INTERIM) CNO, CMO (INTERIM)
Name
Title of Chief who reviewed

Approved by: ____________________
Name
Title of Chief who approved

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Acceptance: 5/25/2020 Submitted by: Kelli Davis INTERIM CEO
Chief Officer

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Submission of Materials to the Board of Directors	
Scope:	Manual: Administration
Source: Chief Executive Officer	Effective Date:

Background

In order to maintain transparency, consistency, and uniformity of the materials presented to the Northern Inyo Healthcare District (NIHD) Board of Directors, procedures have been established for submission of document(s).

Policy

1. Board agenda items are classified as either **informational** items or **action** items, and generally fall into one of the following categories:
    a. Policies and Procedures
    b. Medical Staff (Medical Executive Committee) reports, including clinical Policies and Procedures, and Medical Staff privileging
    c. Regulatory and governmental items
    d. Reports, routine reports, and informational updates
    e. Financial matters, transactions and expenditures, including equipment purchases
    f. Personnel matters, including staffing and physician staffing
    g. Contracts and agreements
    h. Closed session (confidential) items, including litigation
    i. Other

2. Submissions to the Board of Directors must include the "Submission to the Board request form."

3. Action items that are **clinical policies and procedures or Medical Staff privileging** presented by the Medical Executive Committee have already been vetted by the Medical Staff and approved by the appropriate Committees, and may go directly to the Board of Directors for approval.."

4. The "Submission to the Board request form" must be written so any member of the public can read and quickly understand why, without any prior information, this issue is being brought to the Board.

5. All acronyms must be spelled out the first time used.

6. The submission method for all documents for the Board meeting packet is electronic and documents must include "Submission to the Board" review/approval signature form, attached.

7. Items should be submitted to the Chief Officer who supports the area of the requestor via email/electronically. An initial review of the submitted item will be done during the regularly scheduled Monday Executive Team Meeting approximately 10 days prior to the scheduled Board Meeting in which the agenda item is requested to be presented.

Title: Submission of Materials to the Board of Directors	
Scope:	Manual: Administration
Source: Chief Executive Officer	Effective Date:

8. If you have brochures or similar types of items, they will need to be scanned or added electronically.

Procedure

1. **Informational items** with the completed "Submission to the Board" review and approval form, and supporting documents, if any, must be submitted to the Board Clerk for inclusion in the Board packet.

2. **Action items** with supporting documentation must be submitted for the Board packet with a completed "Submission to the Board" (fillable form attached), including review/approvals.

   a. The form includes the following information:
      i. Summary the proposed item or issue
      ii. Financial impact of the agenda item, including cost
      iii. Involvement of external agencies
      iv. CEO recommendation
      v. Review and approval sign-off

   b. The recommendation for action should include a clear, precise, and succinct statement of the recommendation, its purpose, rationale and, if appropriate, the date the action will become effective.

   c. Renewals and modifications of contracts should reference previously executed documents and should contain an explanation of all changes.

   d. All recommendations requesting a new or revised policy and procedure require the documented review and approval of the appropriate relevant committees.

3. All submissions must be sent to any approvers deemed necessary by the Executive Team upon their initial review. This may include but is not limited to the (Director of Human Resources, Chief Financial Officer, Director of Information Technology Services, and/or the Compliance Officer).

4. Items not previously reviewed by Legal Counsel will be reviewed in the Board Packet, for advice and counsel to the Board at the meeting, if necessary.

Timeline

1. Requests to place an item on a Board agenda must be submitted to the Chief Officer who supports the area of the requestor by the end of the day two Fridays prior to the Board

Title: Submission of Materials to the Board of Directors	
Scope:	Manual: Administration
Source: Chief Executive Officer	Effective Date:

meeting (12 days in advance of each regular meeting). Items not accompanied by a completed tracking sheet will not be considered.

2. **Please note:** Regular Board of Directors meetings are scheduled for the 3rd Wednesday of each calendar month. Every attempt will be made to avoid the necessity of scheduling Special Board Meetings to address individual items, so items requiring Board action must be submitted according to the timeline stated in order to allow the District Board of Directors adequate time for review and consideration of the information.

Approval	**Date**
Executive Team	5/25/2020
Board of Directors	
Last Board of Directors Review	

Developed: 5/2020
Reviewed:
Revised:
Supersedes:

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

Date: The date of submittal of the form

Title: **THE NAME OF THE PRESENTATION** (ALL CAPS AND **BOLD**)

Presenter(s): Presenters Name
Presenters Title (if any)

Synopsis: The synopsis should contain a clear, precise, and succinct statement of the presentation. Summaries of presentations to the Board should be one page or less in length.

Prepared by: ______________________________
Name
Title

Reviewed by: ______________________________
Name
Title

Approved by: ______________________________
Name
Title

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Acceptance: ________ Submitted by: ______________________________
Chief Officer

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

Date: The date of submittal of the form

Title: **THE NAME OF THE RECOMMENDATION** (ALL CAPS AND **BOLD**)

Synopsis: A very brief (preferably one sentence) description of the recommendation.

The description of the recommendation must begin with a specific statement of the action to be taken. Such as: **"It is recommended that the Board of Directors…".** It should be a clear, precise and succinct statement of the recommendation, its purpose, rationale and, if appropriate, the date the action will become effective. In addition, the description should reference any pertinent legal requirements or outside authority or documentation and should be easily interpreted by anyone.

Prepared by: ______________________________
Name
Title

Reviewed by: ______________________________
Name
Title of Chief who reviewed

Approved by: ______________________________
Name
Title of Chief who approved

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Acceptance: ________ Submitted by: ______________________________
Chief Officer

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

Date: The date of submittal of the form

Title: **THE NAME OF THE REPORT** (ALL CAPS AND **BOLD**)

Synopsis: A short report can be submitted as a one-page report. The report should be clear, precise and as succinct as possible.

If the report requires more than one page, this same one-page template should be prepared as a cover sheet for the lengthy report with a brief description (i.e., summary) of the nature of the report and a notation that the report is attached. A signature line(s) with title should provide the name of the individual(s) who prepared the report.

Prepared by: ______________________________
Name
Title

Reviewed by: ______________________________
Name
Title of Chief who reviewed

Approved by: ______________________________
Name
Title of Chief who approved

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Acceptance: __________ Submitted by: ______________________________
Chief Officer

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

Date: June 10, 2020

Title: **REQUEST FOR A SPECIAL BOARD MEETING FOR PRESENTATION, REVIEW AND APPROVAL OF THE NIHD FISCAL YEAR 2021 OPERATIONAL AND CAPITAL ITEM BUDGET**

Synopsis: To ensure a timely review, approval and implementation of a July 1, 2020, NIHD Operational and Capital Budget, a special Board of Directors Meeting is being requested for June 24, 2020, at 5:30pm or a day/time in June of the Board of Directors' choosing.

It is recommended that the Board of Directors approve having a June 2020 Special Board Meeting on June 17, 2020 at the regularly scheduled monthly Board of Directors' meeting.

Prepared by: ______________________________
Kelli Davis
Interim CEO

Reviewed by: ______________________________

Approved by: ______________________________

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Acceptance: Submitted by: ______________________________

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

Date: June 10, 2020

Title: **SOUTHERN INYO HEALTHCARE DISTRICT AND NIHD LAFCO AND AGREEMENT FOR PEDIATRIC AND ORTHOPEDIC SERVICES IN LONE PINE**

Synopsis: NIHD filed a LAFCO petition to provide pediatric and orthopedic clinic services at SIHD, Lone Pine. An agreement for such services was signed and dated on February 11, 2020, between Kevin Flanigan, MD, CEO at NIHD and Peter Spiers, CEO at SIHD. This is a new contract requiring legal review. This is a new service line requiring economic consideration and return on investment analysis.

Prepared by: ______________________________
Kelli Davis
Interim CEO

Reviewed by: ______________________________
Kelli Davis
Interim CEO

Approved by: ______________________________
Name
Title of Chief who approved

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Acceptance: ________ Submitted by: ______________________________
Chief Officer

Inyo Local Agency Formation Commission

168 North Edwards Street
Post Office Drawer L
Independence, California 93526

Phone: (760) 878-0263
FAX: (760) 872-2712
E-Mail: inyolafco@inyocounty.us

PROCESSING FEE AGREEMENT

APPLICATION TYPE: (Check the type of processing requested)

- ☐ ANNEXATION/DETACHMENT/REORGANIZATION
- ☐ ANNEXATION OF A SINGLE FAMILY RESIDENCE FOR REASONS OF PUBLIC HEALTH OR SAFETY
- ☐ CONSOLIDATION/DISSOLUTION
- ☐ DISTRICT FORMATION
- ☒ OUT-OF-AGENCY SERVICE CONTRACT REQUEST
- ☐ INCORPORATION
- ☐ RECONSIDERATION OF LAFCO DETERMINATION
- ☐ SPHERE OF INFLUENCE AMENDMENT

APPLICANT INFORMATION: (Contact person)

Applicant Name Northern Inyo Healthcare Dist **Day Phone:** (760) 873-2838

Billing Address: 150 Pioneer Lane, Bishop, CA Zip Code 93514

Landowner Name: ____ Day Phone: ( )

Mailing Address: ____ Zip Code ____

Agent Name: ____ Day Phone: ( )

Mailing Address: ____ Zip Code ____

PROPERTY INFORMATION: Assessor's Parcel Number(s): ____ Total Site Area ____

Legal Description: Lot ____ Block ____ Tract ____ (or),

Section ____ Township ____ Range ____ Base line & Meridian ____

Site Location: (if no street address, describe first with name of road providing access to the site, then nearest roads, landmarks):

Pursuant to §56383, Local Agency Formation Commissions may establish a schedule of fees to recover the costs of processing applications. These costs include personnel and overhead costs, as indicated on the attached schedule, as well as the cost of materials necessary to process the application. The deposit you pay is an estimate of the cost of processing the application and may not cover the entire cost for which you will ultimately be responsible.

Your initial deposit amount of $ 1000 — will be applied toward processing your application(s). Interest does not accrue on this deposit. Monthly withdrawals against this deposit will be made based on the costs incurred in processing your application(s). Statements will be sent to you each month documenting the draws against your deposit. If the deposit reaches a balance of $400.00 or less, you could be asked to make a subsequent deposit. You would be expected to deposit these additional fees within 30 days of a request for additional funds. If there is a balance remaining after reconciling the final bill, a refund check will be mailed to you within 45 days of the final closure of the project.

In order to implement the cost recovery provisions, please sign this statement indicating your agreement to the cost recovery procedure. The signed agreement is required for your application(s) to be accepted for processing. If you have questions regarding the billing status of your application(s), contact **Project Coordinator, Diane Fortney** at **(760) 878-0263**, and provide her with your project file number(s).

I, NIHD (Kevin S. Flanigan) (applicant's name), agree to pay the Inyo County Local Agency Formation Commission (LAFCO) Processing Fee, which consists of the costs, as described above, incurred by LAFCO in processing this application. Such payment will be made to the Inyo County Local Agency Formation Commission, P.O. Drawer L, Independence, CA 93526. I understand and agree that processing of my application will be suspended pending receipt by LAFCO of all requested deposits. In the event of default of my obligations, I agree to pay all costs and expenses incurred by Inyo County LAFCO in securing performance of this obligation, including the cost of suit and reasonable attorneys' fees.

BY SIGNING THIS AGREEMENT THE APPLICANT/PROPERTY OWNER AGREES TO DEFEND, INDEMNIFY, AND HOLD THE COUNTY AND INYO LAFCO HARMLESS FROM ANY CLAIM, ACTION, OR PROCEEDING ARISING FROM THIS AGREEMENT OR BROUGHT TO ATTACK, SET ASIDE, VOID OR ANNUL THE COUNTY AND LAFCO'S APPROVAL OF THE APPLICATION, AND ANY ENVIRONMENTAL REVIEW ASSOCIATED WITH THE PROPOSED PROJECT.

Responsible Party's Signature* [signature] Date 2-11-2020
Project File Number(s): ____
* Applicant or Landowner listed above

Inyo Local Agency Formation Commission
168 North Edwards Street
Post Office Drawer L
Independence, California 93526

Phone: (760) 878-0263
(760) 872-2706
FAX: (760) 878-0382
E-Mail: inyolafco@inyocounty.us

No.____________________

PETITION OF APPLICATION

To: Local Agency Formation Commission
County of Inyo

Inyo LAFCO Staff:

The undersigned hereby applies for the initiation of proceedings before the Local Agency Formation Commission of Inyo County pursuant to Part 3, Division 3, Title 5 of the California Government Code (commencing with Section 56000, Cortese/Knox/Hertzberg Local Government Reorganization Act of 2000)

Petition is made for a proposal to (circle appropriate action):

Annex to existing city

Incorporate a new city

Annex to a district

Dissolution or Disincorporation

Detach from an existing city

Consolidation of districts

Create a new district

Detach from an existing district county service area

Expansion of Sphere Boundaries

Other (Please describe)

By agreement with SIHD, NIHD will sublease space in the SIHD RHC building for the provision of medical services including but not limited to Pediatrics and Orthopedics.

The undersigned do hereby request and petition that proceedings be taken for the expansion of medical services to said District(s) and territory hereinafter described pursuant to the Cortese/Knox/Hertzberg Local Government Reorganization Act of 2000, commencing with Section 56000 et. seq. of the Government Code.

Please circle appropriate action:

Petition   Resolution (attached)

Please complete the following: FAILURE to answer the questions and required attachments could delay the processing of your application.

1. The name(s) of the affected city, counties and/or districts and action proposed to be initiated are as follows:

Southern Inyo Healthcare District- Provision of medical care to the residents of Southern Inyo Healthcare District through subleasing space in their medical office.

2. The reasons for this proposal are as follows:

Southern Inyo Healthcare District by agreement with Northern Inyo Healthcare District will allow for provision of medical services by NIHD providers at the SIHD RHC office.

3. If proposal is for annexation or detachment state whether area is inhabited (12 or more registered voters) OR uninhabited. Also set forth description of the exterior boundaries of such territory.

N/A

4. Is this proposal consistent with the sphere of influence of the affected city and/or district(s)?

Yes

5. It is desirous that the proposed increased access to medical services and specialists provide for and be made subject to the following terms and conditions:

With support and by agreement with SIHD

6. Copies of maps (13) and legal description of the specific boundaries of the territory involved in this proposal are attached and made a part hereof, together with all other required forms.

N/A

7. Copies of the Executive Officer's Report, mailed notice of any hearing upon this proposal, and other communication regarding this proposal should be directed to:

Name Kevin S. Flanigan, MD MBA Phone No.760-873-2838
Address 150 Pioneer Lane; Bishop, CA 93514

Name ______________________ Phone No.______________
Address____

Name______________________ Phone No.______________
Address____

Respectfully Submitted,

Kevin S. Flanigan, MD MBA
CEO NIHD

Chief Petitioner

Documents Required:
Application
Petition
Resolution
Landowner's Consent

Justification Proposal
Legal Description
Entire Boundary Map
Negative Declaration

Paula Riesen

From:	Paula Riesen
Sent:	Tuesday, March 24, 2020 4:17 PM
To:	'John.Tremble@nih.org'; 'pspiers@sihd.org'
Cc:	Cathreen Richards
Subject:	LAFCO Applications
Attachments:	2020-01 NIH TO SIH - OT,PT,ST.pdf; 2020-02 NIH TO SIH - Pediatrics and Orthopedics.pdf

Good Afternoon;

I would like to email each of you a copy of the LAFCO Resolutions.
Please if you have any other questions, don't hesitate to ask.
Thank you,

Paula Riesen
Project Coordinator
Inyo County Planning
(760) 878-0263
priesen@inyocounty.us

From: John Tremble [mailto:John.Tremble@nih.org]
Sent: Thursday, March 5, 2020 10:19 AM
To: Cathreen Richards; Peter Spiers
Subject: RE: NOENCRYPT: LAFCO application

John, Peter,

I have scheduled a LAFCO hearing for this out of area service contract, as well as the one for services at the Owens Valley school, for March 19th. The meeting will be at Bishop City Hall in the Council Chambers beginning at 9:00a.m. There is a closed session item before yours, but it shouldn't take too long.

It is not mandatory that you be there, but a good idea, in case the commissioners have questions that would be best answered by you.

I have attached the staff reports for the two projects. Please let me know if you have any questions.

Cathreen Richards

From: John Tremble [mailto:John.Tremble@nih.org]
Sent: Monday, February 24, 2020 3:54 PM
To: Cathreen Richards; Peter Spiers
Subject: RE: NOENCRYPT: LAFCO application

NIHD is in the process of cutting the check tomorrow for this Application.

BEFORE THE LOCAL AGENCY FORMATION COMMISSION,
COUNTY OF INYO, STATE OF CALIFORNIA:

RESOLUTION No. 2020-01/ NORTHERN INYO HOSPITAL DISTRICT

A RESOLUTION OF THE INYO LOCAL AGENCY FORMATION COMMISSION MAKING DETERMINATIONS AND APPROVING LAFCO APPLICATION No. 2020-01/NORTHERN INYO HOSPITAL DISTRICT SERVICE EXTENSION AND THE AGREEMENT BETWEEN THE NORTHERN INYO HOSPITAL DISTRICT AND THE SHOUTHERN INYO HOSPITAL DISTRICT

Resolved, by the Inyo County Local Agency Formation Commission, that

WHEREAS, Government Code Section 56133 provides a district or city may provide new or extended services by contract or agreement only if it first requests and receives written approval by the local agency formation commission in the affected county; and

WHEREAS, on November 8, 2019 an application for approval of a service extension contract between the Northern Inyo Hospital District (NIHD) and the Southern Inyo Hospital District (SIHD) was filed with the Executive Officer of the Inyo County Local Agency Formation Commission pursuant to Title 5, Division 3, commencing with Section 56000 of the California Government Code; and

WHEREAS, the Executive Officer has reviewed the Agreement between NIHD and SIHD for rehabilitation services to include occupational and physical therapy and speech pathology at the Owens Valley School, located in Independence, California and found said agreement to be in compliance with the requirements of Government Code Section 56133; and

WHEREAS, the Inyo LAFCO is the lead agency for determining compliance of this project with the requirements of the California Environmental Quality Act of 1970, as amended, and has found said project to be exempt from the requirements of CEQA; and

WHEREAS, on March 19, 2020 this Commission considered the report of the Executive Officer, including her recommendation thereon, public comment, and all other evidence presented with respect to this proposal; and

NOW, THEREFORE BE IT RESOLVED the Inyo Local Agency Formation Commission does approve LAFCO Application No. 2020-01/Northern Inyo Hospital District for Rehabilitation Services in the boundary of SIHD; and

BE IT FURTHER RESOLVED, the Executive Officer is hereby authorized and directed to mail certified copies of this Resolution to the NIHD and SIHD.

PASSED AND ADOPTED this 19th day of March, 2020.

AYES:

NOES:

ABSENT:

ABSTAIN:

Chairperson
Inyo Local Agency Formation Commission

ATTEST: Executive Officer
Inyo Local Agency Formation Commission

**BEFORE THE LOCAL AGENCY FORMATION COMMISSION,
COUNTY OF INYO, STATE OF CALIFORNIA:**

RESOLUTION No. 2020-02/ NORTHERN INYO HOSPITAL DISTRICT

A RESOLUTION OF THE INYO LOCAL AGENCY FORMATION COMMISSION MAKING DETERMINATIONS AND APPROVING LAFCO APPLICATION No. 2020-02/NORTHERN INYO HOSPITAL DISTRICT SERVICE EXTENSION AND THE AGREEMENT BETWEEN THE NORTHERN INYO HOSPITAL DISTRICT AND THE SHOUTHERN INYO HOSPITAL DISTRICT

Resolved, by the Inyo County Local Agency Formation Commission, that

WHEREAS, Government Code Section 56133 provides a district or city may provide new or extended services by contract or agreement only if it first requests and receives written approval by the local agency formation commission in the affected county; and

WHEREAS, on February 11, 2020 an application for approval of a service extension contract between the Northern Inyo Hospital District (NIHD) and the Southern Inyo Hospital District (SIHD) was filed with the Executive Officer of the Inyo County Local Agency Formation Commission pursuant to Title 5, Division 3, commencing with Section 56000 of the California Government Code; and

WHEREAS, the Executive Officer has reviewed the Agreement between NIHD and SIHD for medical services including but not limited to pediatrics and orthopedics to be conducted at the SIHD Rural Health Clinic, located in Lone Pine California, and found said agreement to be in compliance with the requirements of Government Code Section 56133; and

WHEREAS, the Inyo LAFCO is the lead agency for determining compliance of this project with the requirements of the California Environmental Quality Act of 1970, as amended, and has found said project to be exempt from the requirements of CEQA; and

WHEREAS, on March 19, 2020 this Commission considered the report of the Executive Officer, including her recommendation thereon, public comment, and all other evidence presented with respect to this proposal; and

NOW, THEREFORE BE IT RESOLVED the Inyo Local Agency Formation Commission does approve LAFCO Application No. 2020-02/Northern Inyo Hospital District for Medical Services, including but not limited to pediatrics and orthopedics within the boundary of SIHD; and

BE IT FURTHER RESOLVED, the Executive Officer is hereby authorized and directed to mail certified copies of this Resolution to the NIHD and SIHD.

LAFCO
Resolution # 2020-02
NIHD-SIHD (Pediatrics)

PASSED AND ADOPTED this 19th day of March, 2020.

AYES:

NOES:

ABSENT:

ABSTAIN:

Chairperson
Inyo Local Agency Formation Commission

ATTEST: Executive Officer
Inyo Local Agency Formation Commission

2

Inyo Local Agency Formation Commission
168 North Edwards Street
Post Office Drawer L
Independence, California 93526

Phone: (760) 878-0263
FAX: (760) 872-2712
E-Mail: inyolafco@inyocounty.us

INYO LOCAL AGENCY FORMATION COMMISSION AGENDA

March 19, 2020
9:00 A.M.

To be held at:
Bishop City Council Chambers
301 West Line Street
Bishop, CA. 93514

Commission supports a negotiation of parties.

Commissioners:	Rick Pucci (Inyo County)
	Jeff Griffiths (Inyo County)
	Laura Smith (City of Bishop)
	Stephen Muchovej (City of Bishop)
	Alan Tobey (Public) Chairperson
Alternates:	Dan Totheroh (Inyo County), Jim Ellis (City of Bishop)
Executive Officer:	Cathreen Richards
Staff Analyst/Clerk:	Paula Riesen
Counsel:	Marshall Rudolph

Items will be heard in the order listed on the agenda unless the Inyo Local Agency Formation Commission (LAFCO) rearranges the order or the items are continued.

The LAFCO Chairperson will announce when public testimony can be given for items on the agenda. Please be aware that the Commission will consider testimony on both the project and related environmental documents.

If you challenge in Court any findings, determination or decision made following any Public Hearing announced in this agenda in Court, you may be limited to raising only those issues you or someone else rose at the Public Hearing, or in written correspondence delivered to the Inyo LAFCO at, or prior to, the Public Hearing.

Public Notice: In Compliance with the Americans with Disabilities Act, if you need special assistance to participate in this meeting please contact Inyo LAFCO at (760) 878-0263 (28 CFR 35.102-3.104 ADA Title II). Notification 48 hours prior to the meeting will enable the Commission to make reasonable arrangements to ensure accessibility to this meeting. Should you because of a disability require appropriate alternative formatting of this agenda, please notify Inyo LAFCO at least 72 hours prior to the meeting to enable the Commission to make the agenda available in a reasonable alternative format (Government Code Section 54954.2).

ITEM 1: **Pledge of Allegiance** April 10th Trial Date will be vacated?

ITEM 2: **Roll Call** – Roll call will be taken by staff.

ITEM 3: **Public Comment Period** – This is the opportunity for anyone in the audience to address the Commission on any relevant subject that is not scheduled on the Agenda.

Closed Session: Statute of Limitations: (Don't know when SMHD began medical billing).

ITEM 4: **Conference with Legal Counsel – Existing Litigation**. (Paragraph (1) of subdivision (d) of Government Code Section 54956.9) Name of case(s): *Inyo LAFCO and Northern Inyo Healthcare District v. Southern Mono Healthcare District* (Sacramento Superior Court and California Court of Appeal, Third District).

Reviewed Relevant Pleadings; motion for contempt?

– Appeal still pending – No Southern Mono brief filed.
– Appeal Statute of Limitations – Attorney Fees Denial by SMHD.

Open Session:

ITEM 5: **Report on Closed Session as required by law.**

ITEM 6: **Approval of Minutes (Action Item)** – the Commission will consider the minutes from November 18, 2019.

ITEM 7: **Approval of an Out of Area Service Contract (Action Item)** - Northern Inyo Hospital District to Southern Inyo Hospital District for Occupational Therapy to be located at the Owens Valley School in Independence.

ITEM 8: **Approval of an Out of Area Service Contract (Action Item)** - Northern Inyo Hospital District to Southern Inyo Hospital District for medical services including but not limited to pediatrics and orthopedics to be located at the Southern Inyo Rural Health building in Lone Pine.

ITEM 9: **Election of the Chair (Action Item)** – the Commission will entertain motions and conduct an election for the Chair.

ITEM 10: **Election of the Vice-Chair (Action Item)** – the Commission will entertain motions and conduct an election for the Vice-Chair.

ITEM 11: **Public Comment Period** – This is the opportunity for anyone in the audience to address the Commission on any relevant subject that is not scheduled on the Agenda.

ITEM 12: **Executive Officer's and Commissioners' Reports**

ITEM 13: **Determine Time and Location for the Next Meeting of Inyo LAFCO**

ITEM 14: **Adjournment**

Inyo Local Agency Formation Commission
168 North Edwards Street
Post Office Drawer L
Independence, California 93526

Phone: (760) 878-0263
FAX: (760) 872-2712
E-Mail: inyolafco@inyocounty.us

Commissioners:
Rick Pucci – Inyo County
Laura Smith - City of Bishop
Allen Tobey – Public (Chair)
Stephen Muchovej – City of Bishop
Jeff Griffiths – Inyo County

Alternates:
Dan Totheroh (Inyo County)
Jim Ellis (City of Bishop)

LAFCO Staff:
Cathreen Richards – Inyo County - (Executive Officer)
Marshall Rudolph (Counsel)
Paula Riesen – Inyo County – (Project Coordinator)

Minutes for Monday, November 18, 2019 – Special Meeting

These Minutes are for consideration for approval by Inyo LAFCO at its next meeting.

The Inyo Local Agency Formation Commission met on Monday, November 18, 2019, at City of Bishop Council Chambers, Bishop, CA. Chair Tobey opened the meeting at 9:03 a.m.

ITEM 1: **Pledge of Allegiance** – All recited the Pledge of Allegiance.

ITEM 2: **Roll Call** – Roll Commissioners Present: Chair Allen Tobey, Laura Smith, Jeff Griffiths, Stephen Muchovej.

Staff present: Cathreen Richards, Executive Officer, Marshall Rudolph, County Counsel and Paula Riesen, Project Coordinator.

ITEM 3: **Public Comment Period** – This is the opportunity for anyone in the audience to address the Commission on any relevant subject not scheduled on the Agenda.

The only person from the public present was Dr. Kevin Flanigan, he was present for the Special Closed Session Litigation Meeting. Chair Alan Tobey, closed the public comment period at 9:04 a.m.

ITEM 4: **Approval of Minutes (Action Item)** – the Commission will consider the minutes from May 16, 2019.

Chair Toby made a motion to approve and seconded by Laura Smith.
The motion passed 4-0.

Closed Session:

ITEM 5: **Update from Legal Counsel: Existing Litigation [Pursuant to Government Code §54956.9(d)(1)]** – Inyo Local Agency Formation Commission and Northern Inyo Healthcare District vs. Southern Mono Healthcare District.

Marshal Rudolph gave update of Litigation regarding the trial court's decision.

Closed Session ended at 9:44 am

ITEM 6: Report on Closed Session as Required by Law.
There was nothing it report it was an informational session only.

Open Session:

Executive Officer's and Commissioners' Reports
None given at this time.

Directors Report - Cathreen Richards, Planning Director said there is no new business at this time.

Determine Time and Location for the Next Meeting of Inyo LAFCO

Since there is not any pressing issues next meeting will be determined at another time as needed.

Adjournment – Chair Alan Tobey adjourned meeting at 9:50 am.

Inyo Local Agency Formation Commission
168 North Edwards Street
Post Office Drawer L
Independence, California 93526

Phone: (760) 878-0263
(760) 872-2706
FAX: (760) 872-2712
E-Mail: inyolafco@qnet.com

LAFCO STAFF REPORT

AGENDA ITEM No. **7 (Action Item - Public Hearing)**

DATE OF MEETING: **March 19, 2020**

SUBJECT: **LAFCO Application 2020-01/Northern Inyo Hospital District Extension of Services**

EXECUTIVE SUMMARY

This application is a request for approval of an extension of services from the Northern Inyo Hospital District (NIHD) for rehabilitation services that include: occupational therapy, physical therapy and speech pathology to students who reside in the Southern Inyo Hospital District (SIHD). These services are intended to be performed at the Owens Valley School (OVS) located in Independence and the SIHD is currently unable to provide them. This area is outside the NIHD boundary and completely within SIHD's.

Government Code Section 56133(a) states that a city or district may provide new or extended services by contract or agreement outside of its jurisdictional boundary only if it first requests and receives written approval from the commission. Staff is recommending the Inyo LAFCO approve the proposal by NIHD for the extension of services as it will result in the provision of necessary services to students who attend the Owens Valley School.

PROJECT INFORMATION:

Application: LAFCO Application No. 2019-02/Northern Inyo Hospital District
Applicant: Northern Inyo Hospital District
Landowner: Owens Valley School District
Location: Southern Inyo Hospital District
A.P.N.: N/A
Territory Size: N/A
Zoning: Public (P)
General Plan: Public Facility (PF)

Proposal: NIHD is requesting the approval of LAFCO for an extension services in the SIHD to provide rehabilitation services to students that attend the Owens Valley School, located within the SIHD boundary, consistent with an agreement from SIHD and with the Owens Valley School District.

Recommendation Staff is recommending the Inyo LAFCO approve the proposal by NIHD for the extension of services into SIHD's boundary as it will result in the provision of necessary services to students who attend the Owens Valley School.

Action: ***Adopt the Resolution*** of the Commission making findings and approving the extension of services by NIHD into the SIHD territory.

Alternatives: ***Do not approve the*** extension of services. This is not recommended as these services are vital to the students in the SIHD who require them.

Project Planner: Cathreen Richards

ANALYSIS:
The NIHD was approached by the Owens Valley School superintendent inquiring if the District could provide rehabilitation services to OVS students. These rehabilitation services include: occupational and physical therapy and speech pathology. NIHD agreed to provide the services to OVS on the condition that SIHD supported it and that NIHD could get approval from LAFCO. NIHD then asked SIHD if they would agree to the extension of services into their territory. SIHD answered in support and agreed to the extension of services by NIHD in a letter dated July 18, 2019. NIHD is now asking LAFCO for approval.

Government Code Section 56133 provides for LAFCO consideration of the extension services by a city or district. Specifically, Section 56133 (a) provides:

> *"A city or district may provide new or extended services by contract or agreement outside its jurisdictional boundary only if it first requests and receives written approval from the commission."*

ENVIRONMENTAL REVIEW
The out of area service agreement is exempt from CEQA pursuant to a Class 1 Categorical Exemption (CEQA Guidelines Section 15301- Existing Facilities).

STAFF RECOMMENDATION
Staff recommends the Commission approve the proposed out of area service agreement by adopting the attached resolution entitled "A Resolution of the Inyo Local Agency Formation Commission Making Determinations and Approving the Agreement Between the NIHD and SHID.

ATTACHMENTS:
- Agreement from SIHD for NIHD services
- Draft LAFCO Resolution

Southern Inyo Healthcare District
501 E. Locust St. P.O. Box 1009 Lone Pine, CA 93545
Phone: 760-876-5501 Fax: 760-264-4292

07/18/2019

Dr. Kevin Flannigan, MD-CEO
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

RE: Support for Northern Inyo Healthcare District to Provide Services within Southern Inyo Healthcare District Boundaries

To Whom It May Concern:

Please accept this letter as formal support for Northern Inyo Healthcare District's request to provide Rehabilitation Services (Occupational Therapy, Physical Therapy & Speech Pathology) to the students within Southern Inyo Healthcare District. We are pleased to partner with Northern Inyo Healthcare District to meet the needs of our students.

Additionally, we welcome a partnership with Northern Inyo Healthcare District for the delivery of pediatric care to the youth of Southern Inyo Healthcare District. While Southern Inyo Healthcare District currently provides care to children through our Family Medicine service; having a partnership with Northern Inyo Healthcare District specialty trained providers to support our team is clearly in the best interest of the patients we serve.
In closing we wish to be clear, we welcome Northern Inyo Healthcare District as a partner with the full understanding that as Southern Inyo Healthcare District expands services Northern Inyo Healthcare District will withdraw any approved service once it is available directly through Southern Inyo Healthcare District.

Sincerely,

Jaque Hickman
Board of Directors Southern Inyo Healthcare District

BEFORE THE LOCAL AGENCY FORMATION COMMISSION, COUNTY OF INYO, STATE OF CALIFORNIA:

RESOLUTION No. 2020-01/ NORTHERN INYO HOSPITAL DISTRICT

A RESOLUTION OF THE INYO LOCAL AGENCY FORMATION COMMISSION MAKING DETERMINATIONS AND APPROVING LAFCO APPLICATION No. 2020-01/NORTHERN INYO HOSPITAL DISTRICT SERVICE EXTENSION AND THE AGREEMENT BETWEEN THE NORTHERN INYO HOSPITAL DISTRICT AND THE SHOUTHERN INYO HOSPITAL DISTRICT

Resolved, by the Inyo County Local Agency Formation Commission, that

WHEREAS, Government Code Section 56133 provides a district or city may provide new or extended services by contract or agreement only if it first requests and receives written approval by the local agency formation commission in the affected county; and

WHEREAS, on November 8, 2019 an application for approval of a service extension contract between the Northern Inyo Hospital District (NIHD) and the Southern Inyo Hospital District (SIHD) was filed with the Executive Officer of the Inyo County Local Agency Formation Commission pursuant to Title 5, Division 3, commencing with Section 56000 of the California Government Code; and

WHEREAS, the Executive Officer has reviewed the Agreement between NIHD and SIHD for rehabilitation services to include occupational and physical therapy and speech pathology at the Owens Valley School, located in Independence, California and found said agreement to be in compliance with the requirements of Government Code Section 56133; and

WHEREAS, the Inyo LAFCO is the lead agency for determining compliance of this project with the requirements of the California Environmental Quality Act of 1970, as amended, and has found said project to be exempt from the requirements of CEQA; and

WHEREAS, on March 19, 2020 this Commission considered the report of the Executive Officer, including her recommendation thereon, public comment, and all other evidence presented with respect to this proposal; and

NOW, THEREFORE BE IT RESOLVED the Inyo Local Agency Formation Commission does approve LAFCO Application No. 2020-01/Northern Inyo Hospital District for Rehabilitation Services in the boundary of SIHD; and

BE IT FURTHER RESOLVED, the Executive Officer is hereby authorized and directed to mail certified copies of this Resolution to the NIHD and SIHD.

PASSED AND ADOPTED this 19th day of March, 2020.

AYES:

NOES:

ABSENT:

ABSTAIN:

____
Chairperson
Inyo Local Agency Formation Commission

ATTEST: ______________________________
Executive Officer
Inyo Local Agency Formation Commission

Inyo Local Agency Formation Commission
168 North Edwards Street
Post Office Drawer L
Independence, California 93526

Phone: (760) 878-0263
(760) 872-2706
FAX: (760) 872-2712
E-Mail: inyolafco@qnet.com

LAFCO STAFF REPORT

AGENDA ITEM No. **8 (Action Item - Public Hearing)**

DATE OF MEETING: **March 19, 2020**

SUBJECT: **LAFCO Application 2020-02/Northern Inyo Hospital District Extension of Services**

EXECUTIVE SUMMARY

This application is a request for approval of an extension of services from the Northern Inyo Hospital District (NIHD) for services to be conducted within the Southern Inyo Hospital District (SIHD) boundary. These services are for the provision of medical services to include but limited to pediatrics and orthopedics. NIHD will lease a space(s) at the SIHD Rural Health Clinic located in Lone Pine to see patients. This area is outside the NIHD boundary and completely within SIHD's.

Government Code Section 56133(a) states that a city or district may provide new or extended services by contract or agreement outside of its jurisdictional boundary only if it first requests and receives written approval from the commission.

PROJECT INFORMATION:

Application: LAFCO Application No. 2019-02/Northern Inyo Hospital District
Applicant: Northern Inyo Hospital District
Landowner: Southern Inyo Hospital District
Location: Southern Inyo Hospital District
A.P.N.: N/A
Territory Size: N/A
Zoning: Administrative and Professional Offices (C3)
General Plan: Public Facility (PF)

Proposal: NIHD is requesting the approval of LAFCO for an extension services in the SIHD to provide medical services to include but not limited to pediatrics and orthopedics at the SIHD Rural Health building, located in Lone Pine and within the SIHD boundary. This request is consistent with an agreement between SIHD and NIHD.

Recommendation Staff is recommending the Inyo LAFCO approve the proposal by NIHD for the extension of services as it will result in the provision of services not conveniently available to people who live in the SIHD. Currently these services can only be

	obtained in the City of Bishop, which is a long distance for people who live within the SIHD boundary.
Action:	***Adopt the Resolution*** of the Commission making findings and approving the extension of services by NIHD into the SIHD territory.
Alternatives:	***Do not approve the*** extension of services. This is not recommended as these services not currently available within the SIHD boundary for people who require them.
Project Planner:	Cathreen Richards

ANALYSIS:

The NIHD and SIHD worked out a mutually beneficial agreement for NIHD to provide medical services within the SIHD boundary. The proposed medical services include but are not limited to pediatrics and orthopedics. The SIHD territory covers close to 6,000-square-miles and includes several small communities located long distances to certain medical services that are only located in the City of Bishop. The furthest of these communities is Pearsonville at about 115-miles from Bishop and the closest, Independence, is about 45-miles. SIHD is in support of and agreed to the extension of services by NIHD in a letter dated February 13, 2020. NIHD is now asking LAFCO for approval.

Government Code Section 56133 provides for LAFCO consideration of the extension services by a city or district. Specifically, Section 56133 (a) provides:

> *"A city or district may provide new or extended services by contract or agreement outside its jurisdictional boundary only if it first requests and receives written approval from the commission."*

ENVIRONMENTAL REVIEW

The out of area service agreement is exempt from CEQA pursuant to a Class 1 Categorical Exemption (CEQA Guidelines Section 15301- Existing Facilities).

STAFF RECOMMENDATION

Staff recommends the Commission approve the proposed out of area service agreement by adopting the attached resolution entitled "A Resolution of the Inyo Local Agency Formation Commission Making Determinations and Approving the Agreement Between the NIHD and SHID.
Attachments:

- Agreement between the NIHD and SIHD.
- Draft LAFCO Resolution.

ATTACHMENTS:

- Agreement from SIHD for NIHD services
- Draft LAFCO Resolution

Southern Inyo Healthcare District
501 E. Locust St. P.O. Box 1009 Lone Pine, CA 93545
Phone: 760-876-5501 Fax: 760-264-4292

02/13/2020

Local Agency Formation Commission
Attn: Cathreen Richards
168 N. Edwards Street
PO Drawer L
Independence, CA 93526

Dear Cathreen Richards,

Please accept this letter as Southern Inyo Healthcare District's support and agreement of Northern Inyo Healthcare District's request to provide the stated services:

NIHD will sublease space in SIHD Rural Health Clinic building for the provision of medical services including but not limited to pediatrics and orthopedics.

If you should have any questions feel free to contact the Administration Office at (760) 876-2210.

Best Regards,

Peter Spiers, Ph.D.
Chief Executive Officer

BEFORE THE LOCAL AGENCY FORMATION COMMISSION,
COUNTY OF INYO, STATE OF CALIFORNIA:

RESOLUTION No. 2020-02/ NORTHERN INYO HOSPITAL DISTRICT

A RESOLUTION OF THE INYO LOCAL AGENCY FORMATION COMMISSION MAKING DETERMINATIONS AND APPROVING LAFCO APPLICATION No. 2020-02/NORTHERN INYO HOSPITAL DISTRICT SERVICE EXTENSION AND THE AGREEMENT BETWEEN THE NORTHERN INYO HOSPITAL DISTRICT AND THE SHOUTHERN INYO HOSPITAL DISTRICT

Resolved, by the Inyo County Local Agency Formation Commission, that

WHEREAS, Government Code Section 56133 provides a district or city may provide new or extended services by contract or agreement only if it first requests and receives written approval by the local agency formation commission in the affected county; and

WHEREAS, on February 11, 2020 an application for approval of a service extension contract between the Northern Inyo Hospital District (NIHD) and the Southern Inyo Hospital District (SIHD) was filed with the Executive Officer of the Inyo County Local Agency Formation Commission pursuant to Title 5, Division 3, commencing with Section 56000 of the California Government Code; and

WHEREAS, the Executive Officer has reviewed the Agreement between NIHD and SIHD for medical services including but not limited to pediatrics and orthopedics to be conducted at the SIHD Rural Health Clinic, located in Lone Pine California, and found said agreement to be in compliance with the requirements of Government Code Section 56133; and

WHEREAS, the Inyo LAFCO is the lead agency for determining compliance of this project with the requirements of the California Environmental Quality Act of 1970, as amended, and has found said project to be exempt from the requirements of CEQA; and

WHEREAS, on March 19, 2020 this Commission considered the report of the Executive Officer, including her recommendation thereon, public comment, and all other evidence presented with respect to this proposal; and

NOW, THEREFORE BE IT RESOLVED the Inyo Local Agency Formation Commission does approve LAFCO Application No. 2020-02/Northern Inyo Hospital District for Medical Services, including but not limited to pediatrics and orthopedics within the boundary of SIHD; and

BE IT FURTHER RESOLVED, the Executive Officer is hereby authorized and directed to mail certified copies of this Resolution to the NIHD and SIHD.

PASSED AND ADOPTED this 19th day of March, 2020.

AYES:

NOES:

ABSENT:

ABSTAIN:

____
Chairperson
Inyo Local Agency Formation Commission

ATTEST: __________________________________
Executive Officer
Inyo Local Agency Formation Commission

Kelli Davis

From:	Peter Spiers <pspiers@sihd.org>
Sent:	Monday, May 4, 2020 11:48 AM
To:	Kelli Davis
Cc:	Maritza Perkins
Subject:	[EXTERNAL MAIL]Peds Agreement
Attachments:	LAFCO - SIHD Agreement 02.12.2020.pdf

** This message has originated from outside the NIH network and has been tagged as EXTERNAL **

** Use care when opening attachments. Attachments are a common method for delivering malware. Do you know the sender? Were you expecting this attachment? If the message appears suspicious to you in any way, DO NOT click on any links or open the attachment(s) and **NEVER FORWARD** any emails that you have questions about.
If you are unsure what to do please Contact the service desk by email or phone servicedesk@nih.org or X2835. **

Hi Kelli,

Here's the executed copy of the professional services agreement with LAFCO approval.

Great speaking with you this morning! Ritz will work with Cori to get us on each other's calendar for a weekly update/strategy call.

Best,

Peter

Peter J. Spiers, Ph.D.
Chief Executive Officer
Southern Inyo Healthcare District
501 East Locust Street
Lone Pine,Ca.93545
760-876-5501 ext. 2225
pspiers@sihd.org

This Lease is entered into on January 1, 2020 by and between, Northern Inyo Healthcare District for the Northern Inyo Associates Pediatric Service (hereinafter "Tenant",)and Southern Inyo Healthcare District, a California Healthcare District located in Lone Pine, California (hereinafter "Landlord")

Recitals

Tenant is a California Health Care District, organized and existing pursuant to the Local Health Care District Law, Health & Safety Code section 32000, et. seq., with its principal place of business at Bishop, California.

Tenant owns and operates a Pediatric Clinic located at 152 Pioneer Lane, Bishop, California.

Landlord owns and operates a medical office building in Lone Pine designed for the practice of outpatient medicine.

Landlord wishes to have Tenant offer Pediatric services at 510 East Locust St in the City of Lone Pine, County of Inyo, State of California

Lease

Subject to and governed by the terms and conditions set forth below, Landlord hereby leases to Tenant, and Tenant hereby leases from Landlord, on the terms and conditions set forth in this lease use of space in a 1000 square foot Medical office suite (the Premises) located at 510 East Locust St, in the City of Lone Pine, County of Inyo, State of California. Lease shall include the work provided by office administrative and clerical support staff.

Term of Lease

The term of this lease shall be for a term of one year, beginning February 1, 2020, unless terminated sooner as provided in this lease.

Rent

Tenant agrees to pay to Landlord as rent for the term of this lease the sum of $18,000 (Eighteen Thousand dollars) per year, payable in month increments of $1,500 (One thousand five hundred dollars) commencing on the first day of the lease February 1, 2020.

Repairs, Maintenance and Improvements

Improvements to be made by Landlord. Landlord is responsible to maintain and improve the property in order to provide a facility in compliance with State, Local and National standards for a Medical Office Building, and to maintain the common space, parking, sidewalks and in good working condition and good environmental condition.

Present Condition of Premises. Tenant has inspected the Premises, agrees, and hereby stipulates with Landlord that the Premises be in good and tenantable condition for its purposes on the date of this lease.

Repairs by Landlord. During the term of this lease or extension of the term of this lease, Landlord shall at Landlord's own cost and expense, keep the exterior roof, sidewalls, structural supports, doors, windows, and foundation of the building on the Premises in good repair and make all necessary repairs to, or replacements of, the plumbing, and electrical systems on the Premises; provided, however, Landlord shall not be required to make any repairs due to the negligence or above of the property by the Tenant.

Repairs by Tenant: Tenant is responsible for all repairs to their suite, including interior walls, windows, cabinets and suite specific heating and cooling units.

Hazardous Waste: Tenant is responsible for the removal of all hazardous waste generated because of their business use. Tenant agrees to meet all state, local and federal requirements for the handling and removal of hazardous waste.

Tenant Alterations: Tenant may make nonstructural alterations or improvements to the Premises as deemed necessary by the Tenant with Landlord's approval. All improvements or alterations made by Tenant on the Premises shall comply with the requirements of any federal, state or local authority having jurisdiction.

Tenant Improvements and Trade Fixtures: Any alterations, improvements or installations made by Tenant to the Premises shall become part of the realty and belong to the Landlord upon the expiration or termination of the Lease. Tenant shall have the right to remove its trade fixtures from the Premises at the expiration or termination of the Lease. Tenant shall repair or be responsible for the cost of any damage caused by the removal of the Tenant's trade fixtures.

Liens: Tenant agrees to keep all of the Premises free and clear of all mechanics and other liens.

Landlord is Right of Inspection: Landlord or Landlord's duly authorized agents may enter the Premises at any reasonable time during the term of this lease to perform any acts authorized by this lease to be performed by Landlord or to show the Premises to future tenants if the Tenant has given notice to terminate the Lease.

Surrender of Premises: On expiration or earlier termination of this lease, Tenant shall promptly surrender possession of the Premises to Landlord in as good condition as the Premises are on the date of this lease, less reasonable wear and tear excepted.

Use of Premises

Tenant shall use the Premises for operating and conducting a practice of a medical specialty or other permitted use and for no other purpose without the written consent of Landlord. Landlord shall not unreasonably withhold consent.

The Premises shall not be used or permitted by Tenant to be used in violation of any law or local ordinance. Tenant shall maintain the Premises in a clean and sanitary manner and shall comply with all laws, ordinances, rules, and regulations applicable to the Premises.

Staff, Insurance, Taxes and Utilities

Landlord shall, at Landlord's own cost and expense, secure and maintain during the length of the lease, general liability and property damage insurance insuring Tenant against all bodily injury, property damage, personal injury and other loss or liability caused by or connected with Tenant's occupation and use of the Premises in amounts not less than:

> $300,000 for injury to or death of one person, or not less than $1,000,000 for injury or death of two or more persons as a result of any one accident or incident; and
>
> $250,000 for property damage.

Tenant shall be named as an additional insured and the policy or policies shall contain cross-liability endorsements.

Tenant may purchase Personal Property insurance. The Landlord is responsible for damage, destruction or theft of personal property and/or trade fixtures of the Tenant.

Tenant shall maintain Worker's Compensation insurance in accordance with the laws of California.

Taxes: Landlord shall promptly pay, and not allow to fall into arrears, all personal property taxes assessed against it by the Count of Inyo, State of California.

Utilities: Landlord shall pay all charges incurred for utilities furnished to and/or used in Tenant's practice within the occupancy of, the Premises including but not limited to propane, electricity, water, telephone, internet, garbage, hazardous waste and any other public utilities.

Conditions: Landlord agrees that Tenant shall be supported in its function as a healthcare provider by Landlord's staff including clerical and clinical personnel. Failure to provide such support shall result in termination of the Lease.

Destruction of Premises or Condemnation

If any improvement, including buildings and other structures located on the Premises are damaged or destroyed during the term of this lease the Tenant or the Landlord shall have the right to terminate this lease if the Premises are destroyed from any causes whatsoever, insured or uninsured.

Either party may terminate this lease by giving 30 days' notice of termination to the other from the date of the destruction event or condemnation. Tenant shall not be entitled to collect any insurance proceeds attributable to the Premises except those attributable to the Tenant's personal property and trade fixtures.

If this lease is terminated, all sums due Landlord or refund due Tenant shall be calculated based on the proportion of time for the month that the Premises was occupied out of the days in the event month.

Default and Remedies

Remedies in Tenant's Default: If Tenant breaches this lease or abandons the Premises before the natural expiration of the leave; Landlord, in addition to any other remedy given Landlord by law or equity, may: Terminate this lease and recover from the Tenant:

- The worth at the time of award of the unpaid rent that has been earned at the time of termination of the lease.
- The worth, at the time of award of the amount by which the unpaid rent that would have been earned after termination of the lease until the time of award exceeds the amount of rental loss that Tenant proves could have been reasonable avoided.
- Any other amount necessary to compensate Landlord for all detriment proximately caused by Tenant's failure to perform the obligations under this lease.

Definition of Tenant Default: Default shall occur when one or more of the following events occur.

Failure to Pay Rent when Due within 20 days

Failure to perform any covenant or conditions of the Lease

The bankruptcy or insolvency of Tenant

Abandonment of the Premises. Abandonment means the failure to occupy the Premises for 30 consecutive days and to practice the primary business of medicine.

Notices:

Notices shall be expressly written to each party as prescribed by California law.

To Tenant: Northern Inyo Healthcare District, CEO
150 Pioneer Lane
Bishop, California 93514

To Landlord: Southern Inyo Healthcare Distirct
Peter Spiers, PHD
510 East Locust
Lone Pine, California 93545

Executed at Bishop, California, on the day, month and year written below:
Southern Inyo Healthcare District (Landlord)

By Peter Spiegel CEO

Date 2/11/2020

Northern Inyo Healthcare District on behalf of Northern Inyo Associates (Tenant)

By ______________________________

Date ______________________________

This Lease is entered into on January 1, 2020 by and between, Northern Inyo Healthcare District for the Northern Inyo Associates Pediatric Service (hereinafter "Tenant",)and Southern Inyo Healthcare District, a California Healthcare District located in Lone Pine, California (hereinafter "Landlord")

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Present Condition of Premises. Tenant has inspected the Premises, agrees, and hereby stipulates with Landlord that the Premises be in good and tenantable condition for its purposes on the date of this lease.

Repairs by Landlord. During the term of this lease or extension of the term of this lease, Landlord shall at Landlord's own cost and expense, keep the exterior roof, sidewalls, structural supports, doors, windows, and foundation of the building on the Premises in good repair and make all necessary repairs to, or replacements of, the plumbing, and electrical systems on the Premises; provided, however, Landlord shall not be required to make any repairs due to the negligence or above of the property by the Tenant.

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Liens: Tenant agrees to keep all of the Premises free and clear of all mechanics and other liens.

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Surrender of Premises: On expiration or earlier termination of this lease, Tenant shall promptly surrender possession of the Premises to Landlord in as good condition as the Premises are on the date of this lease, less reasonable wear and tear excepted.

Use of Premises

Tenant shall use the Premises for operating and conducting a practice of a medical specialty or other permitted use and for no other purpose without the written consent of Landlord. Landlord shall not unreasonably withhold consent.

The Premises shall not be used or permitted by Tenant to be used in violation of any law or local ordinance. Tenant shall maintain the Premises in a clean and sanitary manner and shall comply with all laws, ordinances, rules, and regulations applicable to the Premises.

Staff, Insurance, Taxes and Utilities

Landlord shall, at Landlord's own cost and expense, secure and maintain during the length of the lease, general liability and property damage insurance insuring Tenant against all bodily injury, property damage, personal injury and other loss or liability caused by or connected with Tenant's occupation and use of the Premises in amounts not less than:

> $300,000 for injury to or death of one person, or not less than $1,000,000 for injury or death of two or more persons as a result of any one accident or incident; and
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> $250,000 for property damage.

Tenant shall be named as an additional insured and the policy or policies shall contain cross-liability endorsements.

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Conditions: Landlord agrees that Tenant shall be supported in its function as a healthcare provider by Landlord's staff including clerical and clinical personnel. Failure to provide such support shall result in termination of the Lease.

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- The worth, at the time of award of the amount by which the unpaid rent that would have been earned after termination of the lease until the time of award exceeds the amount of rental loss that Tenant proves could have been reasonable avoided.
- Any other amount necessary to compensate Landlord for all detriment proximately caused by Tenant's failure to perform the obligations under this lease.

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Notices:

Notices shall be expressly written to each party as prescribed by California law.

To Tenant: Northern Inyo Healthcare District, CEO
150 Pioneer Lane
Bishop, California 93514

To Landlord: Southern Inyo Healthcare Distirct
Peter Spiers, PHD
510 East Locust
Lone Pine, California 93545

Executed at Bishop, California, on the day, month and year written below:
Southern Inyo Healthcare District (Landlord)

By ____________________

Date ____________________

Northern Inyo Healthcare District on behalf of Northern Inyo Associates (Tenant)

By ____________________

Date 2-11-2020

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

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

TO: NIHD Board of Directors
FROM: Stacey Brown, MD, Chief of Medical Staff
DATE: June 2, 2020
RE: Medical Executive Committee Report

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

A. Medical Staff Appointments (*action items*)
   1. Gregory Gaskin, MD (*emergency medicine*) – provisional active staff
   2. Timothy Brieske, MD (*family medicine*) – provisional active staff

B. Telemedicine Staff Appointments – credentialing by proxy (*action item*)
   As per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon Adventist Health's credentialing and privileging decisions.
   1. Armand Rostamian, MD (*cardiology*) – telemedicine staff
   2. Diana Havill, MD (*psychiatry*) – telemedicine staff

C. Staff Category Change (*action item*)
   1. Ruhong Ma, DO (*internal medicine*) – change from locums to provisional active staff. Privileges valid through 12/31/2021.

D. Resignations (*action items*)
   1. Peter Bloomfield, MD (*emergency medicine*) – active staff – effective 5/26/20

E. Policies and Procedures (*action items*)
   1. *Pharmacy Downtime Procedure*
   2. *Opioid Sedation Scale*
   3. *Opioid Administration*
   4. *Pain Assessment and Documentation*
   5. *Scope of Service Acute/Subacute*
   6. *Telemetry Criteria Guideline*
   7. *MRI Safety*
   8. *Code Blue Procedure – Code Blue Team*
   9. *Cardiac Stress Test Protocol and Procedure*

F. Annual Approvals (*action items*)
   1. Radiology Critical Indicators 2020

G. Internal Medicine Core Privilege Form update (*action item*)

H. CMO and CEO Discussion (*information item*)

NORTHERN INYO HEALTHCARE DISTRICT MEDICAL STAFF

OFFICERS, SERVICE CHIEFS, AND COMMITTEES

July 1, 2020 – June 30, 2021

OFFICERS

CHIEF OF STAFF	Stacey Brown, M.D.
VICE CHIEF OF STAFF	Charlotte Helvie, M.D.
IMMEDIATE PAST CHIEF OF STAFF	William Timbers, M.D.

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Member-at-Large, [Medical] Executive and Quality Improvement Committees:

Anne Wakamiya, M.D.

6/3/2020

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Pharmacy Downtime Procedure**	
Scope: Departmental	Department: **Pharmacy**
Source: Director of Pharmacy	Effective Date:

PURPOSE:
To ensure the continuity of pharmaceutical care during electronic or power outages.

POLICY:
In the event of electronic or power outage of the hospital computer system, the following procedures will be followed:

PROCEDURE:

Hospital Staff

During pharmacy hours (0630-1700) call pharmacy.
After pharmacy hours call House Supervisor. (who may then call On-Call Pharmacist)

EHR is down:

Two processes exist for MAR manufacture if EHR inoperative.

1. Obtain backup Mars from Home Drive (preferred) or

2. Use automatic dispensing cabinets (Omnicell).

1. Instructions for identified staff to obtain backup Mars from Home Drive (preferred)

   Go to Home Drive in Computer

draft

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Pharmacy Downtime Procedure**	
Scope: Departmental	Department: **Pharmacy**
Source: Director of Pharmacy	Effective Date:

Note: Backup MAR is only available for Med-Surg, ICU, Perina-tal, & ED

House Supervisor, Pharmacy, Clinical/Quality Informatics, & ITS have access.

- Home Drive

-

-

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Name	Date modified
Emergency	11/3/2019 10:45 AM
ICU	11/3/2019 10:45 AM
Med_Surg	11/3/2019 10:45 AM
Perinatal	11/3/2019 10:45 AM

- Open folder and select patients
- Go to file to print
- Make sure you close out each PDF after printing.
- H:\Shared\MAR

End of document

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Pharmacy Downtime Procedure**	
Scope: Departmental	Department: **Pharmacy**
Source: Director of Pharmacy	Effective Date:

2. Option 2 Using Omnicell

Call pharmacy or oncall pharmacist if help needed however process should be able to be managed by House Supervisor after hours. All Omnicell units have backup power except Diagnostic Imaging hence information is retrievable from all others.

Procedure to retrieve information from cabinets:

-Retrieve blank MAR paper forms from file on Med Surg
-Login to automatic dispensing cabinet
-User Menu
-Find Patient
-Remove Item
-Active Orders

Fill MAR blank sheet out with the following items:

-Fill in patient name & med rec number.
-Fill in dates, Note times of shifts = 2 dates.
-Fill In Scheduled Medications or PRN
-Put in Allergies
-Fill in each medication into one square
-Put Route of administration under route
-For scheduled meds put the "due" times in the appropriate square.
-Put last dose under medication name
-Nurse caring for patient must check work and sign off
-Automatic Dispensing Unit is available to double check patient's profile

REFERENCES:

1. Omnicell Training Manual Downtime Procedure pages 236-240
2. ISMP: Guidelines for Safe Use of Medication Cabinet 2/7/19

CROSS REFERENCE

1. NIHD Medication Security Policy
2. NIHD Access to Medication in Absence of Pharmacist

Draft

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Pharmacy Downtime Procedure**	
Scope: Departmental	Department: **Pharmacy**
Source: Director of Pharmacy	Effective Date:

APROVALS	
Pharmacy and Therapeutics Committee	5/14/2020
CCOC	3/23/2020
Medical Executive Committee	6/2/2020
Board of Directors	
Last Board of Director review	

Responsibility for review and maintenance: Director of Pharmacy
Index Listings:
Initiated: 5/01/12
Revised/Reviewed: 5/13/13, 5/17/17, 3/2020fl

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Opioid Sedation Scale*	
Scope: Acute/Subacute Services, Perinatal Services, ICU & Emergency Department	Manual: CPM - Medication (MED)
Source: Manager - ICU Acute/Subacute	Effective Date: 10/15/16

PURPOSE:
The goal is to objectively assess and monitor a patient's level of sedation during opioid treatment and provide the most appropriate level of analgesia while maintaining a safe level of sedation.

POLICY:
To assess and document a patient's level of sedation using the Pasero Opioid-Induced Sedation Scale (POSS). This policy does not apply to comfort care and end of life patients.

PROCEDURE:
1. Utilize the scale shown below.
2. The Pasero Opioid –Induce Sedation Scale includes the consideration and use of Naloxone. *3 and *4 below is a consideration and not an order.
   At Northern Inyo Hospital, an order from a privileged practitioner is required prior to the administration of any reversal agent including Naloxone.

Medscape

Pasero Opioid-Induced Sedation Scale (POSS)

S = Sleep, easy to arouse
Acceptable; no action necessary; may increase opioid dose if needed
1 = Awake and alert
Acceptable; no action necessary; may increase opioid dose if needed
2 = Slightly drowsy, easily aroused
Acceptable; no action necessary; may increase opioid dose if needed
3 = Frequently drowsy, arousable, drifts off to sleep during conversation
Unacceptable; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory; decrease opioid dose 25% to 50%[1] or notify prescriber[2] or anesthesiologist for orders; consider administering a non-sedating, opioid-sparing nonopioid, such as acetaminophen or a NSAID, if not contraindicated.
4 = Somnolent, minimal or no response to verbal and physical stimulation
Unacceptable; stop opioid; consider administering naloxone[3,4]; notify prescriber[2] or anesthesiologist; monitor respiratory status and sedation level closely until sedation level is stable at less than 3 and respiratory status is satisfactory.

*Appropriate action is given in italics at each level of sedation.
[1]Opioid analgesic orders or a hospital protocol should include the expectation that a nurse will decrease the opioid dose if a patient is excessively sedated.
[2]For example, the physician, nurse practitioner, advanced practice nurse, or physician assistant responsible for the pain management prescription.
[3]Mix 0.4 mg of naloxone and 10 mL of normal saline in syringe and administer this dilute solution very slowly (0.5 mL over 2 minutes) while observing the patient's response (titrate to effect) (Source for naloxone administration: Pasero, Portenoy, McCaffery M. Opioid analgesics. In *Pain: Clinical Manual* [ed 2]. St. Louis, MO, Mosby 1999, p. 267; American Pain Society [APS]. *Principles of Analgesic Use in the Treatment of Acute Pain and Chronic Cancer Pain* [ed 5]. Glenview. IL. APS. 2003.)
[4]Hospital protocols should include the expectation that a nurse will administer naloxone to any patient suspected of having life-threatening opioid-induced sedation and respiratory depression.

Source: Pain Manag Nurs © 2009 W.B. Saunders

Title: Opioid Sedation Scale*	
Scope: Acute/Subacute Services, Perinatal Services, ICU & Emergency Department	Manual: CPM - Medication (MED)
Source: Manager - ICU Acute/Subacute	Effective Date: 10/15/16

ASSESSMENT:
A proper sedation assessment requires the nurse to observe how quickly the patient rouses when stimulated by the presence of the nurse, a touch, or conversation. The patient's ability to stay awake once aroused is a critical indicator of level of sedation. To determine this, the patient should:

- Be asked to wake up and answer a simple question. A patient who is easy to arouse will be able to awaken readily and respond with a complete answer to the question without falling asleep (sedation level 1 or 2 on the POSS).
- Falling asleep mid-sentence indicates a sedation level of 3 on the POSS.
- POSS score of 3 or more requires the nurse to hold the opioid dose, notify the medical provider and increase monitoring frequency, based upon provider order, until the patient has a sedation level of less than 3.
- POSS score of 3-4 requires the nurse to notify the medical provider if respiratory assessment (rate and depth) is inadequate. Rapid Response Team initiation should strongly be considered.
- Sedation level and respiratory status is assessed prior to administration of opioid medications and at the time of pain reassessment.
- Initiation of long acting opioid medication requires POSS every 4 hours during the first 24 hours of opioid treatment.
- For chronic pain patients with a stable dosage of opioid, the patient should be assessed prior to administration of opioid and at time of pain reassessment. (See Pain Assessment and Documentation policy)

A proper respiratory assessment during opioid treatment requires the nurse to:

- Watch the rise and fall of the patient's chest to determine the rate, depth, and regularity of respirations. Current respiratory rate should be compared with previous rates, and trends should be noted. Shallow respirations or periods of apnea, even brief periods, require further evaluation.

RN's will follow the Patient Controlled Analgesia (PCA) policy found in Lippincott procedures when administering opioids via PCA pump.

CAUTION: Other sedating agents in addition to opioid may have an additive effect on sedation.

INTERVENTION:
The POSS links nursing interventions to the various levels of sedation. Actions, per provider orders, may include increasing the opioid dose in a patient who is easy to arouse and reports unacceptable pain relief, or decreasing or holding the opioid dose in a patient who is excessively sedated. Medical Provider shall be notified by nurse of POSS score associated with potential need to reduce opioid prescription.

DOCUMENTATION:
Documentation will be entered into the EHR.

REFERENCES:
1. Nisbet, A. & Mooney-Cotter, F. (2009). Comparison of Selected Sedation Scales for Reporting Opioid-Induced Sedation Assessment. *Pain Management Nursing*, 10(3), pp. 154-164.

Title: Opioid Sedation Scale*	
Scope: Acute/Subacute Services, Perinatal Services, ICU & Emergency Department	Manual: CPM - Medication (MED)
Source: Manager - ICU Acute/Subacute	Effective Date: 10/15/16

2. Pasero, C. (2009). Assessment of Sedation During Opioid Administration for Pain Management. *Journal of PeriAnesthesia Nursing*, 24(3), pp. 186-190.
3. The Joint Commission. (2012). "Sentinel event alert: Safe use of opioids in hospitals" [Online]. Accessed October 2018 via the Web at https://www.jointcommission.org/assets/1/18/SEA_49_opioids_8_2_12_final.pdf (Level VII)

CROSS REFERENCE P&P:
1. Lippincott Procedures. (2019). Patient-controlled analgesia.
2. Opioid Administration
3. Pain Assessment and Documentation

Approval	Date
CCOC	3/23/2020
Pharmacy & Therapeutics	5/14/2020
MEC	6/2/2020
Board of Directors	
Last Board of Directors Review	

Developed: 4/16 ab, la
Reviewed: 2/17la
Revised: 4/17la, 2/19ta, 2/20 jn
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Opioid Administration*	
Scope: Nursing Services	Manual: CPM - Medication (MED)
Source: Manager - ICU Acute/Subacute	Effective Date: 11/16/16

PURPOSE:
To provide safe and appropriate opioid pain relief to patients.

POLICY:
1. A thorough assessment of a patient is to be completed by a licensed RN prior to opioid administration (see procedure below for more detailed information).
2. An opioid can be administered by a Registered Nurse (RN) or provider. A Licensed Vocational Nurse (LVN) may administer opioids excluding IV opioid administration.
3. An order from a privileged provider has to be obtained prior to any opioid administration.

DEFINITION:
Acute pain – is a normal sensation that alerts us to possible injury.
Chronic pain – any pain lasting more than 12 weeks; may arise from an initial injury, or there may be an ongoing cause, such as illness.
Opioid – a medicine possessing some properties characteristic of opiate narcotics but not derived from opium.
Opioid naïve – implies patients are not chronically receiving opioids on a daily basis.
Opioid tolerant – implies patients are chronically receiving opioids on a daily basis.

PROCEDURE:
1. Assessment: Upon admission, a thorough assessment should be performed on a patient by a licensed RN prior to any opioid administration. To ensure patient safety, this should be reviewed and updated as needed with each shift as necessary. This assessment includes, but is not limited to:
   - Assessing cognitive abilities to ensure an appropriate pain scale (e.g. 0-10 numeric scale, FACES, or FLACC) and pain goal is applied. This pain goal should be decided upon admission and charted on EHR.
     a) Is the patient alert and oriented?
     b) Are they able to appropriately describe their pain?
     c) What pain scale should be used and what is the patient's desired pain goal if not all pain can be eliminated?
   - Are they age appropriate to be receiving the ordered dose and route prescribed?
   - Asking about history and current medication use
     a) Does the patient have acute or chronic pain?
     b) Do they take any opioid pain medications and for how long?
     c) Does the patient have history of Substance Use Disorder (SUD)?
2. Education: Prior to opioid administration, education for the medical personnel and for the patient is imperative.
   - Education for the personnel pertains to understanding the potential effects of opioid administration and what to monitor, such as:
     a) Sedation level
     b) Pain Assessment
     b) Drug interactions
     c) Drug compatibility

   d) Side effects - constipation, nausea and vomiting, respiratory depression, risk of falls, CNS depression, impact on psychomotor and cognitive function
   e) Potential for addiction, tolerance, physical dependency, and withdrawal
- Education for the patient should include:
   a) Understanding the use of the medications, the desired effects, the potential adverse effects, how the medication will be administered
   b) Pain scale and pain goal and how it relates to what type of pain relief measures can be provided
   c) Onset of action and duration to expect effect of medication

3. Administration: When considering the use of an opioid, a series of checks should be completed:
- A multimodal approach should be taken when treating pain and trialed prior to ultimately giving an opioid:
   a) Psychosocial support
   b) Coordination of care
   c) Promotion of healthful behaviors
   d) Non-pharmacological approaches
      i. Distraction
      ii. Relaxation techniques
      iii. Positioning
      iv. Cool or warm packs
   e) Non-opioid medications
      i. Non-steroidal anti-inflammatory agents
      ii. Muscle relaxants
- If after doing the above and an opioid is needed, an order from a privileged practitioner must be obtained
   a) If written as a PRN order, there should be parameters according to a pain scale (e.g. Morphine 2 mg IV as needed for severe pain 7-10)
- Timely assessment and appropriate monitoring is essential when opioids are administered to permit intervention to counteract an adverse reaction should it occur – refer to Lippincott's 'Patient-Controlled Analgesia' (PCA), 'Pain Assessment and Documentation' and the 'Opioid Sedation Scale' for monitoring guidelines and interventions.
   a) Patients with the following are at high risk for over-sedation and respiratory depression:
      i. Sleep apnea or sleep disorders
      ii. Morbid obesity
      iii. Snoring
      iv. Older age (over 61 years old)
      v. Opiate Naïve (no recent opioid use)
      vi. Post-surgery (particularly upper abdominal surgery)
      vii. Increased opioid dose requirement
      viii. Receiving other sedating drugs (benzodiazepines, CNS depressants, etc.)
      ix. Preexisting pulmonary or cardiac disease or other major organ dysfunction
      x. Smoker
- Continually assess the need for opioid administration and advocate for its discontinuation as promptly as able to, per patient's condition
- Educate other staff members within the multi-disciplinary team to take extra precautions with the patient

4. Wasting of opioids:

Title: Opioid Administration*	
Scope: Nursing Services	Manual: CPM - Medication (MED)
Source: Manager - ICU Acute/Subacute	Effective Date: 11/16/16

- Follow the Opioid Waste policy

DOCUMENTATION:
- Documentation for opioid administration is performed within the Medication Administration Record in the patient chart.
- Documentation for monitoring and assessment of pain and sedation is performed in the Electronic Health Record.

REFERENCES:
1. Centers for Medicare and Medicaid Services. (2014). *Requirements for hospital medication administration, particularly intravenous (IV) medications and post-operative care of patients receiving IV opioid.*
2. Curtis, Mitchell. (2015). *Hospital accreditation: CMS and IV opioid administration*. Retrieved from http://blog.cihq.org/cms-and-iv-opioid-administration
3. Medline Plus. Retrieved April 30, 2016 from https://www.nlm.nih.gov/medlineplus/mplusdictionary.html
4. The Joint Commission. (2012). *Safe use of opioids in hospital, 49*, pp. 1-5.
5. UpToDate. (2016). Drug search engine found on http://www.uptodate.com/contents/search

CROSS REFERENCE P&P:
1. Barcode Medication Administration
2. Opioid Sedation Scale
3. Pain Assessment and Documentation
4. Patient Controlled Analgesia. (August 2019) *Lippincott Procedures*.
5. Safe medication administration practices, ambulatory care. (April, 2016). *Lippincott Procedures*. Retrieved on May 1, 2016 from http://procedures.lww.com
6. Opioid Waste policy

Approval	Date
CCOC	3/23/2020
Med Services/ICU	5/21/2020
STTA	4/22/2020
Emergency Services Committee	5/12/2020
Perinatal/Pediatrics Committee	4/28/2020
Pharmacy and Therapeutics	5/14/2020
MEC	6/2/2020
Board of Directors	
Last Board of Director review	

Developed: 6/16 la
Reviewed: 1/17 la
Revised: 2/19ta, 2/20jn

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Pain Assessment and Documentation*	
Scope: Nursing Services	Manual: Cognitive and Perceptual (NSC), CPM - Neurological, Sensory
Source: Manager - ICU Acute/Subacute	Effective Date: 5/16/17

PURPOSE:
1. To provide for standardization of pain screening/assessment, management and documentation across the treatment continuum, with a particular focus on the hospital in-patient.
2. Assessment of pain for the verbally non-communicative infant, child or adult must rely on behavioral and or physiologic parameters.

POLICY:
Pain assessment will be documented on the Admission Nursing Assessment form initially and on a regular basis on the unit patient care flow sheet or unit nursing record thereafter.

At a minimum, the following standards for pain assessment, treatment, and documentation will be followed. Additionally, individual unit's standards of care that pertain to pain assessment, management, and documentation will be followed.

The same numerical scale for pain assessment will be used for each individual patient If the type of pain scale is changed it will be noted.
The following scales will be used:

A. **Neonatal/Infant Pain Scale (NIPS)**
   This scale may be used for *infants less than 1 year* of age.
   See addendum I

B. **Facial, legs, activity, cry, consolability scale (FLACC)**
   This scale can be used in *children ages 2 months to 7 years.*
   FLACC Behavioral Pain Assessment Scale is a behavioral assessment that can be used to determine pain level when a child can't report his level of pain. It can be used in children ages 2 months to 7 years. Five categories are scored from 0 to 2. The categories are then totaled to obtain the child's pain score. The pain score can range from 0 to 10; the higher the score, the greater the pain.
   See addendum II

C. **Wong-Baker FACES Pain Rating Scale:** This scale is used for adults and pediatric *patients older than 3 year of age.* The Wong-Baker FACES Pain Rating Scale can also be used with *patients who have mild dementia* or for those who are unable to understand a numeric pain scale.
   It is a self-report tool in which the patient points to the face that corresponds to his pain intensity. NIH uses the 0 to 10 scale.
   See addendum III

D. **Patient Self Report of Pain:** The Numeric Pain Scale may be used for patients
   5 years of age or older.
   The patient must be able to count.
   The patient reports pain severity on a 0-10 scale by associating with a numerical value or facial expression.
   See addendum IV

E. **Observational Pain Scale for Critically Ill Adults:** May be used for patients who are unable to communicate their pain level. May be used for sedated, somnolent, sleeping, or cognitively impaired patients.
See Addendum V

STANDARDS:

1. Patients or their representatives will be informed that they have a right to be involved in their pain management as stated in the Patient Bill of Rights. This information will be included in the Conditions of Admission that the patient signs on admission to the hospital.

2. Patients or their representatives will be instructed in the use of the pain rating scale to report their pain (age-appropriate, condition appropriate, and language appropriate). The type of pain scale used will be documented on the patient care record.

3. When possible, patients will be asked to participate in setting a comfort goal. Pertinent comfort measures will be taught to the patient and family. This information will be documented on the patient care record.

4. The pain goal is set by the patient, their representative, nurse or other clinical discipline for patients who are unable to set a goal. The goal is monitored for inpatients at a minimum of every 24 hours as part of the Interdisciplinary plan.

   Pain Screening and assessment:

   A. Screening:
      a. All patients will be screened for the presence of pain:
         i. On admission or initial patient encounter
         ii. Before and after a procedure
         iii. With a change in condition
         iv. With patient's self-report of recurring or new pain
         v. As appropriate for patient's condition
      b. With each routine vital sign assessment. If the patient is being screened by a CNA, Tech or MA, only patient self-report of pain severity may be used. The screener will immediately report to licensed personnel using the following guidelines:
         i. Pain that is above the patient's acceptable level of pain
         ii. Any chest pain
         iii. Any new onset of pain

5. Upon Admission, all patients will be asked about the presence and intensity of pain at the time of initial evaluation and as clinically indicated.
6. Initial pain assessment and or new report of pain:
   A. When the patient denies pain: if the patient denies pain, document zero (0) as well as the patient's acceptable pain severity level in the electronic health record. No further pain documentation is needed at this time.
   B. Once pain has been identified, further pain assessment must be completed by a nurse or physician and includes the following elements:

a. **Pain Severity** is determined by the patient's self-assessment or by alternative pain scales such as the FLACC or NIPS
b. The nurse may collaborate with the family and or significant other as well as review suspected causes of pain to evaluate the patients' pain. This is especially helpful with pain assessments of the non-communicative patient.
c. **Location** The location of pain will be assessed and documented. For patients evaluated using the FLACC or NIPS, pain location may not be assessable. The RN will use knowledge about the patients' condition, behavior and history to assist in pain location assessment.
d. **Acceptable severity** of pain on a 0-10 scale. The patient may change the acceptable level at any time.
e. **Additional/optional elements** that should be noted during a pain assessment and may assist with the development of a plan of care include:
   i. Quality and Character of pain
   ii. Radiation location as appropriate
   iii. Duration and frequency of pain
   iv. Effects of pain: impact on daily functioning and associated symptoms
   v. Alleviating factors, response to past interventions, what helps decrease or relieve pain, usual relief measures
   vi. Aggravating factors: what increases or triggers pain

7. Pain must always be assessed and evaluated in light of the patient's entire clinical condition. Examples of scenarios that may not require additional assessment:
   A. Pain level less than or equal to patient reported acceptable severity
   B. Patient declines additional assessment or intervention
8. Any patient declination of assessment or intervention will be documented in the health record.

Focused re-assessment

1. Focused pain reassessment must be completed by a nurse or trained team member as part of the shift assessment or treatment plan and in response to the patient's initial assessment. The team member documents in the shift assessment a minimum of every shift. The assessment is documented in the EHR and includes:
   A. Pain severity
   B. Pain location
   C. If possible, an acceptable severity of pain on a 0-10 scale will be used. If a patient denies pain it may be documented as "denies pain", or it may be documented as zero (0).
   A post intervention reassessment is conducted within a reasonable time frame after pharmacologic intervention and or other pain management interventions have occurred.
      a. After pharmaceutical intervention, the RN/LVN reassesses the patient's response:
         i. Pain shall be assessed and pain intensity documented within 15 minutes ± 10 minutes after Intravenous administration of pain medication.
         ii. Pain shall be assessed and pain intensity documented within 60 minutes ± 15 minutes after Intramuscular injection of pain medication for inpatient and outpatient admissions.
         iii. Pain shall be assessed and pain intensity documented with 60 minutes ± 15 minutes after oral drug therapy for inpatient and outpatient admissions.

Title: Pain Assessment and Documentation*	
Scope: Nursing Services	Manual: Cognitive and Perceptual (NSC), CPM - Neurological, Sensory
Source: Manager - ICU Acute/Subacute	Effective Date: 5/16/17

D. Re-assessment must be performed in light of the patient's entire clinical condition. Examples of scenarios that may not require additional assessment:
   a. Pain level less than or equal to patient reported acceptable level
   b. Patient declined additional assessment or intervention

E. Pain intensity will be assessed prior to any repeated PRN pain medication administration.

Pain management and plan of care:

The RN will begin development of the pain management plan of care in collaboration with the patient, family, significant other, medical plan of care and interdisciplinary care team. An evidence-based, individualized plan of care is created upon admission and updated as needed based on the diagnosis or patient's individual needs (Gulanick & Myers, 2011). The individualized plan of care includes nursing interventions for pain management.

1. A pain rating higher than the patient's comfort goal will elicit intervention. Interventions will be initiated as ordered. If pain persists, the physician will be notified.

DOCUMENTATION:

The following will be documented in the patient's medical record:
   a. Patient/family (as applicable) teaching
   b. Type of scale used
   c. The comfort goal, when appropriate
   d. Initial and subsequent pain assessments
   e. Pain relief intervention
   f. Any interdisciplinary review
   g. Any modification of the treatment plan

The following records/forms may contain this documentation:
   a. Admission Nursing Assessment
   b. Nursing Plan of Care
   c. Unit Nursing Record or Patient Care Flow Sheet
   d. Medication Documentation Sheet (if applicable)
   e. Discharge Instructions

REFERENCES:

1. http://wongbakerfaces.org/
2. https://www.nlm.nih.gov/research/umls/sourcereleasedocs/current/LNC_FLACC/
3. https://www.uwhealth.org/healthfacts/parenting/7711.pdf
4. https://com-jax-emergency-pami.sites.medinfo.ufl.edu/files/2015/02/Neonatal-Infant-Pain-Scale-NIPS-pain-scale.pdf
   From Hockenberry, M. J., & Wilson, D. (2016). *Wong's essentials of pediatric nursing* (10th ed.). St. Louis, MO: Mosby. Reprinted with permission.
5. *From* Merkel, S. I., et al. (1997). The FLACC: A behavioral scale for scoring postoperative pain in young children. *Pediatric Nursing, 23,* 293–297
6. McCaffery M, Pasero C: Pain: Clinical Manual, p. 410 Copyright 1999 Mosby, inc.)
7. Warden V, Hurley AC, Volicer L. Development and psychometric evaluation of the Pain Assessment in Advanced Dementia (PAINAD) scale. *J Am Med Dir Assoc. 2003;4(1):9-15.*

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Pain Assessment and Documentation*	
Scope: Nursing Services	Manual: Cognitive and Perceptual (NSC), CPM - Neurological, Sensory
Source: Manager - ICU Acute/Subacute	Effective Date: 5/16/17

CROSS REFERENCE P&P's:

1. Nursing Assessment/Reassessment
2. Opioid Sedation Scale
3. Opioid Administration

Approval	Date
CCOC	3/23/2020
Peri-Peds Committee	4/28/2020
Pharmacy & Therapeutics Committee	5/14/2020
Med/ICU Committee	5/21/2020
Surgery Tissue Committee	4/22/2020
Medical Executive Committee	6/2/2020
Board of Directors	
Last Board of Director Review	12/18/2019

Initiated: 12/99
Revised: 4/00, 8/00, 11/00, 04/02, and 02/2006 SM, 10/07, 04/10 AW, 9/12 AW 4/13, 2/17la, 2/19ta
Reviewed: 05/11AW, 3/2020jn

Title: Pain Assessment and Documentation*	
Scope: Nursing Services	Manual: Cognitive and Perceptual (NSC), CPM - Neurological, Sensory
Source: Manager - ICU Acute/Subacute	Effective Date: 5/16/17

Addendum I:

NEONATAL INFANT PAIN SCALE (NIPS)

Use for infants less than one year of age

The Neonatal infant Pain Scale (NIPS) is a behavioral scale and can be utilized with both full-term and Pre-term infants. The tool was adapted from the CHEOPS scale and uses the behaviors that nurses have described as being indicative of infant pain or distress. It is composed of six (6) indicators:

- Facial expression
- Cry
- Breathing patterns
- Arms
- Legs
- State of arousal

Each behavioral indicator is scored with 0 or 1 except "cry" which has three possible descriptors (scored 0.1.or 2). See the NIPS Scale for the description of infant behavior in each indicator group.

Infants should be observed for one minute in order to fully assess each indicator.

Total pain scores ran from 0-7. The suggested interventions based upon the infant's level of pain are listed below.

Evaluate newborn for causes of pain versus the need for routine comfort measures.

Pain indicated by:

3. Birth injuries/trauma
4. Maternal drug history indicating potential for neonatal withdrawal symptoms
5. Painful procedures (i.e., IV starts, lab draws, tube placement, injections, circumcision, etc)

Discomfort indicated by:

1. Need for repositioning
    a. Reposition for correct body alignment, flexed midline position.
2. Need for diaper or linen change
    a. Change diapers or clothing
3. Signs of hunger (i.e., hand-mouth activity, sucking, rooting)
    a. Feed per orders or offer non-nutritive sucking for infants unable to feed for medical reasons

Title: Pain Assessment and Documentation*	
Scope: Nursing Services	Manual: Cognitive and Perceptual (NSC), CPM - Neurological, Sensory
Source: Manager - ICU Acute/Subacute	Effective Date: 5/16/17

NEONATAL INFANT PAIN SCALE (NIPS)

Scores	0	1	2	
Facial Expression	**Relaxed Muscles** Restful face Neutral expression	**Grimace** Tight facial muscles, furrowed brow, chin, jaw (negative facial expression – nose, mouth, and brow)		
Cry	**No cry** Quiet, not crying	**Whimper** Mild moaning, intermittent	**Vigorous cry** Loud scream, rising , shrill, continuous (note: silent cry may be scored if baby is intubated, as evidenced by obvious mouth, facial movement)	
Breathing Patterns	**Relaxed** Usual pattern for this baby	**Change in breathing** In drawing, irregular, faster than usual, gagging, breath holding		
Arms	**Relaxed / Restrained** No muscular rigidity, occasional random movements of arms	**Flexed / Extended** Tense, straight arms, rigid and/or rapid extension, flexion		
Legs	**Relaxed / Restrained** No muscular rigidity, occasional random leg movement	**Flexed / Extended** Tense, straight legs, rigid and/or rapid extension, flexion		
State of Arousal	**Sleeping / Awake** Quiet, peaceful,	**Fussy** Alert, restless, and thrashing		

	sleeping or alert and settled			
Total:				

Pain Level Intervention
0-2 = mild to no pain none
3-4 = mild to moderate pain Non-pharmacological intervention with a reassessment in 30 minutes
>4 = severe pain Non-pharmacological intervention and possibly a pharmacological intervention

Title: Pain Assessment and Documentation*	
Scope: Nursing Services	Manual: Cognitive and Perceptual (NSC), CPM - Neurological, Sensory
Source: Manager - ICU Acute/Subacute	Effective Date: 5/16/17

Addendum II:

Facial, legs, activity, cry, consol ability scale (FLACC)
For children ages 2 months to 7 years.
The FLACC Behavioral Pain Assessment Scale is a behavioral assessment that can be used to determine pain level when a child can't report his level of pain. It can be used in children ages 2 months to 7 years. Five categories are scored from 0 to 2. The categories are then totaled to obtain the child's pain score. The pain score can range from 0 to 10; the higher the score, the greater the pain. See Addendum IV

FLACC Behavioral Pain Assessment Scale[19]

The FLACC Behavioral Pain Assessment Scale is a behavioral assessment that can be used to determine pain level when a child can't report his level of pain. It can be used in children ages 2 months to 7 years. Five categories are scored from 0 to 2. The categories are then totaled to obtain the child's pain score. The pain score can range from 0 to 10; the higher the score, the greater the pain.

	Scoring		
Category	**0**	**1**	**2**
Face	No particular expression or smile	Occasional grimace or frown, withdrawn, disinterested	Frequent to constant frown, clenched jaw, quivering chin
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consol ability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort
Total score:			

From Merkel, S. I., et al. (1997). The FLACC: A behavioral scale for scoring postoperative pain in young children. *Pediatric Nursing, 23,* 293–297.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Pain Assessment and Documentation*	
Scope: Nursing Services	Manual: Cognitive and Perceptual (NSC), CPM - Neurological, Sensory
Source: Manager - ICU Acute/Subacute	Effective Date: 5/16/17

Addendum III:

Wong-Baker FACES Pain Rating Scale
For adults and pediatric patients older than 3 year of age or who have mild dementia or who do not understand the numeric pain scale.
It's a self-report tool in which the patient points to the face that corresponds to his pain intensity. NIH uses the 0 to 10 scale. Explain to the patient what each face means before having him rate his pain.
To use the FACES scale, explain to the patient that each face represents a person who feels happy because he has no pain or is sad because he has some or a lot of pain. Face 0 is very happy because he doesn't hurt. Face 1 hurts just a little bit. Face 2 hurts a little more. Face 3 hurts even more. Face 4 hurts a whole lot. Face 5 hurts as much as you can imagine, although you don't have to be crying to feel this bad. Ask the patient to choose the face that best describes how he is

feeling.

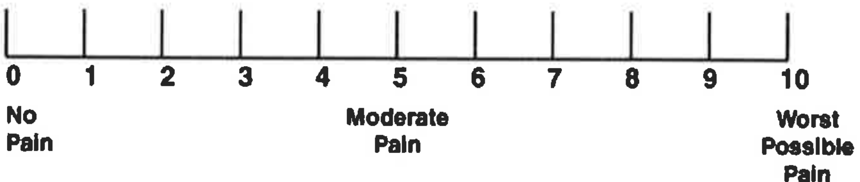
Legs	Normal position or relaxed	Uneasy, restless, tense	Kicking, or legs drawn up
Activity	Lying quietly, normal position, moves easily	Squirming, shifting back and forth, tense	Arched, rigid, or jerking
Cry	No cry (awake or asleep)	Moans or whimpers, occasional complaint	Crying steadily, screams or sobs, frequent complaints
Consol ability	Content, relaxed	Reassured by occasional touching, hugging, or being talked to, distractible	Difficult to console or comfort
Total score:			

Title: Pain Assessment and Documentation*	
Scope: Nursing Services	Manual: Cognitive and Perceptual (NSC), CPM - Neurological, Sensory
Source: Manager - ICU Acute/Subacute	Effective Date: 5/16/17

Addendum IV:

Numeric Pain Scale

A numeric pain scale is a self-report tool. To use it, the patient must have a concept of numbers and their relationship to each other. The scale can be used vertically or horizontally. The numbers range from 0 to 10, where 0 is no pain and 10 is the worst possible pain. The nurse should ask the patient to pick which number corresponds to her/his pain level



NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Pain Assessment and Documentation*	
Scope: Nursing Services	Manual: Cognitive and Perceptual (NSC), CPM - Neurological, Sensory
Source: Manager - ICU Acute/Subacute	Effective Date: 5/16/17

Addendum V:

Observational Pain Scale:
Used for patients who are unable to communicate their pain level

Instructions: Observe the patient for five minutes before scoring his or her behaviors. Score the behaviors according to the following chart. The patient can be observed under different conditions (e.g., at rest, during a pleasant activity, during care giving, after the administration of pain medication).

Categories	0	1	2	Score
Face	No particular expression or smile	Occasional grimace, tearing, frowning, wrinkled forehead	Frequent grimace, tearing, frowning, wrinkled forehead	
Activity (movement)	Lying quietly, normal position	Seeking attention through movement or slow, cautious movement	Restless, excessive activity and/or withdrawal reflexes	
Guarding	Lying quietly, no positioning of hands over areas of body	Splinting areas of the body, tense	Rigid, stiff	
Physiology (vital signs)	Stable vital signs	Change in any of the following: • SBP>20 mm Hg • HR>20/min	Change in any of the following: • SBP>30 mm Hg • HR>25/min	
Respiratory	Baseline RR/SpO_2 Compliant with ventilator	RR>10 above baseline, or 5% ↓SpO_2 mild asynchrony with ventilator	RR>20 above baseline, or 10% ↓SpO_2 mild asynchrony with ventilator	
			TOTAL SCORE	

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Each of the 5 categories is scored from 0-2, which results in a total score between 0 and 10.
Document total score by adding numbers from each of the 5 categories.
Scores:
0-2 indicate no pain
3-6 moderate pain
7-10 severe pain

Title: Pain Assessment and Documentation*	
Scope: Nursing Services	Manual: Cognitive and Perceptual (NSC), CPM - Neurological, Sensory
Source: Manager - ICU Acute/Subacute	Effective Date: 5/16/17

Addendum VI

Deep Breathing for relaxation with the option of peaceful imagery

1. Breathe in slowly and deeply.
2. As you breathe out slowly, feel yourself beginning to relax; feel the tension leaving your body.
3. Now breathe in and out slowly and regularly, at whatever rate is comfortable for you.
4. To help you focus on your breathing and breathe slowly and rhythmically:
   Breathe in as you say silently to yourself "In two three"
   Breathe out as you say silently to yourself "Out two three"
   Or
   Each time you breathe out, say silently to yourself a word such as peace or relax
5. You may imagine that you are doing this in a place you have found very calming and relaxing for you, such as laying in the sun at the beach.
6. Do steps 1 through 4 only once or repeat steps 3 and 4 for up to 20 minutes.
7. End with a slow, deep breath. As you breathe out you may say to yourself, "I feel alert and relaxed."

Additional points:

- This technique for relaxation has the advantage of being very adaptable. You may use it for only a few seconds or for up to 20 minutes. For example, you may do this regularly for 10 minutes twice a day. You may also use it for one or two complete breaths any time you need it throughout the day or when you awaken in the middle of the night.
- If you use this technique for more than a few seconds try to get in a comfortable position in a quiet environment.
- A very effective way to relax is to add peaceful images once you have performed steps 1 through 4 above. Following are some ideas about finding your own peaceful memories.

Something may have happened to you a while ago that can be of use to you now. Something may have brought you deep joy or peace. You may be able to draw on the past experience to begin you peace or comfort now. Think about these questions:

- Can you remember any situation even when you were a child, when you felt calm, peaceful, secure, hopeful, or comfortable?
- Have you ever laid back, kicked off your shoes, and daydreamed about something peaceful? What were you thinking of?
- Do you get a dreamy feeling when you listen to music? Do you have any favorite music?
- Do you have any favorite poetry that you find uplifting or reassuring? Are you now or have you ever been religiously active? Do you have favorite readings, hymns, or prayers? Even if you haven't heard or thought of them for many years, childhood religious experiences may still be very soothing.

Very likely some of the things you think of in answer to these questions can be recorded for you, such as your favorite music or a prayer read by your clergyman. Then you can listen to the recording whenever you wish. Or, if your memory is strong, you may simply close your eyes and
recall the events or words.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Scope of Service Acute/Subacute*	
Scope: Medical Surgical Dept	Manual: Medical/Surgical, MS - Structure Standards
Source: Manager - ICU Acute/Subacute	Effective Date: 5/18/16

I. Department Description:

The Acute/Subacute Services department is a 16-bed unit on the second floor of the new hospital. Access is open to the department from the primary entrance. The back entrance stairwell is badge access only. There are 2 sets of elevators one for visitors and one for employees and patients accompanied by employees only.

The department has16 patient rooms, one of which is a negative pressure room utilized for patients with airborne precautions; one is a larger room with a large bathroom and a bariatric bed.

II. Scope:

The Acute/Subacute Services department provides inpatient nursing care for patients of all ages meeting the specialized medical care needs of a predominantly elderly patient population, as well as, surgical, telemetry, orthopedic, medical and pediatric patients. The unit also provides care for outpatient observation patients, swing bed patients and palliative care/hospice patients.

Patients whose acuity exceeds the standards of care for the Acute/Subacute Services department are transferred either to the NIH ICU or to a tertiary care facility.

III. Staffing:

The Acute/Subacute Services patient is under the care of the NIHD credentialed provider who has 24/7 responsibility. Specialty physicians such as surgeons can choose to consult with the hospitalist for coordinated care.

Nursing staff includes;
Nurse Manager
Assistant Manager
RN
CNA
Department Clerk
LVN's are not part of core staffing but are on occasion floated to the unit to provide care.

IV. Customers

The Acute Sub Acute Services management is a joint function of the Medical Staff and Nursing Department working in close cooperation with: Rehabilitation Services, Social Worker, Cardio Pulmonary Services, Lab, Pharmacy, Dietary, and Radiology departments.

V. Ages Serviced:

The Acute/Sub Acute services provides care across the life span
Pediatrics: 28 days to 13th birthday
Adult: 13 years of age up to 65 years of age
Geriatric: > 65 years

VI. QA/PI:

The Acute/Sub Acute Services Manager integrates all nursing quality improvement functions on the unit, tracks identified problems, assist the nursing unit in the development and evaluation of effective performance improvement reviews, ensures appropriate follow up occurs, and prepares a yearly Pillar of Excellence report concerning nursing quality improvement programs which is reported to the Nurse Executive Committee, Peri-

Title: Scope of Service Acute/Subacute*	
Scope: Medical Surgical Dept	Manual: Medical/Surgical, MS - Structure Standards
Source: Manager - ICU Acute/Subacute	Effective Date: 5/18/16

Peds Committee, and Medical Services/Intensive Care Committee. Activities of the Acute/Sub Acute Performance Improvement program will be documented in the minutes of the unit staff meetings and will be reported to the Nurse Executive Committee.

VII. Budgeted Staff:
Refer to Master staffing plan

Approval	Date
CCOC	3/08/16
Perinatal/Pediatric Committee	4/28/2020
Medical Services/ICU Committee	5/21/2020
MEC	6/2/2020
Board of Directors	
Last Board of Directors Review	4/18/18

Developed: 12/14
Reviewed: 1/17 la,
Revised: 2/16 la, 2/20jn
Supersedes:
Index Listings:

Dev. 7/14

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: MRI Safety	
Scope: MRI	Manual:
Source:	Effective Date: 7/2005

PURPOSE: To ensure safety in the MRI environment

Magnetic resonance imaging (MRI) requires a unique set of high-level safety precautions in order to safely administer this essential diagnostic modality. This policy delineates protocol for the following safety areas:

1. Static magnetic field hazards related to projectiles
2. Medical device hazards
3. Time-varying magnetic field hazards including tissue heating and acoustic noise
4. Pregnancy-related hazards
5. MRI contrast material-related hazards
6. Patient comfort, psychological care and claustrophobia
7. Cryogen hazards
8. The Medical Director for MRI Services (MRMD) has overall authority and responsibility for safety policy at ALL sites where MRI is performed. The MRMD may delegate certain responsibilities and actions to the MRI Safety Officer (MRSO).

The Medical Director for MRI Services has overall authority and responsibility for safety policy at ALL sites where MRI is performed.

Section I: Personnel Designations, Screening and Training

1. Personnel are placed in one of four categories in order to clarify who will have access to the MRI site and who has decision making responsibility in ambiguous cases.
2. Every person entering the MRI scanner room must be screened to determine personal risk for entering the MR environment. The method of screening will vary as described below.
3. MRI safety training will vary with each individual's level of security clearance. All training will be through online learning modules with online examinations and must be renewed annually. The following are the personnel categories and screening/training requirements:
4. **Non-MRI personnel**
   I. **Includes:**
      a. Patients and research subjects
      b. Radiology staff not working with MRI
      c. General hospital staff including physicians, nurses, PAs, anesthesia technologists
      d. Housekeeping and maintenance staff who have no access to Zone 3 or 4
      e. Visitors
      f. Family/escorts of patients

   II. **Screening** (using the MRI Safety Screening Form, see Appendix D)
      a. MUST be screened each time they enter Zone IV.

b. MUST be screened by at least one Level II MR personnel face-to-face with written documentation of screening
c. All screening forms are scanned and stored in PACS, associated with the relevant exam.

III. **Training**
a. Not required

5. **Level I MR personnel**: All staff working in the MR environment with access to controlled areas

I. **Includes**
a. ALL Radiology attending physicians, nurses and PAs.
b. ALL MRI staff
- Reception, transport, housekeeping associates who work in MRI

II. **Screening**
a. Radiology Associates: ALL are screened at time of employment and annually thereafter when completing MR Safety training. Documentation is kept in the associate's personnel file.
- Any subsequent injury or medical procedure must be reported by the associate immediately because this may affect their personal safety when entering MRI.

b. **Non**-Radiology Associates: ALL are screened at time of employment and annually thereafter when completing MR Safety training.
- Any subsequent injury or medical procedure must be reported by the associate immediately because this may affect their personal safety when entering MRI.

III. **Training**
a. Completion of the current online Basic MRI Safety training module annually including successful completion of the online examination.

6. **Level II MR personnel**:

I. **Includes**
a. MR users requiring additional training regarding time varying magnetic fields, cable and other equipment management, contrast agents, etc.
b. ALL Radiology attending physicians who protocol or supervise MRI exams
c. ALL Radiology in-training physicians
d. ALL Anesthesiology and other staff who administer sedation or anesthesia in MRI.
e. MR technologists
f. MR supervisors
g. MR nurses & PA's

II. **Screening**
a. As for Level I Personnel

III. **Training**

a. Completion of the current online Advanced MRI Safety training module including successful completion of the online examinations. Each associate must also complete a Specialized MRI Safety training module corresponding to their specific clinical role. New employees will be required to complete training before they can work in the MR environment.

7. **Level III MR personnel:** These individuals have decision-making power in ambiguous cases.

   I. **Includes**

   a. The Medical Director for MRI Services, the Clinical MRI physicist, the facility MRSO.

   II. **Screening**

   a. As for Level II

   III. **Training**

   a. On a biannual basis, must complete and submit 12 hours of Continuing Education that focus on MR Operations and / or Safety.

Section II: MRI Site Access Restrictions

1. The MRI site is classified into four regions:

   Zone I: Outside of the MRI site.

   a. Unrestricted access.

   Zone II: The unsecured, interface area between the publicly accessible, uncontrolled Zone I and the strictly controlled Zones III and IV.

   b. Patients are greeted, registered, and screened in Zone II, but access to Zone II is not restricted.

   Zone III: Secure areas immediately adjacent to the MRI scanner room. "If you can walk over and touch the door to the scanner room, you are within Zone III"

   a. Only Level I or higher MRI personnel may enter unaccompanied.
   b. Secured by card access system.
   c. Only Level I or higher personnel may hold cards coded to open these doors.
   d. Doors to have automatic closing and locking devices.

   Zone IV: The MRI scanner room.

   a. Only Level II or higher MRI personnel may enter unaccompanied.
   b. Doors to have a closing and locking devices.

2. **Signs**

   a. Warning signs are posted in all entrances to Zones III, and IV.
   b. "Magnet is always on" floor mat place in entrance to Zone IV.

Section III: Implants

1. Any special circumstance not covered below must be evaluated and approved in

writing by a level III MR physician prior to allowing the patient or other individual to enter Zone IV.

2. **Unsafe Implants, which MAY NOT ENTER ZONE IV**
    a. Pacemakers/Defibrillators – **MAY NOT ENTER ZONE IV.**
    b. Spinal stimulators, neurostimulators – **MAY NOT ENTER ZONE IV.**
    c. Cochlear implants – **MAY NOT ENTER ZONE IV.**
    d. Aneurysm Clips: **MAY NOT ENTER ZONE IV.**
3. **Devices that may generally be considered safe 6 weeks following initial implantation of device include but are not necessarily limited to:**
    a. MR Conditional Vena Cava Filters
    b. MR Conditional Prosthetic Heart Valves
    c. MR Conditional Vascular and Other Stents
4. **Safe Implants:**
    a. Manufacturer assurance: A patient implanted with any medical device warranted by the manufacturer, with FDA approval, to be SAFE for MRI may be scanned EVEN IMMEDIATELY FOLLOWING IMPLANTATION. Confirmation of the safety of the device MUST be confirmed by consulting the manufacturer (package insert, website, telephone support or other means) or Level II or III MR personnel knowledgeable about the specific device.
    b. Orthopedic Hardware: Safe immediately after implantation, even if partially ferromagnetic. Precautions to prevent thermal injury should be taken as described below.
    c. Skin Staples: Safe, even within the immediate postoperative period. Precautions to prevent thermal injury should be taken as described below.

Section IV: Equipment

1. The MRI scanner will be maintained to ensure its optimal imaging performance and safety by the radiological team including the radiological technologists, the MRI or site manager, the MRI engineers, and the MRI physicist. A Quality Control Program will be in place, which exceeds standards set forth by the American College of Radiology.
2. ONLY MR safe equipment or MR Conditional equipment (provided that all conditions are met), may be brought into the MR scanner room (Zone IV).
3. Equipment labeled MR Conditional may not pass the demarcation line within zone IV.
4. Medical device (e.g., ventilator, implant) safety must be based on manufacturer's FDA approved usage, not on local testing of devices.
5. Testing:
    a. Implants: NO on-site testing for MR compatibility is permitted. Only the manufacturer's statement of safety will be relied upon.
    b. Equipment: A strong hand magnet (>0.1 Tesla) can be used to test new

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equipment. Testing of equipment with a hand magnet must ONLY be performed by personnel appropriately trained and credentialed to know how to perform testing and how to interpret the results of testing. These personnel include Level II and III MR personnel. The hand magnet itself is a significant safety hazard, which could lead to equipment damage, serious injury or death if it were inadvertently brought near the magnetic field. Therefore, the magnet is kept secured and is not available in the MRI suite (Zones III and IV).

c. If a device/equipment leaves MRI suite for repair/service, it must be tested/verified again for MR safety and labeled appropriately before it is introduced in the MR suite.

d. If the MR safety of an object is unclear or in dispute, Level II or III MR personnel must make the determination as to safety. If there is any doubt as to safety, err on the side of caution.

6. Signage: Within Zones III and IV, ALL equipment, regardless of size, must be labeled "MR Safe", "MR Unsafe" or "MR Conditional" using ASTM approved symbols. Equipment that is permanently fixed in place is exempt from this requirement.

7. Use of equipment in Zone III and Zone IV.
   a. MR safe equipment: MRI safe models of basic medical equipment can be used and kept in MRI controlled Zones (III and IV) (for example, stethoscope, sphygmomanometer, scissors, ambu bag and mask, physiologic monitoring equipment).
   b. Only MR Conditional fire extinguishers may be brought into and kept within Zone III.
   c. Ventilators, anesthesia machines, physiological monitors, power injectors and infusion pumps: Only devices manufacturer-certified and FDA-approved for MRI may be used only within the conditions specified by the manufacturer.
   d. Oxygen/Gas cylinders: are prohibited within Zone IV. Patients requiring oxygen therapy must be connected to oxygen cylinder that is left OUTSIDE Zone IV.
   e. Inspections:
      - Check for labeling of all equipment in Zones III and IV.
      - Removal of prohibited, unnecessary or unsafe equipment from Zones III and IV.
      - Check for potential fire hazards in Zone IV, and remove all unnecessary power cords, wires, linens, foam pads, and devices out of the MRI scanner room.
      - Testing of anesthesia equipment including carts and tanks.
      - Critical assessment for cleanliness throughout the MRI suite. This must include inspection of the MRI equipment/electronics rooms. Patient positioning devices should be assessed for wear and cleanlinless and discarded if found imperfect.

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Title: MRI Safety	
Scope: MRI	Manual:
Source:	Effective Date: 7/2005

8. Projectile Incident Response Plan
   a. Extreme caution must be exercised when attempting to remove a ferromagnetic object from the magnetic field, in order to minimize the possibility of second injuries or further equipment damage. See "**Removal of ferromagnetic objects that enter the room"** below. When in doubt consult the MR Physicist and Medical Director.
   b. If the projectile is small (e.g., pens, paperclips, key-rings) and there is certainly no risk of human injury or equipment damage, the object may be removed by Level II MR personnel. However, all medical equipment involved in an incident has to be assessed before it can be used for patient care.
   c. When a large object is stuck against the magnet, follow the procedure as in "**Removal of ferromagnetic objects that enter the room".**
   d. Quench the magnet only when the object held against the MRI scanner poses an imminent threat to of injury or death, such as if a patient or staff member is pinned between the object and the magnet. Note that quench is a potentially dangerous procedure and essential precautions must be taken before and after quenching the magnet. See: "**Quench and Cryogen Handling**".
   e. Any incident or near-miss incident which involve the harming or potential harming of patients or staff AND involve a projectile MUST be reported using the "Unusual Occurrence Form" reporting system from NIHD's intranet.
   f. **Removal of ferromagnetic objects that enter the room**:
      In the event that a ferromagnetic object is brought into Zone IV and is stuck against the scanner, the Medical Director for MRI Services, the MRI physicist, or an on-site Level III MR Personnel must be notified immediately. MRI service technicians should be called to remove the device. Imprudent attempts to remove a device may result in severe injury or death.
   g. Quench the magnet only when the object held against the MRI scanner poses an imminent threat to of injury or death, such as if a patient or staff member is pinned between the object and the magnet. Note that quench is a potentially dangerous procedure and essential precautions must be taken before and after quenching the magnet. See: "**Quench and Cryogen Handling**".

Section V: Gradient and Radiofrequency Hazards

1. Background: Two types of time-varying magnetic fields are employed in MR imaging: Gradient magnetic fields (GMF) and radiofrequency magnetic fields (RF). Each has specific hazards and, therefore requires specific safety precautions. The primary hazard of GMF is the induction of current (1) in the patient leading to nerve stimulation or (2) in a conductor leading to electrical current within tissue. The predominant hazard of RF is (3) tissue heating leading to discomfort or burns. Additionally, both GMF and RF produce potentially hazardous levels of acoustic noise.

a. **Nerve or muscle stimulation**: Clinical MRI equipment performs within FDA specified safety limitations that generally preclude the induction of sufficient current within tissue to cause direct nerve or muscle stimulation. Some high duty cycle applications, such as Echo Planar Imaging (EPI) and Single Shot Fast Spin Echo (SSFSE) may nonetheless cause nerve or muscle stimulation, especially at higher static magnetic field (e.g., 3.0 Tesla). This stimulation is not hazardous, but may be uncomfortable. If a patient complains of twitching or pain during a high duty cycle acquisition (especially EPI), the scan should be stopped immediately. The remainder of the examination may proceed, provided that the patient is comfortable. If the examination cannot be continued, the incident should be reported using the NIHD's Unusual Occurrence Form.

b. **Induction of current in metallic implants**: High duty cycle MR imaging pulse sequences can induce current within metallic foreign bodies (such as wires, pacemaker leads, brain electrodes, etc.) and therefore these implants will disqualify a patient for MRI services at NIHD and will be referred elsewhere for services.

c. **Tissue Heating**: Clinical MRI equipment performs within FDA limits for tissue heating.

d. **Preventing Burns:** Pulse sequences may deposit power more efficiently in metallic objects within or outside the patient, leading to serious burns. The following precautions should be taken:

   i. All metal must be removed from the patient. This includes, but is not limited to jewelry, transdermal drug delivery patches and external orthopedic braces or prostheses.

   ii. The patient is required to remove **ALL** personal clothing and change into clothing provided by the MRI facility. Note that fabrics, particularly in undergarments, may contain unsuspected metallic components, which can lead to serious burn.

   iii. **Non-removable conductive items:** Tattoos and permanent makeup as well as implanted metallic items, such as orthopedic hardware, may undergo significant heating.

      - The patient must be informed of this possibility and asked to report any suggestive symptoms. The technologist must communicate verbally with the patient throughout the examination to ascertain symptoms of heating.
      - Dry cold packs or wet wash clothes may be applied to any such superficial, non-removable conductive material, such as tattoos or subcutaneous implants (e.g., infusion pumps), to function as a heat sink and minimize tissue heating.

   iv. All unnecessary coils, cables, wires, and monitoring leads must be removed from the MR scanner prior to scanning. Any necessary

external wires or cables including the cables connecting the RF coil to the scanner should be carefully managed with attention to the following:

- The wires/cables must be **insulated** from the patient using sheets, sponges or other means. The wires/cables must not touch the patient's skin.
- The wires/cables must NOT form any loops.
- The wires/cables must be placed as far from the inner walls of the MRI bore as possible.
- The patient should be positioned so that they are not in contact with the inner walls of the MRI bore.

v. More extensive caution and use of cold packs should be employed in unconscious or poorly responsive patients including young children. It is advisable to avoid MRI altogether in such patients to minimize risk of burns.

vi. The staff positioning the patient in the MRI scanner should ensure that no large loops are formed with the patient's tissue. Arms and legs should not be crossed.

vii. The technologist MUST communicate with the patient between scans and monitor patient feedback during scans. The scan should be stopped immediately if the patient complains of discomfort due to heating, tingling or electric-like shocks. Correct the situation before proceeding.

e. **Burn Care:** If the patient complains about severe heating or burning during MRI, the following procedures should be taken:

i. The scan MUST be stopped immediately.

ii. Apply cold compresses or ice to affected or reddened areas.

iii. For severe burns, contact the attending radiologist and if unavailable report occurrence immediately to medical team (for inpatients) or take the patient to the emergency room (outpatients) for further examination and treatment.

iv. The incident must be reported to the site manager/supervisor by the MRI technologist with detailed patient information and specific imaging parameters including the coil(s) used, how they were connected and specified in software. The incident must be reviewed by the Medical Director for MRI Services and the MRI physicist to determine and address the cause of the injury.

v. All MRI burn incidents MUST be reported using the NIHD's Unusual Occurrence Form.

vi.

f. **Acoustic noise:**

i. All patients must be provided hearing protection (earplugs and/or MRI safe headphones).
ii. All non-patients MUST USE hearing protection if they are in the scanner room during imaging.
iii. The scanner room door must remain closed during imaging.

Section VI: Pregnancy hazards

1. Patients: While MRI is not known to have any adverse effect on the fetus, comprehensive controlled long-term studies have not been conducted. As a result, we endeavor to avoid MR imaging of a pregnant women if at all feasible. Women of childbearing age will be assessed for potential of pregnancy. Any patient unsure of pregnancy will status must sign MRI Consent for pregnant patient undergoing Imaging Procedure.
2. **Precautions:**
    a. Postpone the examination until after pregnancy, if at all possible.
    b. Determine if the results of MRI will alter management white the patient is still pregnant.
    c. Determine if the diagnostic information required could be obtained from another imaging modality that does not employ ionizing radiation.
    d. If the above criteria has been satisfied, the ordering or supervising provider must confirm medical necessity.
3. MRI Staff: MRI staff may work during pregnancy even within the MR scanner room (Zone IV). However, any worker who *may be* pregnant must NOT remain within the room during scanning.
4. Others: May not enter the MR scanner room (Zone IV) if they *may be* pregnant as described above.

Section VII: Contrast Agent Usage

1. In NIHD MRI department, *Multihance* is the MRI contrast we use for our procedures. Staff will follow the protocols within the MRI Gadalinium injection policy and when indicated, must obtain lab results of BUN, Creatinine, and eGFR prior to have contrast procedures performed.
2. If there are hypersensitivity reaction occur in patients with a history of asthma or other allergic disorders, observe patients for signs and symptoms of hypersensitivity reaction during and after the procedure. Immediately ask MRMD or radiologist in charge of the department that day to assess patient and he or she will determine if patient need to be admitted to emergency room or take appropriate medical actions.

Section VIII: Emergency Situations

1. **Medical Emergencies:** In the event of a medical emergency involving a patient in the MR scanner room (Zone IV), the patient WILL BE REMOVED FROM Zone IV prior

to BLS being initiated. Further resuscitation may continue in Zone III. Access restriction to Zone IV **MUST** be maintained during resuscitation and other emergent situations for the protection of the patient and all involved.

NO UNSAFE EQUIPMENT IS TO BE BROUGHT INTO THE MR SCANNER ROOM – INCLUDING CRASH CARTS, DEFIBRILLATORS, LARYNGOSCOPES, ETC.

2. **Fire/Police Emergencies:** In the event of a fire within the MR Scanner room (Zone IV) or a large fire in the vicinity of the magnet, leading to excessively high room temperature, immediate quench of the magnet should be undertaken to avoid magnet explosion. Only MR Conditional fire extinguishers may be used within the MR suite. If fire or police personnel need to enter the MR scanner room, MR personnel who have completed MRI Emergency Training must be consulted regarding quenching the magnet. The MRI technologist and/or radiological staff-on-duty must ensure that non-MR personnel including police, firefighters, and security are restricted from entering the MRI scan room with their equipment (axes, air canisters, weapons, etc.) during emergencies, until it can be confirmed that the magnet is not at field, as there may still be considerable static magnetic field present despite a quench or partial quench of the magnet.

NO EQUIPMENT, INCLUDING FIREARMS, AXES, AIR TANKS, HOSES, ETC., MAY BE BROUGHT INTO THE MR SCANNER ROOM WHILE THE MAGNET IS AT FIELD.

3. **Cryogen Handling and Quench Situations**
   a. Only trained service personnel may handle cryogens. During cryogen fills, Zone IV and Zone III must be evacuated of all, but trained service personnel.
   b. Each MR scanner room will be equipped with an audible oxygen alarm. If the alarm sounds, the patient and all others must be evacuated from Zone III and IV and the MR service team, hospital security, MR Physicist and Medical Director for MRI Services must be notified immediately.
   c. In the event of a spontaneous quench, the MR scanner room (Zone IV) and adjoining rooms (Zone III and Zone II) must be evacuated immediately. All doors and windows in the MRI facility should be opened. The MR service team, MR Physicist, hospital security and Office of the Medical Director for MRI Services must be notified immediately.
   d. **If cryogens leak into the room (may appear as clouds of smoke):**
      i. The patient should be evacuated from the room as rapidly as is safe, to prevent asphyxiation

ii. Staff entering the room to evacuate the patient should be careful to maintain orientation in the room; keep the exit door in sight
iii. Cryogen condensate (on the floor and horizontal surfaces) is extremely cold and may cause thermal injury (frostbite) on contact.
iv. If pressure within the room prevents opening the door:
   - The window to the control room should be broken
   - Ventilate adjacent areas as they may also rapidly fill with cryogen vapor
v. Secure the MR suite and maintain restricted access after evacuation. Communicate with first responders regarding the safety status of the magnet and the MRI suite. Evaluation of the status by the MR Service Engineer or the MRI Physicist may be needed.

REFERENCES:

1. Magnetic Resonance
2. Bioeffects
3. Safety and Patient Management
4. Shellock
5. Kanal. Lippincott, 1996. Injuries Associated with MR Imaging: Survey of Safety Records and Methods Used to Screen Patients for Metallic Foreign Bodies before Imaging. AJR 1994. The AAPM/RSNA Physics Tutorial for Residents: MR Imaging Safety Considerations, Price.
6. Radiographics 1999. ACR Guidance Document for Safe MR Practices, AJR, 2007.
7. ACR Guidance Document on MR Safe Practices: 2013, JMRI, 2013.
8.

CROSS REFERENCE P&P:

Approval	Date
CCOC	6/1/2020
Radiation Safety Committee	02-04-20
Radiology Services Committee	02-13-20
Medicine ICU	05-21-20
Emergency Services Committee	05-12-20
MEC	06-02-20
Board of Directors	
Last Board of Directors Review	

Title: MRI Safety	
Scope: MRI	Manual:
Source:	Effective Date: 7/2005

Developed: 7/2005
Reviewed: 1/2020
Revised: 1/2020lw

Appendix A: Precautions: External Potentially Ferromagnetic Objects

1. Personnel must remove all potentially ferromagnetic objects prior to entering Zone IV unless they are known to be non-ferromagnetic.
   a. Gold, sterling silver, copper, brass and aluminum are non-ferromagnetic.
   b. Any alloy or plated object should be considered ferromagnetic.
   c. Stainless steel should not be assumed to be non-ferromagnetic and must be tested.
2. ANYONE wishing to enter the MR scanner room must comply with this policy. This includes, but is not limited to: Patients, technologists, nurses, physicians, maintenance staff and housekeeping staff.
3. ALL individuals who will be subjected to MR scanning must remove ALL external potentially conductive or ferromagnetic objects including ALL clothing and change into site-provided gowns. Note that these individuals must remove all metal (e.g. jewelry), even if not ferromagnetic, in order to prevent thermal injury.
4. The following is a PARTIAL list of items that may be dangerous: Watches, jewelry, pagers, cell phones, pens (even if only the spring or point is metal), paperclips, bobby pins, hair clips, staples, body piercings [if removable], contraceptive diaphragms, metallic drug delivery patches, cosmetics containing metallic particles [such as eye make-up], and clothing items that may contain metallic fasteners, hooks, zippers, loose metallic components, or metallic fabric, logos or threads.

Hypodermic needles may NOT be brought into Zone IV. IV catheters should be placed in Zone II or Zone III and only plastic injection ports should be used in Zone IV

Appendix D: Screening Form

ALL segments of the screening form must be completed and signed by the patient or their guardian. Minors who are under 18 years old may not sign the screening form and it must be completed under the supervision of a parent or knowledgeable guardian

LEVEL 1 SCREENING:

1. Registered Nurse who is taking care of that patient will fill out MR screening forms from Emergency Department and MED-SURG. The same screening form will be checked again at "full stop and final check" by MRI technologist prior to MRI procedure.
2. The screening form must be reviewed by Level I or II MR personal to identify any positive responses to the screening questions. Any of these "yes" responses must be communicated to the MR technologist. The screener must sign in the Level I

screening box on the screening form.

LEVEL 2 SCREENING – TO BE PERFORMED ONLY BY THE MR TECHNOLOGIST:

1. The technologist must review the screening form in the presence of the patient and verbally confirm the patient's responses to the screening questions. The technologist then marks their determination as to the safety of the patient for MRI on the screening form.
2. If further clarification is required from the Radiologist, the technologist must complete the applicable section.
3. A legible, printed technologist's name and signature must be completed; initials are NOT sufficient.
4. If the patient can communicate, but is unable to write, the technologist may fill in the answers and document in writing on the form how/why they did so.
5. The screening form must be completed as described above prior to the patient entering Zone IV.
6. The technologist who scans the patient (as indicated in RIS) is the person who will be held responsible for any lapse in policy adherence and its consequences.
7. If a family member or any person other than the patient or physician supplies patient information, documentation occurs in the form of that person's signature; relationship to the patient is also indicated on the form.
8. Every completed Safety Screening Form must be scanned into PACS and thereby becomes part of the medical record.
9. Prior to placing any patient into the MR scanner, the patient's prior Radiology exams AND reports MUST be reviewed in PACS and RIS by the technologist to detect pacemakers, intracranial aneurysm clips, metallic foreign bodies or other potential hazards. The MR technologist must visually review the most recent prior chest radiograph, if any is available on PACS.

Appendix E: Patient Comfort and Psychological Care

General Precautions:

1. Patients' experiences in the MRI environment may be discomfort, stress and anxiety provoking for many reasons. These may include concern over an unknown diagnosis, claustrophobia, long scan times, physical discomfort due to the relatively hard tabletop, confining coils and immobilization devices and cold. Statistics indicate that about 10% and up to 20% of the general population is claustrophobic to some degree.
2. Patient comfort will be assured before, during and after the MRI examination by inquiring whether the patient is comfortable or at ease. Blankets, pillows, padding and cushions should be employed to ensure patient ease and comfort. The MRI bore ventilation fan level should be optimized based on patient feedback. Patients should

never be kept in the scanner while technical concerns are evaluated.

3. Every patient must be given the emergency call device and shown how to use it if they need to contact the technologist urgently.

Patients who indicate that they are uncomfortable or claustrophobic:

1. Patient comfort MUST always guide the procedure. The patient must never be asked to remain in the magnet when experiencing discomfort or distress.
2. Patients who express concern about claustrophobia should be informed of options at scanning sites and scanner types as well as sedation/anesthesia, which require their physician's recommendation.
3. Claustrophobic patients should be offered additional care during MRI to improve their comfort and ease. These techniques may include the use of feet first positioning to keep the head and face out of the bore, prone positioning, mirrors or prism glasses, blindfold or "eye pillow", audio and video entertainment, and accompaniment by a family member during the MR procedure.
4. The MRI Operator should terminate the scan if the patient experiences any symptoms of claustrophobia, significant anxiety or panic attack. These may include diaphoresis, tachycardia, perceived dyspnea or "suffocation", chest tightness and faintness or lightheadedness.
5. The patient's concern must be taken seriously and at face value. If a patient asks to stop the exam, leave the scanner, or uses the emergency call device, they must be immediately assessed and removed if necessary

Appendix F: Special patient cases with emergent MR needs

[E.g., patients unable to comply with screening and without accompanying personnel able to provide relevant information]

1. If patient is unable to comply with screening requirements and there is no access to reliable patient history that allows for completion of MR screening process, the ordering provider must consent to proceed with procedure by signing patient consent form in lieu of patient.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Code Blue Procedure - Code Blue Team	
Scope: Hospital Wide	**Department:** Emergency Department, ICU, Med/Surg, OB/Gyn, Outpatient, PACU, Surgery
Source: Resuscitation Committee	**Effective Date:** 6/15/2014

PURPOSE:

The primary goal of the Code Blue Team is the immediate treatment of the patient in cardiopulmonary arrest. This team will respond to an announced Code Blue that occurs anywhere in the hospital building.
The Code Blue Team shall consist of the Emergency Department (ED) physician, Respiratory Therapist, and four members of the nursing staff who are selected by the Nursing Supervisor at the beginning of each shift.

POLICY:

1. The Emergency Department physician shall be the Code Blue team leader.
2. Any cardiac arrests in the operating room will follow the **Cardiac Arrest in the OR** Policy. The House Supervisor will be notified of cardiac arrests in the Operating Room (OR).
3. A Code Blue Critique will be completed after every Code Blue by the RN Leader and House Supervisor.
4. An Unusual Occurrence Report (UOR) will be filled by the House Supervisor or RN leader for Quality Analyst.
5. All codes will be peer reviewed as a critical indicator for the ED physicians.
6. All codes will be reviewed by the Resuscitation Committee.
6. Advanced Directives and Physician Orders for Life Sustaining Treatment (POLST) will be reviewed and communicated to the Code Blue Team Leader as soon as possible.
7. The Code Team will be posted daily and changed as needed on the hospital intranet by the House Supervisors.

PROCEDURE:

RN CODE LEADER:

RN Code Leader will be filled by the ED RN. If the patient is in the Intensive Care Unit (ICU), then the primary nurse will be the RN Leader. Qualifications: ED or ICU RN with current Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS) certification.
Performs or delegates the following:

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

Title: Code Blue Procedure - Code Blue Team	
Scope: Hospital Wide	**Department:** Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Resuscitation Committee	**Effective Date:** 6/15/2014

6. Work with House Supervisor during resuscitation to release staff that are not needed.
7. Insures notification of family and makes sure Social Worker, Case Manager or staff member is assigned to family if present during the resuscitation.

CODE ASSIST RN :

1. Positions bed and removes head board. .
2. Brings crash cart to the bedside except for Code Blues in Perinatal Department. Crash carts are located in ED Rm.1 and 7, ICU, Acute/Subacute, PACU, OR, CT scan, and Cardiopulmonary Department.
3. Applies fast patches and/or monitor leads from the Philips MRX monitor.
4. Runs initial monitor strip.
5. Assist with any additional procedures as needed.
6. Insert NG tube or delegate to another staff member.
7. Insert Foley catheter or delegate to another staff member.
8. Set up procedure trays as needed or prepare Intra-osseous (IO) for physician.
9. Insures that vital signs are done every 5 minutes if blood pressure and pulse present.

CODE COMPRESSIONS: 2 Staff Members

Nurses Assistant, Unit Clerk, RN, LVN, Ancillary Department Staff.
Qualifications: Current BLS card with no medical restrictions for performing CPR.

1. Places backboard under patient. This can be found on the back of the crash cart.
2. Takes over cardiac compressions. This requires frequent changes with no person performing compression for longer than 2 minutes at a time. This is to insure good quality compressions are maintained and to avoid fatiguing staff.
3. For Code Blue in Perinatal Department, 1st Compression staff member will take over compressions, while the 2nd Compressions staff member will bring crash cart from ICU or Acute/Subacute to the department. An Automatic External Defibrillator (AED) is available in the Perinatal Department.

CODE RECORDER:

Recorder may be the House Supervisor, ED RN, or ICU RN. No staff will be assigned to this position if they do not maintain a current ACLS and PALS certification.

1. Recorder - records all information during code on code sheet
2. Accurately times start of Code and all treatments.
3. Charts VS Q 5 min. when BP and pulse present or insures that an electronic record of vital signs is maintained.
4. Prompts Code Leader for appropriate ACLS and PALS protocols.
5. Sees that Quality Review Report and code critique are completed and routed to Quality Analyst~~Analyst~~.

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Code Blue Procedure - Code Blue Team	
Scope: Hospital Wide	**Department:** Cardiovascular, Circulation (OXC), CPM - Respiratory, Oxygen
Source: Resuscitation Committee	**Effective Date:** 6/15/2014

RESPIRATORY THERAPIST:

1. Provides oxygenation and ventilation support with bag valve and/or mechanical ventilation.
2. Manages and secures endotracheal tube.
3. Monitor SpO2 and ETCO2 on all patients in a resuscitation.
4. Assist with transport for procedures or transfer.

REFERENCE:

1. American Heart Association: Advanced Cardiac Life Support

CROSS REFERENCE:

1. Code Blue Documentation
2. Cardiac Arrest in the Operating Room
3. Code Blue (Cardiac Arrest) Documentation

Committee Approval	**Date**
CCOC	3/25/19
Emergency Services Committee	~~3/11/2020~~5/12/2020
Resuscitation Committee	4/20/2020
MEC	6/2/2020
Board of Directors	
Last Board of Director review	5/16/18

Revised: 3/98; 02/01 JK; 12/03, 06/11AS, 7/14 AS, 04/2018 gr, 2/19 gr

draft

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Cardiac Stress Test Protocol & Procedure	
Scope: Diagnostic Imaging	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

PURPOSE:
The purpose of this guideline is to assist the Nuclear Medicine Technologist in performing Myocardial Perfusion Scintigraphy.

POLICY:
Myocardial Perfusion Imaging (MPI) will be performed only with a physician's order for MPI

PROCEDURE:

1. All myocardial perfusion imaging studies will consist of rest and stress imaging
2. Resting dose will be 10 mCi Tc99m Cardiolite or Sestamibi generic.
3. Stress dose will be on a 1:3 ratios, and 3 times higher than the resting dose or 30 mCi Tc99m Cardiolite or Sestamibi generic.
4. Cardiac stress shall be obtained either by physical exercise on a treadmill, or pharmacological means if patient is unable to exercise.
5. Pharmacological stress agents Persantine, Dobutamine, Adenosine, and Regodenosine (Lexiscan) are all approved pharmacological stress agents.
6. Lexiscan will be first choice unless contraindicated and then one of the other agents may be used at the discretion of the ordering or supervising physician.

I. INDICATIONS:
Patients with the following clinical indications or diagnoses are candidates for MPI, with pharmacological induced stress or exercise stress.

1. Chronic Ischemic Heart Disease
2. Dilated Cardiomyopathies or Hypertrophic Cardiomyopathy
3. Congenital Heart Disease
4. Post-Transplant Cardiac Disease
5. Chest pain
6. Coronary Artery Disease
7. Hypertension
8. Physicians may request the procedure for other indications not listed here, as required by the patient's clinical condition.

II. CONTRAINDICATIONS:
~~There are no contraindications to the nuclear medicine portions of the exam.~~ Please refer to the EKG procedure for contraindications and patient preparation for the EKG/Cardiology portion of the exam (see Cross-Reference P&P).

1. Patients with second or third degree AV block or Sinus Node dysfunction unless these patients have a functioning artificial pacemaker
2. Patients with acute bronchospasm
3. Systolic blood pressure <90mm Hg.
4. Use of dipyridamole, or dipyridamole-containing medications in the last 48 hours.
5. Use of aminophylline in the previous 24 hrs.

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6. Ingestion of caffeinated foods such as chocolate, coffee, decaffeinated coffee, tea and sodas.
7. These are contraindications for a standard exercise stress test, however a pharmacologically induced MPI can be performed.
   ~~a. Acute Myocardial Infarction~~
   ~~b. Unstable Angina~~
   ~~c.~~a. Life-threatening arrhythmia
   ~~d.~~b. Acute Cardiac Inflammation
   ~~e.~~c. Critical Aortic Stenosis
   ~~f.~~d. Congestive heart Failure
   ~~g.~~e. Pulmonary Emboli
   ~~h.~~f. Significant uncontrolled HTN
   ~~i.~~g. Serious Non-cardiac diseases
   ~~j.~~h. Allergies to medicines used in testing.

III. EQUIPMENT AND SUPPLIES:

1. IV start kit
2. Bed or recliner.
3. EKG exercise testing station with treadmill
4. Blood pressure machine or cuff
5. Reversal medications for adverse reactions. Aminophylline or Caffeine
6. Crash Cart
7. Oxygen and Cannula and/or mask.
8. Dual head gamma camera with trigger monitor.

IV. PROCEDURE:

A. OUTPATIENT TEST PROCEDURE, PHARMACOLOGICAL STRESS WITH MPI

1. After patient check in at DI, Nuclear medicine technologist will retrieve the paper work and escort the patient to the injection room to insert the IV.
2. After reviewing history with the patient, Technologist will insert the IV, secure, and inject the resting dose of Cardiolite (10 mCi) +- 10%
3. Patient will be returned to waiting room and allowed to rest quietly for 45 minutes.
4. After the waiting period, patient is escorted to scan room and positioned on the Gamma Camera table.
5. Electrodes are placed and the 3 trigger monitor leads are connected.
6. Gated resting images are obtained.
7. After rest images are obtained, patient is escorted to the EKG department stress lab.
8. EKG tech will confirm history, explain the test, and connect the patient to the EKG stress machine.
9. EKG tech will then obtain a baseline blood pressure and EKG
10. If pharmacological test, a nurse will be called from infusion to administer the Lexiscan or other pharmaceutical stress agent.
11. The supervising physician will be alerted and once in the room the test can begin.

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12. The nurse will administer the Lexiscan over the recommended 10 second interval.
13. At peak effect of the stress agent, the Nuclear Medicine Tech will administer the second dose of the Cardiolite (30 mCi)
14. Once patient BP and heart rate have returned to base line, the 12 EKG will be disconnected and the patient allowed to dress.
15. The patient will be ~~escorted to the dining room and receive~~ provided with a food tray and encouraged to eat.
16. Approximately 1 hour after the stress injection, the patient will be escorted back to the Nuclear Medicine Suite and scanned on the gamma camera for the second time.
17. After scanning is complete, the patient's IV access will be DC and the patient allowed to leave.
18. At the earliest opportunity, the Rest/Stress images will be processed and forwarded to the Radiologist along with the paperwork for interpretation and dictation

B. OUTPATIENT TEST PROCEDURE, EXERCISE STRESS WITH MPI

1. After patient check in at DI, Nuclear medicine technologist will retrieve the paper work and escort the patient to the injection room to start the IV.
2. After reviewing history with the patient, Technologist will start the angiocath, secure, and inject the resting dose of Cardiolite (10 mCi) +- 10%
3. Patient will be returned to waiting room and allowed to rest quietly for 45 minutes.
4. After the waiting period, patient is escorted to scan room and positioned on the Gamma Camera table.
5. Electrodes are placed and the 3 trigger monitor leads are connected.
6. Gated resting images are obtained.
7. After rest images are obtained, patient is escorted to the EKG department stress lab.
8. EKG tech will confirm history, explain the test, and connect the patient to the EKG stress machine.
9. EKG tech will then obtain a baseline blood pressure and EKG
10. Once baselines are acquired, the attending physician will be alerted and when in the room, the patient will move to the treadmill and prepare to exercise.
11. When the desired heart rate is reached, the physician will instruct the Nuclear Medicine technologist to inject the Cardiolite.
12. The patient will continue to exercise for 1 minute past injection time and then treadmill will be stopped and patient allowed to recover.
13. When resting heart rate has returned, the patient will be disconnected from the EKG machine and taken to the Nuclear Medicine Suite for stress imaging.
14. After stress images are completed, the IV will be DC'd and the patient escorted back to the waiting room and allowed to leave.
15. The images will be processed according to accepted guidelines and presented to the Radiologist for interpretation and dictation.

C. INPATIENT MPI TESTING PROCEDURE.

Title: Cardiac Stress Test Protocol & Procedure	
Scope: Diagnostic Imaging	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

1. When inpatient stress tests are ordered, the Nuclear Medicine Technologist will ascertain whether or not the patient has been NPO for four hours prior, and no caffeine for 12 hours.
2. If the patient has no contraindications, a resting dose will be drawn and injected into the patient's iv as soon as possible in the am.
3. 45 minutes to an hour after injection, the patient will be brought to the Nuclear Medicine Suite and imaged.
4. After rest images are obtained, the patient will be transferred to EKG stress lab for the stress portion of the test.
5. Stress testing will be performed by the above described guidelines and the second (30 mCi) dose of Cardiolite injected at peak stress.
6. The patient will then be returned to his room and allowed to eat and rest for an hour.
7. After the hour is up, the inpatient will be returned to the Nuclear Medicine Suite and Stress images obtained.
8. The images will be processed according to accepted guidelines and presented to the Radiologist for interpretation and dictation.

D. 2 DAY MPI PROTOCOL

1. On occasion, due to body habitus, weight, or other factors, an MPI may be performed over a 2-day period. If so the rest or stress may be performed first, but the second part of the test should be performed in order to furnish the Radiologist with complete data for interpretation. If the stress is performed first, the Radiologist may look at the images and decide that the rest need not be performed.

E. SIDE EFFECTS FROM PHARMACOLOGICAL STRESS TESTING

1. The most common reactions to the administration of Lexiscan (Regadenoson) are shortness of breath, headache and flushing.
2. Less common reactions are chest discomfort, angina pectoris, or ST-segment depression, dizziness, chest pain, nausea, abdominal discomfort, dysguesia and feeling hot.
3. Most adverse reactions begin soon after dosing, and generally resolve within approximately 15 minutes, except for headache which resolves in most patients within 30 minutes.
4. Aminophylline may be administered in doses ranging from 50 to 250 mg by slow IV push to attenuate severe and /or persistent adverse reactions.
5. The supervising physician will direct this treatment if and when necessary.

REFERENCES:

1. ACR-NASCI-SPR-STR PRACTICE PARAMETER FOR THE PERFORMANCE OF CARDIAC SCINTIGRAPHY, 2015, RESOLUTION 44

draft

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Cardiac Stress Test Protocol & Procedure	
Scope: Diagnostic Imaging	Manual: Diagnostic Imaging
Source: Operations - Director of Diagnostic Services (DI & Lab)	Effective Date:

CROSS REFERENCE P&P:

1. Cardiopulmonary Department Cardiac Stress Test Policy

Approvals	**Date**
CCOC	4/20/2020
Radiology Services Committee	5/20/2020
Medicine / ICU Committee	5/21/2020
Medical Executive Committee	6/2/2020
Board of Directors	
Board of Directors Last Review	

SOURCES:
The Society of Nuclear Medicine and Molecular Imaging guidelines for Cardiac MPI
The ACR-NASCI-SPE-SRT Practice parameter for the performance of Cardiac Scintigrapy.
Nuclear Medicine Technology Procedures and Quick Reference by Pete Shackett.

Radiology Services Committee

Critical Indicators

2020

1. Death within 24 hours of invasive procedure.
2. Admission to ED within 24 hours of invasive procedure.
3. Severe contrast reaction.
4. Code Blue in the department
5. Patient called back for having wrong procedure performed.
6. Staff concerns.

Approvals

Radiology Services Committee: 02/13/20

Medical Executive Committee: 06/02/20

Board of Directors:

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle ______________
(Office use only)

Practitioner Name: ____________________________________ Date: ______________
Please Print

INTERNAL MEDICINE

Instructions: Please check box next to each core privilege/special privilege requested.

INITIAL CRITERIA

Education/Formal Training:

- Completed accredited residency training in Internal Medicine or equivalent.
- Board Certified/Board Eligible by the American Board of Internal Medicine or equivalent.

INPATIENT CORE PRIVILEGES

Current ACLS certification required

Request ☐

- Admit, evaluate, diagnose, perform H&P, consult and provide nonsurgical treatment to patients presenting with general medical problems.
- Admit, evaluate, diagnose, perform H&P, consult and provide nonsurgical treatment to patients presenting with critical illnesses, needing ICU care.
- Ventilator management.

OUTPATIENT CORE PRIVILEGES

Current BLS or ACLS certification required

Request ☐

- Admit, evaluate, diagnose, perform H&P, consult and provide nonsurgical treatment to patients presenting with general medical problems to the outpatient setting.

SPECIAL PRIVILEGES

(Requires experience within last 2 years and recommendation by Chief of Medicine)

- ☐ Anoscopy
- ☐ Arterial line placement
- ☐ Arterial puncture
- ☐ Arthrocentesis - small joint
- ☐ Arthrocentesis - large joint
- ☐ Aspiration of intra-, subcutaneous cysts, furnucles, etc
- ☐ Bronchoscopy
- ☐ Buprenophine (Suboxone) – certification required
- ☐ Cancer chemotherapy (in consultation with oncologist per protocol)
- ☐ Central venous line placement
- ☐ Conscious sedation (requires tutorial and current ACLS certificate)
- ☐ Diagnostic and therapeutic paracentesis
- ☐ Diagnostic and therapeutic thoracentesis
- ☐ Diaphragm fitting
- ☐ EKG/Holter/Event Monitor interpretation
- ☐ Electrical cardioversion
- ☐ ~~Emergency pericardiocentesis~~
- ☐ ~~Emergency tracheostomy/cricothroidotomy~~
- ☐ Endotracheal tube placement
- ☐ I&D cutaneous abscess
- ☐ Insertion/management of PA catheters
- ☐ Insertion/management of temporary transvenous pacemaker
- ☐ IUD insertion
- ☐ IUD removal
- ☐ Liquid nitrogen treatment warts, keratosis
- ☐ Lumbar puncture
- ☐ PFT interpretation
- ☐ Removal of a non-penetrating corneal foreign body, foreign body from conjunctival sac, ear, nose, skin
- ☐ Rigid/flexible sigmoidoscopy
- ☐ Skin biopsy
- ☐ Sleep Study Interpretation (Board certified by American Board of Sleep Medicine or completion of Sleep Medicine fellowship program)
- ☐ Stress test interpretation
- ☐ Suture minor lacerations
- ☐ Therapeutic injection - small or large joint
- ☐ Toe nail avulsion
- ☐ Tube thoracotomy (chest tube placement)

~~CONSULTING PRIVILEGES~~

~~(for Consulting Staff only)~~

~~**Request**~~ ☐

- ~~Provide consultation, order, interpret, and evaluate diagnostic tests to identify and assess patients' clinical problems and health care needs on request from Active or Provisional Staff members or Temporary Privileges Practitioners in the following ABIM subspecialty area (must be fellowship trained & board certified/eligible):~~
  - ~~Cardiovascular Disease~~
  - ~~Interventional Cardiology~~
  - ☐ ~~Infectious Disease~~

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle ______________
(Office use only)

Practitioner Name: ______________________________ Date: ______________
Please Print

Acknowledgment of Practitioner:
I have requested only those privileges for which by education, training, health status, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Medical Staff Bylaws, Rules and Regulations, and policies and procedures applicable.
(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

______________________________ ______________
Practitioner Signature *Date*

APPROVALS

COMMENTS/MODIFICATIONS TO REQUESTED PRIVILEGES:

______________________________ ______________
Chief of Medicine/Intensive Care *Date*

______________________________ ______________
Chief of Surgery *Date*

Approvals	*Committee Date*
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(Office use only)

CALL TO ORDER	The meeting was called to order at 5:30 pm by Jean Turner, District Board Chair.
PRESENT	Jean Turner, Chair Robert Sharp, Vice Chair Jody Veenker, Secretary Mary Mae Kilpatrick, Treasurer Topah Spoonhunter, Member-At-Large Kelli Davis MBA, Interim Chief Executive Officer and Chief Operating Officer Tracy Aspel RN, BSN, Chief Nursing Officer Will Timbers MD, Interim Chief Medical Officer Stacey Brown MD, Chief of Staff Keith Collins, District Legal Counsel
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Turner announced 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, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the agenda for the meeting. Comments were heard from Tracy Aspel, Chief Nursing Officer.
INTRODUCTION OF HUMAN RESOURCES DIRECTOR	Interim Chief Executive Officer Kelli Davis introduced Northern Inyo Healthcare District (NIHD) Director of Human Resources Richard Ulibarri. Mr. Ulibarri was welcomed to the NIHD leadership team.
CITY OF BISHOP PROCLAMATION, HEALTHCARE DISTRICT MONTH	Ms. Davis reported that the City of Bishop has declared the month of May 2020 to be *Healthcare District Month*, in honor of all community healthcare workers and first responders. The designation acknowledges community heroes throughout Inyo County for their tireless work during the Covid 19 pandemic.
INTRODUCTION OF FINANCIAL CONSULTANT VINAY BEHL	Ms. Davis introduced NIHD financial consultant Vinay Behl, who provided an overview of the District's current financial condition. Mr. Behl's presentation included the following: - A review of NIHD's income statements and financial statements - An overview of current financial challenges relating to the Covid 19 crisis (those challenges include a significant reduction in revenue without a corresponding significant reduction in expenses) - Statement of the fact that the District is barely bringing in enough revenue to cover expenses - An urgent need exists for the District to reduce its debt service

- NIHD leadership is currently working to negotiate the lowest possible price for its new Electronic Health Record (EHR)
- It is critical that the District invest in technology and in specific service lines in order to increase revenue
- The District should attempt to capitalize on all Covid 19-related assistance programs; monies available; and financial opportunities
- Cash flow is a significant concern at this time. The District needs to reduce its outstanding Accounts Receivable as soon as possible.
- There is a need to improve the District's service model in order to improve the gross margin
- General strategies for improving the District's financial condition were provided, for a 90 day period, and for the next 365 days
- A need exists to correct deficiencies identified in NIHD's accounting processes
- The District's bond rating has recently been reduced from BB status to B- status

Mr. Behl noted that the District faces very critical financial challenges going forward, however he is impressed with the NIHD team and has confidence in their ability to accomplish the work that needs to be done.

AUTHORIZATION OF BANKING LINE OF CREDIT, DISTRICT BOARD RESOLUTION 20-04

Board member Robert Sharp recused himself from discussion of the next agenda item, exiting the room at this time. NIHD Controller Genifer Owens called attention to proposed District Board Resolution 20-04 which authorizes an application for a $3,500,000-$5,000,000 line of credit with Eastern Sierra Community Bank/Oak Valley Community Bank, to be available in the event that additional funds are needed to sustain the District during the Covid 19 pandemic. Mary Mae Kilpatrick asked that the proposed Resolution be edited to indicate that authorized District officers are empowered to establish and manage the line of credit acting together only, vs giving them the ability to control the line individually. It was moved by Ms. Kilpatrick, seconded by Jody Veenker and passed 4 to 0 to approve proposed District Board Resolution 20-04 with the words "individually or" being stricken from all wording. Director Sharp, who had recused himself from the vote re-entered the room at this time.

DEPOSIT OF CD MONIES INTO LAIF ACCOUNT

NIHD Controller Genifer Owens called attention to an information item regarding depositing monies from maturing NIHD Certificates of Deposit (CD's) into the District's Local Agency Investments Fund (LAIF) in order to earn a higher rate of interest. The CD monies will be transferred into LAIF upon maturity, during the month of June 2020.

FUNDING OF NIHD 401(A) PENSION PLAN

Ms. Owens additionally informed the Board that the funding expense for the District's 401(a) pension plan, though recorded on the financial statements for the current fiscal year, will not take place until the 2020/2021 fiscal year in order to preserve cash on hand. Funding of the 401(a) plan for the 2019/2020 year will take place sometime after July 1 2020 and prior to October 15 2020.

BUDGET UPDATE, FISCAL YEAR 2020/2021	Ms. Owens also provided an update on progress made toward finalizing the District's July 1 2020 through June 30 2021 annual budget, which will be presented for approval at the June 17 2020 regular meeting of the District Board.
ADD TO AGENDA DUE TO URGENT NEED	Ms. Turner stated that following the financial update provided by Vinay Behl, the Board has identified that there is an immediate need to add an item to the agenda regarding a matter that has come to the Board's attention following the posting of the agenda for this meeting. Per Mr. Behl's report, the Board has need to enter into an agreement with OutSource Inc. to attempt to recover $24,000,000 in outstanding Accounts Receivable held in the Athena Electronic Health Record, at a cost of approximately $39,000 per month. It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve the addition of an agenda item titled "*Approval of contract with OutSource Inc. (action item)*", due to an urgent need to act on that matter at this meeting.
AGREEMENT WITH OUTSOURCE INC.	Kelli Davis then called attention to an agreement with OutSource Inc. to attempt to recover $24,000,000 in outstanding Accounts Receivable that is currently held up in the District's Athena Electronic Health Record system. OutSource Inc. has experience with recapturing Athena system backlogs, and the expense has been determined to be well worth the monies that will be recovered. It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve the proposed agreement with OutSource Inc. as presented.
ELECTRONIC HEALTH RECORD SELECTION PROCESS OVERVIEW	NIHD Project Manager Lynda Vance called attention to an overview of the District's process for selection of its' next Electronic Health Record (EHR). The overview included a review of the Committee established for the selection process; vendor presentations; data collection; and input received from District Staff. The EHR selection process included review of four different EHR products and seven delivery methods. The final recommendation of the EHR Selection Committee is to select the Cerner product to be the District's next Electronic Health Record.
CERNER INTRODUCTORY PRESENTATION AS NEW EHR	Greg Gillis with Cerner Corporation provided an overview of who Cerner is, as well as an overview of the company's experience in the healthcare market. Mr. Gillis reviewed Cerner's history and corporate stability as compared to other companies with EHR products. It was noted that the details of NIHD's agreement with Cerner are still being negotiated, and that the term of the agreement is expected to be 10 years.
DESIGNATION OF 3RD PARTY EHR IMPLEMENTATION MANAGER	Kelli Davis called attention to a proposal to select Wipfli LLP to be the project manager for the District's upcoming EHR implementation, noting that the use of a third party vendor will help to ensure that the project goes well and that NIHD ends up with a quality product. Ms. Davis also noted that Wipfli's services will include both project management and change management oversight. It was moved by Mr. Sharp, seconded by Ms.

Veenker, and unanimously passed to approve the selection of Wipfli LLP to be the District's EHR implementation project manager as requested.

NIHD PASSWORD POLICY

Interim Information Technology Director Bryan Harper called attention to a proposed *Password Policy* being recommended in the interest of improved technological risk management, as well as in the interest of general best practices. It was moved by Mr. Sharp, seconded by Topah Spoonhunter, and unanimously passed to approve the proposed *Password Policy* as presented.

CYBER SECURITY POLICY

Mr. Harper also called attention to a proposed Policy and Procedure titled *Cyber Security Policy*, which is being recommended to provide increased protection of the District's Protected Health Information (PHI). It was moved by Mr. Sharp, seconded by Mr. Spoonhunter, and unanimously passed to approve the proposed *Cyber Security Policy* as presented.

SELECTION OF EXECUTIVE SEARCH FIRM

Ms. Turner then called attention to proposals submitted by prospective Executive Search Firms interested in assisting in the selection process for the District's next Chief Executive Officer (CEO). It was noted that one of the proposals was received within the last 24 hours, and that it may be in the best interest of the selection process to address this agenda item at a time when the District Board has had adequate time to review all of the proposals received. Following brief discussion it was determined that a Special Meeting of the District Board will be held on Thursday, May 28 2020 at 5:30 pm, for the purpose of selecting an Executive Search Firm. Stacey Brown, MD indicated that he would like to provide input on the development of an Executive Search Firm assessment tool.

APPOINTMENT OF BOARD MEMBERS TO THE EXECUTIVE SEARCH COMMITTEE

Ms. Turner then proposed the appointment of Directors Jody Veenker and Topah Spoonhunter to work with NIHD leadership to develop an Executive Search Committee for the purpose of selecting the District's next Chief Executive Officer. It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to appoint Jody Veenker and Topah Spoonhunter to the NIHD Executive Search Committee.

DISTRICT BOARD RESOLUTION 20-03, CONSOLODATION OF ELECTION

Interim CEO Kelli Davis called attention to proposed District Board Resolution 20-03, which would allow for the Healthcare District November election to be combined with the November 3 2020 general election. It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve District Board Resolution 20-03 as presented.

BI-ANNUAL REVIEW OF NIHD CONFLICT OF INTEREST CODE

Ms. Davis also called attention to a bi-annual review of the Northern Inyo Healthcare District Conflict of Interest Code, which is required to be completed by July 1 2020. It was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve the District's existing Conflict of Interest Code with no changes being made at this time.

BOARD AGENDA ITEM REVIEW AND APPROVAL PROCESS	Ms. Turner called attention to a proposed process for vetting agenda items that are presented to the District Board of Directors for approval. Ms. Turner stated that it is the Board's desire to have agenda items come to them thoroughly vetted, in a process that improves transparency and clearly provides a synopsis of the item being addressed. Following brief discussion it was determined that the proposed process and corresponding *Board Agenda Item Approval Form* will undergo further review prior to it being returned to the District Board for consideration.
APPROVAL OF NIH FOUNDATION BOARD MEMBER	NIHD Foundation Executive Director Greg Bissonette requested approval of the nomination of Ms. Cheryl Underhill to be seated as a member of the NIHD Foundation Board. It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and unanimously passed to approve the appointment of Cheryl Underhill to the NIHD Foundation Board.
PIONEER MEDICAL ASSOCIATES MAINTENANCE AGREEMENT	Ms. Davis called attention to a proposed Maintenance Agreement between NIHD and Pioneer Medical Associates (PMA), which will formalize the arrangement between the District and PMA to provide maintenance upkeep for the building located at 152 Pioneer Lane, Bishop. It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve the proposed Maintenance Agreement between NIHD and Pioneer Medical Associates as presented.
RHC ANNUAL REPORT	Medical Director of the NIHD Rural Health Clinic (RHC) Stacey Brown, MD called attention to the 2018 and 2019 RHC Annual Reports, which are required to be submitted on an annual basis. The reports were provided as an informational item for members of the District Board. The Board thanked Dr. Brown for providing the review, noting that the reports provide a clear picture of how the NIHD Rural Health Clinic functions as a medical home for members of this community.
BUILDING SEPARATION PROJECT UPDATED	NIHD Property Manager Scott Hooker reported that the District has received Office of Statewide Healthcare Planning and Development (OSHPD) approval to continue work on the building separation project. Colombo Construction will be back on site at NIHD next week in order to resume work.
GOVERNANCE CONSULTANT UPDATE	Ms. Turner reported that Jim Rice with Gallagher Associates will conduct two half-day Board Governance training sessions for the NIHD Board, and that those trainings will be held on June 26 2020 and June 27 2020.
CHIEF OF STAFF REPORT PROVIDER APPOINTMENTS	Chief of Staff Stacey Brown MD reported following careful review and consideration the Medical Executive Committee recommends approval of the following Medical Staff and Advanced Practice Provider appointments: 1. Jennifer Figueroa, PA-C (*women's health clinic*) – Advanced Practice Provider Staff 2. Benjamin Ebner, MD (*adult cardiology – Renown*) –

Telemedicine Staff
3. Shabnamzehra Bhojani, MD (*adult and pediatric psychiatry – Regroup*) – Telemedicine Staff
4. Shilpi Garg, MD (*pediatric cardiology – Children's Heart Center of Northern Nevad*a) – Telemedicine Staff

It was moved by Ms. Veenker, seconded by Mr. Sharp, and unanimously passed to approve all four Medical Staff appointments as requested.

TELEMEDICINE STAFF APPOINTMENTS

Doctor Brown also reported as per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioner for Telemedicine Privileges relying upon Adventist Health's credentialing and privileging decisions:

1. Sheila Cai, MD (*pediatric psychiatry*) – Telemedicine Staff

It was moved by Ms. Veenker, seconded by Mr. Sharp, and unanimously passed to approve the Telemedicine Staff appointment of Sheila Cai MD as requested.

MECICAL STAFF ADVANCEMENTS

Doctor Brown also stated following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following Medical Staff advancements:

1. James Fair, MD (*emergency medicine*) – advancement to Active Staff
2. Anna Rudolphi, MD (*emergency medicine*) – advancement to Active Staff
3. Bo Nasmyth Loy, MD (*orthopedic sur*gery) – advancement to Active Staff

It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve all three Medical Staff advancements as requested.

MEDICAL STAFF RESIGNATION

Doctor Brown also stated the Medical Executive Committee recommends Board approval of the Medical Staff resignations of the following:

1. Tanya Scurry MD (*peds psychiatry*) – Telemedicine Staff, Adventist Health – effective 3/26/20
2. Arin Aboulian MD (*pulmonology*) – Telemedicine Staff, Adventist Health – effective 4/10/20
3. Kelly Tatum Brace, DPM (*podiatry*) – Provisional Active Staff – effective 4/28/20

It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and unanimously passed to approve all three Medical Staff resignations as requested.

POLICY AND PROCEDURE APPROVALS

Doctor Brown also 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:

1. *Chaperone Use for Sensitive Exams*
2. *Patient Identification for Clinical Care and Treatment/Armband Usage*
3. *Sterile Processing Standards of Practice*

It was moved by Ms. Veenker, seconded by Mr. Sharp, and unanimously passed to approve all three District-wide Policies and Procedures as presented.

ANNUAL APPROVALS

Doctor Brown additionally stated that the Medical Executive Committee recommends approval of the following Annual Approvals:

1. *Standardized Procedure* – Well Child Care Policy for the Nurse Practitioner
2. *Standardized Procedure* – Well Child Care Policy for the Physician Assistant

It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve both Annual Approvals as requested.

FAMILY MEDICINE CORE PRIVILEGE FORM UPDATE

Doctor Brown also requested approval of the *Family Medicine Core Privilege Form* update. It was moved by Mr. Sharp, seconded by Mr. Spoonhunter, and unanimously passed to approve the *Family Medicine Core Privilege Form* update as requested.

PHYSICIAN RECRUITMENT UPDATE

Doctors Brown and Timbers also provided a physician recruitment update which included a report on the addition of hospitalist practitioners; a pediatrician; a family medicine provider; and the potential recruitment of a breast surgeon; plastic surgeon; general surgeon; pain and anesthesia provider; and a potential spine surgeon. Doctor Timbers noted that the District will be doing an increased number of Returns On Investment (ROI's) and financial analyses when considering implementation of potential new lines of service.

CONSENT AGENDA

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

1. *Approval of minutes of the April 2 2020 special meeting*
2. *Approval of minutes of the April 6 2020 special meeting*
3. *Approval of minutes of the April 15 2020 regular meeting*
4. *Approval of minutes of the April 28 2020 special meeting*
5. *Financial and statistical reports as of March 31, 2020*
6. *Chief Nursing Officer report*
7. *Chief Medical Officer report*
8. *Policy and Procedure annual approvals*
9. *Medical staff Pillars of Excellence Quarterly report*
10. *Wipfli required communications letters for Fiscal Year Ending 6/30/19*

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

BOARD MEMBER REPORTS

Ms. Turner then asked if any members of the Board of Directors wished to report on any items of interest. No reports were given.

ADJOURNMENT TO CLOSED SESSION

At 10:04 pm Ms. Turner announced the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. Conference with Legal Counsel, existing litigation (*pursuant to Paragraph (1) of subdivision (d) of Government Code Section 54956.9*), Workers' Compensation claim of Kate Miller.
B. Conference with Legal Counsel, anticipated litigation, significant exposure to litigation (*pursuant to Government Code Section 54956.9(d)(2)*), 2 cases.
C. Public Employee Performance Evaluation (*pursuant to Government Code Section 54957(b)*), title: Interim Chief Executive Officer.
D. Conference regarding possible real estate negotiation, 376 West Yaney Street, Bishop, NIHD agency negotiator Kelli Davis (*pursuant to Government Code Section 54956.8*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 11:40 pm the meeting returned to Open Session. Ms. Turner reported the Board took no reportable action.

ADJOURNMENT

The meeting was adjourned at 11:41 pm.

Jean Turner, Chair

Attest:

Jody Veenker, Secretary

CALL TO ORDER

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

PRESENT

Jean Turner, District Board Chair
Robert Sharp, Vice Chair
Jody Veenker, Secretary
Mary Mae Kilpatrick, Treasurer
Topah Spoonhunter, Member-At-Large
Kelli Davis MBA, Interim Chief Executive Officer and Chief Operating Officer
Via Zoom:
Tracy Aspel RN, BSN, Chief Nursing Officer
Will Timbers MD, Interim Chief Medical Officer
Stacey Brown MD, Chief of Staff

OPPORTUNITY FOR PUBLIC COMMENT

Ms. Turner stated at this time persons in the audience may speak only on items listed on the Notice for this meeting, and speakers will be limited to a maximum of 3 minutes each. No comments were heard.

APPROVAL OF AGREEMENT FOR CERNER ELECTRONIC HEALTH RECORD

Interim Chief Executive Officer Kelli Davis called attention to approval of a contract with Cerner Corporation to purchase a new Electronic Health Record (EHR) for Northern Inyo Healthcare District (NIHD). Ms. Davis stated that the proposed agreement has been appropriately vetted by District Legal Counsel; Compliance; Finance; and Information Technology leadership, and that due diligence has been achieved. Interim Information Technology Director Bryan Harper provided a presentation on the District's EHR selection process, including an overview of how the NIHD workforce chose the Cerner product. It was noted that the District negotiated the best possible price for the Cerner system, and received a total price reduction of $1.2 million off the originally quoted price. The total capital cost for the system will be $2.8 million, paid out over a 10-year period. It was moved by Jody Veenker, seconded by Topah Spoonhunter, and unanimously passed to approve the proposed agreement with Cerner Corporation to purchase NIHD's next Electronic Health Record as requested.

SELECTION OF NIHD EXECUTIVE SEARCH FIRM

Ms. Turner called attention to the selection of an Executive Search Firm to conduct the recruitment effort for NIHD's next Chief Executive Officer. Scoring of the proposals received resulted in the following companies being identified as the top 3 candidates:

- WittKeiffer
- Gallagher MSA Search
- Berkeley Search Consultants

Review and discussion of the three proposals took place, and public comment was and received. At the conclusion of discussion it was moved

by Mr. Spoonhunter, seconded by Robert Sharp, and unanimously passed to select WittKeiffer to be the District's Chief Executive Officer search firm. It was noted that in addition to other strong points, WittKeiffer has specific experience in the California Healthcare Executive market. Monthly updates on the progress of the District's Executive Search will be provided at future meetings of the District Board.

OPPORTUNITY FOR PUBLIC COMMENT

Ms. Turner again asked if any members of the public wished to comment on any items listed on the Notice for this meeting. No comments were heard.

ADJOURNMENT

The meeting was adjourned at 6:04 pm.

Jean Turner, Chair

Attest:

Jody Veenker, Secretary

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

Date: 6/10/2020

Title: **Compliance Quarterly Report**

Synopsis: **It is recommended that the Board of Directors approve the Compliance Quarterly Report as presented to the Board.**

The Compliance Quarterly report is a summary of the work of the compliance department. It also provides a review of the Compliance Program for NIHD and the compliance workplan.

Prepared by: Patty Dickson
Compliance Officer

Reviewed by: ______________________
Name
Title of Chief who reviewed

Approved by: ______________________
Name
Title of Chief who approved

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Acceptance: _________ Submitted by: ______________________
Chief Officer

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Compliance Report
June 2020

1. **Comprehensive Compliance Program review**
    a. As June 1, 2020, 94.3% District's employee (including temporary, traveler, and contract workers) workforce have reviewed the Compliance Program. Of employees who have been here longer than 90 days, 98.2% have reviewed. These numbers fluctuates due to employee turnover.
    b. 52.4% of District workforce, including providers, have completed HIPAA training for CY 2020. The assigned training course is not due to be completed until 6/30/2020.
    c. 98.72% of District workforce, including providers, have completed HIPAA training for CY 2019. Only one overdue course is an employee. All others are providers.
    d. HIPAA Rounding – Developed HIPAA walk-through audit sheets, allows for tracking and just-in-time training for areas at risk for privacy concerns, breaches, and security issues. Started in January 2020. On hold as of March 2020. Will resume when COVID restrictions for workforce are lifted.
    e. Audits as listed below to review for fraud, waste, and abuse.
2. **Breaches**
    a. See attachment A for breaches reported to NIHD Compliance by year. Increased reporting of potential breaches and privacy concerns by the workforce indicates heightened awareness of HIPAA privacy and confidentiality laws. Approximately 10% of cases reported to NIHD Compliance Department require reporting to California Department of Public Health or the Department of Health and Human Services Office of Civil Rights.
    b. Calendar Year (CY) 2019
        i. 91 alleged breaches of PHI (Protected Health Information) potentially affecting approximately 500 patients have been investigated by the Compliance Office
        ii. 11 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 seven (7) cases. All seven were substantiated, but assigned no deficiency.

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2. Four (4) cases are 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.

iii. One reported potential breaches/privacy concerns is still under investigation by the NIHD Compliance Department.

c. CY 2020 – as of May 31, 2020
   i. 31 alleged breaches of privacy have been investigated by Compliance, potentially affecting approximately 33 patients.
   ii. 9 of the alleged breaches 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. Seven cases are still pending CDPH investigation.
      3. Several cases from prior years are still pending letters of findings, indicating that at least some may incur some level of deficiency and penalty.

3. Issues and Inquiries

a. CY 2020 – Several hundred requests for research and input on a wide variety of compliance, ethics, and regulatory topics have been made to the Compliance Department.
b. Compliance currently reviews all new referring physicians to verify they are not on a Federal or State exclusions list.
c. Work on rapid deployment of HIPAA compliant Telehealth solutions in response to COVID-19.
d. Continuous updates to regulations since March 2020 due to COVID-19 epidemic
e. Policy development and consultation work

4. Audits

a. Employee Access Audits (see tables, attachment B) - The Compliance Department Analyst manually completes audits for access of patient information systems to ensure 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.

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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. Audits are also conducted when requested or "for cause"
iv. Compliance performs between 250-800 audits monthly.
    1. Each audit ranges from hundreds of lines of data to thousands of lines of data.
    2. A "flag" is created when any access appears unusual.
    3. Flags are reviewed and resolved by comparison audits, workflow review, discussions with workforce, and discussions with leadership.

b. Business Associates Agreements (BAA) audit
    i. We currently have approximately 150 Business Associates Agreements.
    ii. 3 BAAs are currently in negotiations
    iii. We have executed 15 BAAs since October 1, 2019
c. Vendor Contract reviews
    i. 4 contracts currently in review with vendor and/or legal counsel
    ii. 10 contracts reviewed in conjunction with legal counsel since October 1, 2019
d. Financial Signing Authority Limit review
    i. review of policy and audit of submitted document review is in progress
e. PACS (Picture Archival and Communication System) User Access Agreements
    i. Compliance processes access agreements for external entities/providers to gain access to the NIHD PACS Portal (electronic Imaging system) to ensure appropriate use and regulatory compliance.
f. HIMS scanning audit – Scheduled for Q3 2020
g. Language Access Services Audit
    i. Based on relatively poor compliance with documentation standards during the last audit, workforce tools for Spanish documents have been deployed.
    ii. All Spanish forms available for NIHD are now in a Spanish packet, which includes instructions, and the Spanish and English documents.
    iii. This should greatly improve compliance with Language Access Policies and required documentation.

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   iv. It will also improve the safety of the care services we provide to our limited English proficiency patients. (See attachment C)

h. HIPAA Security Risk Assessment – Completed November 2019 (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. Risk Management plan will be developed/updated following the Penetration Testing Report performed in May 2020. Penetration testing was conducted by a third party in conjunction with the Security Officer, Bryan Harper.
   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 August 2020. Delayed to due COVID 19.

i. 340B audit – pharmacy conducted an internal review of the 340B program. Summary presented to compliance. Action plan completed. Third party audit in progress.

j. Audit of new website (under construction) for compliance with rules, regulations and recommendations.

k. An audit of NIHD Board of Directors Agendas, Minutes, and Resolutions is in progress.

l. Audit of provider contracts for compliance with terms and regulations.

5. Conflicts of Interest questionnaires

a. Compliance will send the 2020 Conflict of Interest Questionnaires soon. Delayed due to COVID 19.

6. CPRA (California Public Records Act) Requests

a. The Compliance office responded to 21 CPRA requests in CY 2019.
   i. Approximately 220 documents were released

b. The Compliance office either has responded or is responding to 26 CPRA requests so far in 2020.
   i. Nearly 1000 documents have already been released in response
   ii. 2 requests for documents were denied as the documents were exempt from disclosure

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7. **Compliance Workplan** (attachment D)
    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 June 2020 for progress and is scheduled for review in the Compliance and Business Ethics Committee.
8. **Unusual Occurrence Reports** (UOR) (Attachment E)
    a. All unusual events are reported through the UOR system. (complaints, med errors, unusual events, privacy concerns, Corrective Action Plan tracking items, etc)
    b. Reported on last 2 quarters of data and data since inception in the attachment, as data for a year makes the charts a bit more difficult to read.
    c. 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
    d. ComplyTrack- tracking software – system went live on 4/15/2019 and will be transitioning to Nursing Quality in June of 2020.
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 are reported here, no less than annually until completed.
        i. All corrective action plans except the one listed below were successful and monitored according to the corrective action plan timeline and showed sustained compliance.
        ii. E 2150 - Infection Prevention Program monitoring
            1. Cleaning Wet time – ongoing monitoring 04/2020
                a. Emailed CNO re: revisiting corrective action plan as not yet successful. (6/3/2020)
10. **The Joint Commission Survey Response**

Northern Inyo Healthcare District

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

   a. Compliance has been working with Department leadership teams to follow corrective actions and monitor for sustained compliance.
   b. See attached spreadsheet. Attachment F

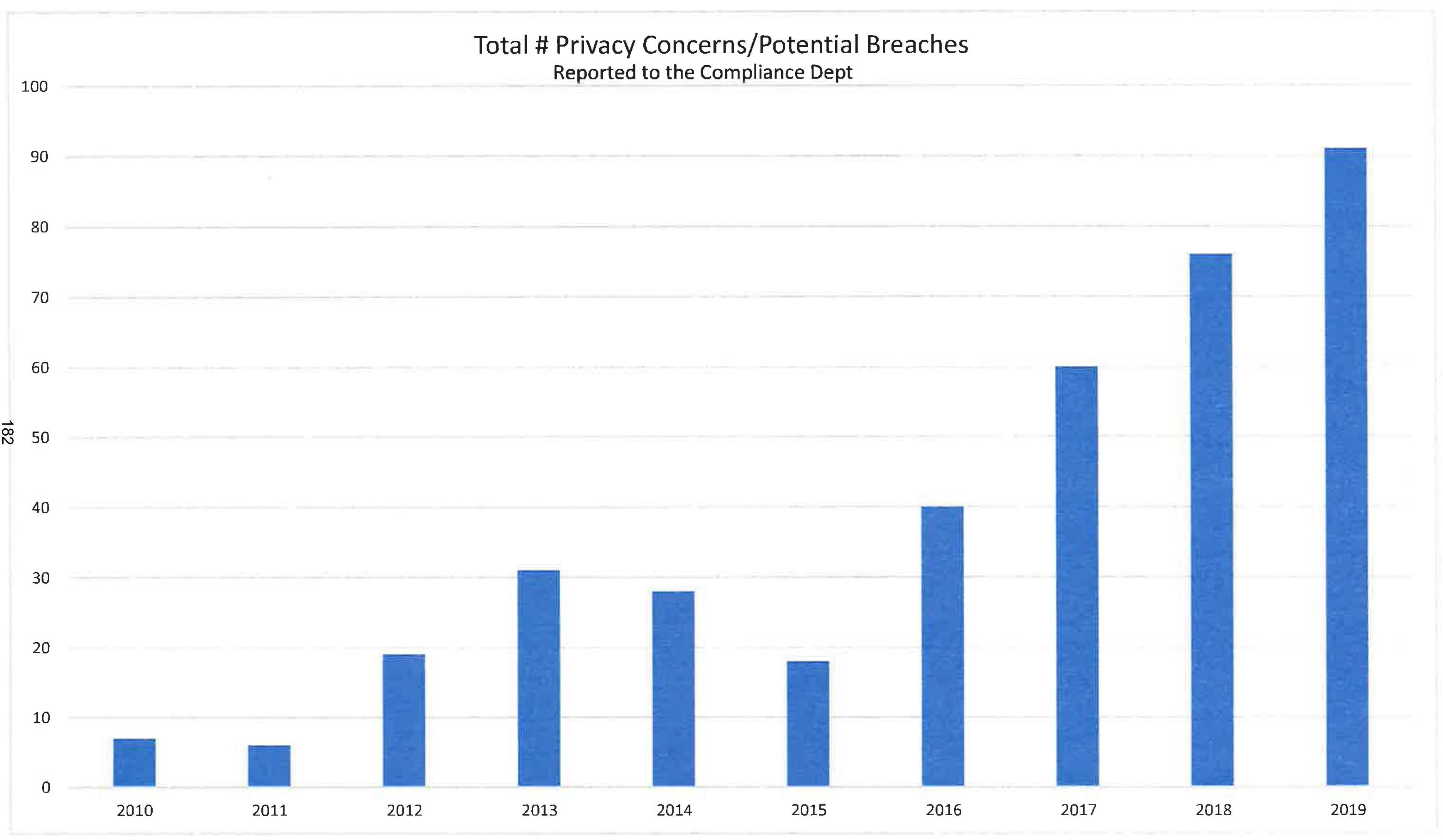
11. Compliance and Business Ethics Committee
   a. Has not met in 2020. Plans to meet Q3.

12. Auditing and Monitoring for CDPH 00580957 (ended March 2020)
   a. Audit of Surgeons for printing documents for intra-facility transport:
      No documents were printed for transport between office and Hospital between April 2018 and June 2020.
   b. Auditing has been completed with no areas of non-compliance.

13. California Division of Occupational Safety and Health (CAL DOSH) Complaint (Attachment G)
   a. Received complaint 1550735 regarding fumes from the incinerator inside building on March 13, 2020.
   b. Response was sent to CAL DOSH on March 27, 2020. Letter is attached to this report, but not all attachments.
   c. No further communication from CAL DOSH at this time.

14. Optimization, update, and audit of Policy Management software
   a. Proper policies and policy management is a large component of an effective Compliance Program.
   b. A small team comprised of nursing, operations, compliance, and ITS representatives have been completing work on the policy management software optimization.
   c. Simultaneous work on a "Policy and Procedure for writing policies and procedures" is occurring, and the policy is being developed by a team with key stakeholders. Training and education will go to policy writers and leadership teams once policy is developed and approved.
   d. This work will allow easier access to policies, updated policies, improved tracking and auditing. It will provide for policy approval committees to sign off approval inside the document tracking system, so that no approval information will be lost or overwritten.
   e. Clean up work is on-going. Development of optimal processes to assign policies will assure that policies are only assigned to readers that must review the policies.
   f. Will reduce employer costs by allowing for better use of employee time by reducing policy assignments to those necessary and required.

Attachment A



Increased reporting to the Compliance department indicates heightened awareness of workforce to potential privacy concern. Mandatory reporting to CDPH or OCR occurs in less than 10% of cases.

Attachment B

Employee Access Audits

	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20
TOTAL ED SAME LAST NAME ENCOUNTERS	234	240	37	12	107	53	70	67	59
AUDITED ED SAME LAST NAMES ENCOUNTERS	234	240	37	12	107	53	70	67	59
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL ED HIGH PROFILE PT ENCOUNTERS	4	5	5	1	13	7	0	1	0
AUDITED ED HIGH PROFILE ENCOUNTERS	4	5	5	1	13	7	0	1	0
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	#DIV/0!	100.0%	#DIV/0!
TOTAL ED - EMPLOYEE ENCOUNTERS	2	10	13	7	8	17	14	6	2
AUDITED ED - EMPLOYEE ENCOUNTERS	2	10	13	7	8	17	14	6	2
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL IP SAME LAST NAME ENCOUNTERS	22	24	16	12	11	12	30	20	39
AUDITED IP SAME LAST NAMES ENCOUNTERS	22	24	16	12	11	12	30	20	39
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL IP HIGH PROFILE PT ENCOUNTERS	0	0	2	0	0	0	0	0	2
AUDITED IP HIGH PROFILE ENCOUNTERS	0	0	2	0	0	0	0	0	2
% AUDITED	#DIV/0!	#DIV/0!	100.0%	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	100.0%
TOTAL IP - EMPLOYEE ENCOUNTERS	0	0	10	3	0	2	10	4	5
AUDITED IP - EMPLOYEE ENCOUNTERS	0	0	10	3	0	2	10	4	5
% AUDITED	#DIV/0!	#DIV/0!	100.0%	100.0%	#DIV/0!	100.0%	100.0%	100.0%	100.0%
TOTAL OP SAME LAST NAME ENCOUNTERS			144	56	28	232	159	309	416
AUDITED OP SAME LAST NAMES ENCOUNTERS			144	56	28	232	159	309	416
% AUDITED	#DIV/0!	#DIV/0!	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL OP HIGH PROFILE PT ENCOUNTERS			18	7	11	26	26	9	32
AUDITED OP HIGH PROFILE ENCOUNTERS			18	7	11	26	26	9	32
% AUDITED	#DIV/0!	#DIV/0!	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL OP - EMPLOYEE ENCOUNTERS			91	125	128	178	159	171	162
AUDITED OP - EMPLOYEE ENCOUNTERS			91	125	128	178	159	171	162
% AUDITED	#DIV/0!	#DIV/0!	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
TOTAL NEW (<90 DAY) EMPLOYEES	2	6	16	7	11	15	10	11	13
AUDITED NEW (<90 DAY) EMPLOYEES	2	6	16	7	11	15	10	11	13
% AUDITED	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
FOR-CAUSE AUDITS	5	9	2	0	4	3	2	7	3
Total # monthly audits	269	294	354	230	321	545	689	603	728

Compliance changed the methodology to provide more effective and efficient auditing of high risk records in August of 2019.

Audit Flags

	19-May	19-Jun	19-Jul	19-Aug	19-Sep	19-Oct	19-Nov	19-Dec	20-Jan	20-Feb	20-Mar	20-Apr
Employee as patient audit	0	0	0	0	1	3	6	5	4	2	3	
High profile patient audit	0	0	0	0	0	1	0	1	1	3	0	
New employee audit	0	0	0	0	0	0	0	0	0	2	0	0
Same last name audit	1	1	5	2	9	1	0	0	0	5	7	
Random	3	2	0	2	0	0	0	0	0	0	0	
Employee Access Audits	0	0	0	0	0	0	0	0	0	0	0	
Total	4	3	5	4	10	5	6	6	5	12	10	
Appears Compliant	4	3	5	4	10	5	6	6	5	11	10	
Appears Non-Compliant										1		
Ongoing Investigation												

Audit flags are concerns that arise during the audit process. They require additional investigation to determine if the access is appropriate use of patient information.

Patty Dickson

From:	Patty Dickson
Sent:	Sunday, April 26, 2020 4:24 PM
To:	SrMgt; NIH Directors; NIH Coordinators; NIH Managers
Cc:	Conor Vaughan; Dee Booth; Jeanette Smith; Cori Stearns
Subject:	Forms, Forms, Forms
Attachments:	2019 Instructions for Spanish documents.pdf

Good afternoon,

We have been working hard to get all the forms in the correct location and sorted on the intranet so they are easier to find.
I have removed the "departments" – it was too difficult to maintain, which led to outdated forms, multiple versions of forms, and many other challenges.

All approved forms are located on the intranet under Forms: Departmental Forms

Every form that has an English and Spanish version is now in a packet, labeled "Spanishp."
The packet includes:
First page: Instructions to complete a translated document
Document in Spanish
Document in English

This will alleviate any confusion on what to do, when to get an interpreter, how to document on the translated form correctly, whether you need the English version of the form, etc.
The instructions cover ALL of it.
We are doing our best to set our staff up for success with limited English proficiency patients.
I have attached the instructions to this email, just in case anyone wants a preview.
(HIMS – the instructions should never be scanned into a Medical Chart.)

If you have any questions, please reach out to me or Jose Garcia.

Respectfully,
Patty Dickson, *CHC, CHPC, BA - HCM, CNMT*
Compliance Officer
Office: 760-873-2022

NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Workforce Instructions for using Translated Spanish Documents

These instructions are not part of the medical record.

1. **Provide an approved interpreter.** This shall be done via telephone, video interpreter unit, or live interpreter. The patient may prefer to use a family member. If they do, they must sign a "Waiver of Interpreter Services." **The District workforce is still legally required to provide a qualified medical interpreter to ensure that the unapproved interpreter is accurate and complete.** You can put the video interpreter unit in the room and let everyone know that for safety, the medical interpreter is only listening in to ensure accuracy of the family.

2. **Print Spanish document.** The Spanish document will print with these instructions and the English version of the same document.

3. **Complete all fill-in-the-blank areas on the English and Spanish form, in English.** If there is no information to fill in, put a line through the blank. There are some common procedure terms already translated on the intranet. You may use these Spanish translations on the Spanish form if they are available.

4. **Provide Spanish document to patient.** Use English document so you can explain and review document with patient.

5. **Read the information you "filled-in" on the forms to the patient and allow the interpreter to interpret.** Interpreters may not interpret from written words (called sight translation), only spoken words.

6. **Review the form and answer all questions using the interpreter.**

7. **Complete all required signatures on the form on BOTH the English and Spanish forms.** Yes, the patient, witness, and workforce need to sign the English and the Spanish forms.

8. **Complete documentation of the Interpreter's name and/or identification number.**

9. **Both the English and Spanish signed forms are part of the patient's legal medical record.** Both should be scanned into the chart or sent to HIMS.

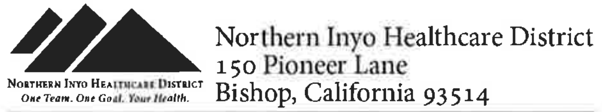
10. **These instructions should not be included in the documents scanned or archived into the patient chart.** Shred this page.

If you still have questions, please ask your supervisor or call:

Language Services – 2147

Compliance - 2022

Developed: 10/11/2019 Revised:



Northern Inyo Healthcare District
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NORTHERN INYO HOSPITAL
AUTORIZACIÓN PARA TRATAMIENTO, ASIGNACIÓN DE BENEFICIOS Y DIVULGACIÓN DE INFORMACIÓN

AUTORIZACIÓN PARA TRATAMIENTO MÉDICO:

El paciente está bajo la atención y supervisión de su doctor; el hospital y su personal tienen la responsabilidad de seguir las instrucciones de dicho doctor. El firmante autoriza los exámenes de imagenología, análisis de laboratorio, EKG, terapia física u otro servicio de paciente ambulatorio prestado al paciente bajo las instrucciones generales y específicas de su doctor.

ASIGNACIÓN DE BENEFICIOS DE SEGURO MÉDICO A FAVOR DE NORTHERN INYO HOSPITAL Y DOCTOR(ES) PROPORCIONANDO ATENCIÓN:

Yo, por este conducto autorizo el pago directo, al aquí mencionado, de los beneficios a los cuales tengo derecho, o que de otra forma se me pagarían como parte de los beneficios de seguro (incluyendo gastos por servicios médicos mayores) sin que excedan los cargos regulares por los servicios prestados. Entiendo que económicamente soy responsable con el hospital por los cargos sin cobertura bajo esta asignación. Además entiendo que en caso que mi cuenta se envíe a un abogado para su colección, yo tendré la obligación de pagar los cargos razonables del abogado y de colección.

AUTORIZACIÓN PARA DIVULGACIÓN DE INFORMACIÓN:

Yo, por este conducto autorizo a Northern Inyo Hospital y doctor(es) atendiéndome a divulgar la información necesaria para procesar cualquier cobro de seguro médico, relacionado con mi atención.

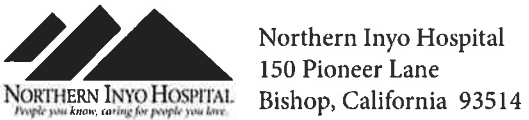
FECHA: ______________________

FIRMA: ____ HORA: _______________

PARENTESCO CON EL PACIENTE: ______________________________

WITNESS: ____ DATE: _______________

Created 6/16 Revised 6/16



Northern Inyo Hospital
150 Pioneer Lane
Bishop, California 93514

NORTHERN INYO HOSPITAL
AUTHORIZATION FOR TREATMENT, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

AUTHORIZATION FOR MEDICAL TREATMENT:

The patient is under the care and supervision of his/her attending physician and it is the responsibility of the hospital and its staff to carry out the instructions of such physician. The undersigned consents to imaging examination, laboratory procedures, EKG, physical therapy, or other outpatient hospital services rendered the patient under the general and special instructions of the physician.

ASSIGNMENT OF INSURANCE BENEFIT TO NORTHERN INYO HOSPITAL AND ATTENDING PHYSICIAN(S):

I hereby authorize direct payment to the above named of the benefits to which I may be entitled, or may otherwise be payable to me, from the insurance benefits (including major medical) not to exceed the regular charges for services rendered. I understand that I am financially responsible to the hospital for charges not covered by this assignment. I further understand that should my account be referred to an attorney for collection, I shall be obligated to pay reasonable attorney's fees and collections expense.

AUTHORIZATION FOR RELEASE OF INFORMATION:

I hereby authorize Northern Inyo Hospital and attending physician(s) to release such information as may be required to process any insurance claims covering my care.

DATE: ____________________

SIGNATURE: ____ TIME: ______________

RELATIONSHIP TO THE PATIENT: ____________________________

WITNESS: ____ DATE: ______________

Created 6/16 Revised 6/16

Attachment D

Annual Compliance Workplan

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 2020
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) Educational and instructional information on Board Oversight and Fiduciary Responsibilities sent to Board in December 2019 and January 2020.	"Takeaways" from HCCA magazine ACHD training certificates
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		FY20-21 in progress
Written Compliance Guidance			
4.	Audit of required Compliance related policies.		Updating District Policy management software application with a team. Compliance policies in progress 05/31/2020
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)		
6.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		
Compliance Education and Training			
7.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance Committee.		
8.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.		
9.	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. Athena unable/unwilling to accommodate.	Stalled due to lack of granularity of Athena access control security. Will revisit with Cerner implementation

Annual Compliance Workplan

10.	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 UORs. Prepare summary report for Compliance Committee on types of issues reported and resolution	Update for Complytrack	Summary report submitted with Compliance Report to the Board. Transitioning non-compliance UORs to Quality/Informatics
12.	Develop a report that evidences prompt documenting, processing, and resolution of complaints and allegations received by the Compliance Department.		
13.	Document test and review of Compliance Hotline.		Completed 02/2020
14.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Completed 01/2020
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 05/2020
16.	Develop a review and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		
17.	Audits		
	a. Physician Contracts	In progress	02/2020
	b. 340B Program	In progress	05/2020
	c. Cost reports		
	d. Payment patterns	PEPR report out in April	Review in progress
	e. Bad debt/ credit balances		
	f. PHH Annual Compliance Audit		02/2020
	g. Audit of District Board Agendas, Minutes, and Resolutions		01/2020 - ongoing
	h. Travel Reimbursement Audits		01/2020-ongoing

Annual Compliance Workplan

	i. Contract Audits		In progress 03/2020
	j. BAA audit		
	k. HIMS Scanned Document accuracy		
	l. Language access documentation accuracy		
	m. TJC corrective action plan		02/2020
	n. CMS Survey Corrective action plan		02/2020
	Lab services	MAC target	
	Imaging services (high cost/high usuage)	MAC target	Review of ABN usage, Authorizations in progress 02-2020
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		Security Risk Assessment Completed 11/2019
	b. Periodic update to SRA		Will update following Penetration Testing Report
	c. Monthly employee access audits		Current through 05/31/2020
21.	Develop metrics to assess the effectiveness and progress of the Compliance Program		
22.	Implement automated access monitoring/auditing software (Protenus)	On hold	Cerner will have a semi-automated access monitoring process.
Response to Detected Problems and Corrective Action			
24.	Verify that all identified issues related to potential fraud are promptly investigated and documented		05/2020
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		See TJC and CDPH monitoring plans - ongoing
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	2/2020
27.	UOR tracking and trending – UOR/Unusual occurrence reporting is now a function on the Compliance Department.	Complytrack – live 04/2019	UORs moving to Informatics/Nursing Quality
	a. Provide trend feedback to leadership to allow for data driven decision-making		05/2020

Annual Compliance Workplan

	I. Overall UOR process		06/2020
	II. Workplace Violence		06/2020
	III. Sharps		06/2020
	IV. Overweight laundry		06/2020
29.	Patient complaints	On-going	moving to Informatics/Nursing Quality
30.	Breach Investigations	On-going	On-going – see Compliance report

2020 Compliance Work Plan – updated 05/2020

Attachment E

UOR Review

UORs- 1 OCT 2019 – 31 Mar 2020

	Oct-2019	Nov-2019	Dec-2019	Jan-2020	Feb-2020	Mar-2020	Total
AMA/Elopement/LWBS	2	3	1	3	1	4	14
Codes - Rapid Response, Blue, Deescalation		2	2	1	1	1	7
Communication	6	4	7	4	4	3	28
Complaints/review request	13	11	8	8	8	8	56
Confidentiality/PHI Breach/HIPAA violation	8	4	6	8	9	4	39
Critical Indicator	4	1			2		7
ED			1	2		1	4
EMTALA			1				1
Equipment/Supply/Devices	7	3	1	2	4	1	18
Falls/Slips	6		4	1	2	1	14
IV issues/Blood transfusion issues	2			1	2	1	6
Med Surg		1	2	2		1	6
Medication Occurrence/Error			1	1			2
Mishandled Sharps	2			1	2		5
OB/Nursery			3	2	4	3	12
Procedure/Test/Specimen problem	16	11	8	17	21	5	78
Safety/Security	2	2	2	2	4	9	21
Skin integrity concern					1	3	4
Surgery					1		1
Transfer - Internal or External	1	2		1			4
Transportation			1				1
Workplace Violence	1	7	1	4	4	1	18
Total	70	51	49	60	70	46	346

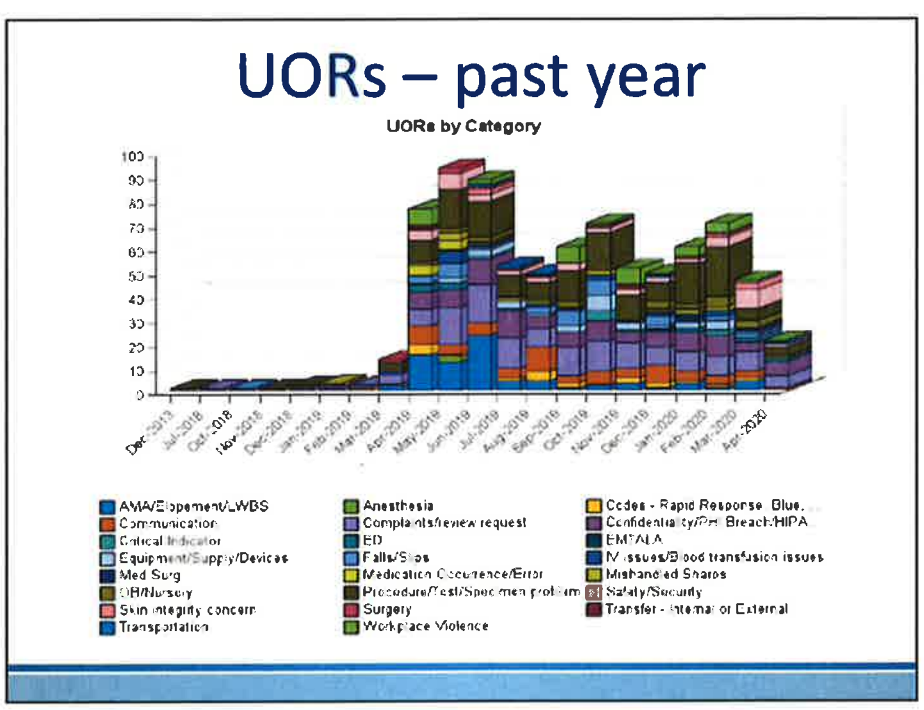
UORs – past year

UORs by Category

100
90
80
70
60
50
40
30
20
10
0

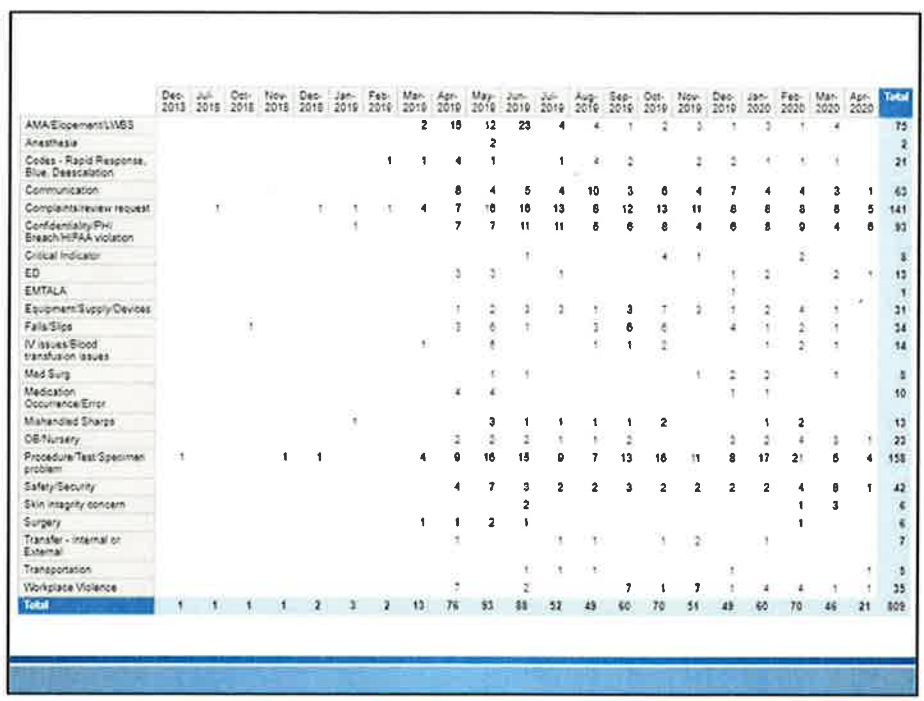
Dec-2013, Jul-2018, Oct-2018, Nov-2018, Dec-2018, Jan-2019, Feb-2019, Mar-2019, Apr-2019, May-2019, Jun-2019, Jul-2019, Aug-2019, Sep-2019, Oct-2019, Nov-2019, Dec-2019, Jan-2020, Feb-2020, Mar-2020, Apr-2020

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



Unusual Occurrence Reports for the first year of use of the Complytrack system. Reports prior to April 15, 2019 were entered after that date, however, had an occurrence date before April 15th. The significant decrease in UORs beginning in July 2019 is due to the Emergency Department Medical Staff updating critical indicators. AMA/LWBS (Against Medical Advice/ Left without being seen) was removed from the critical indicators list and replaced with unusual occurrences that would be better able to provide significant feedback. Therefore, ED no longer reports AMA/LWBS as an unusual occurrence.

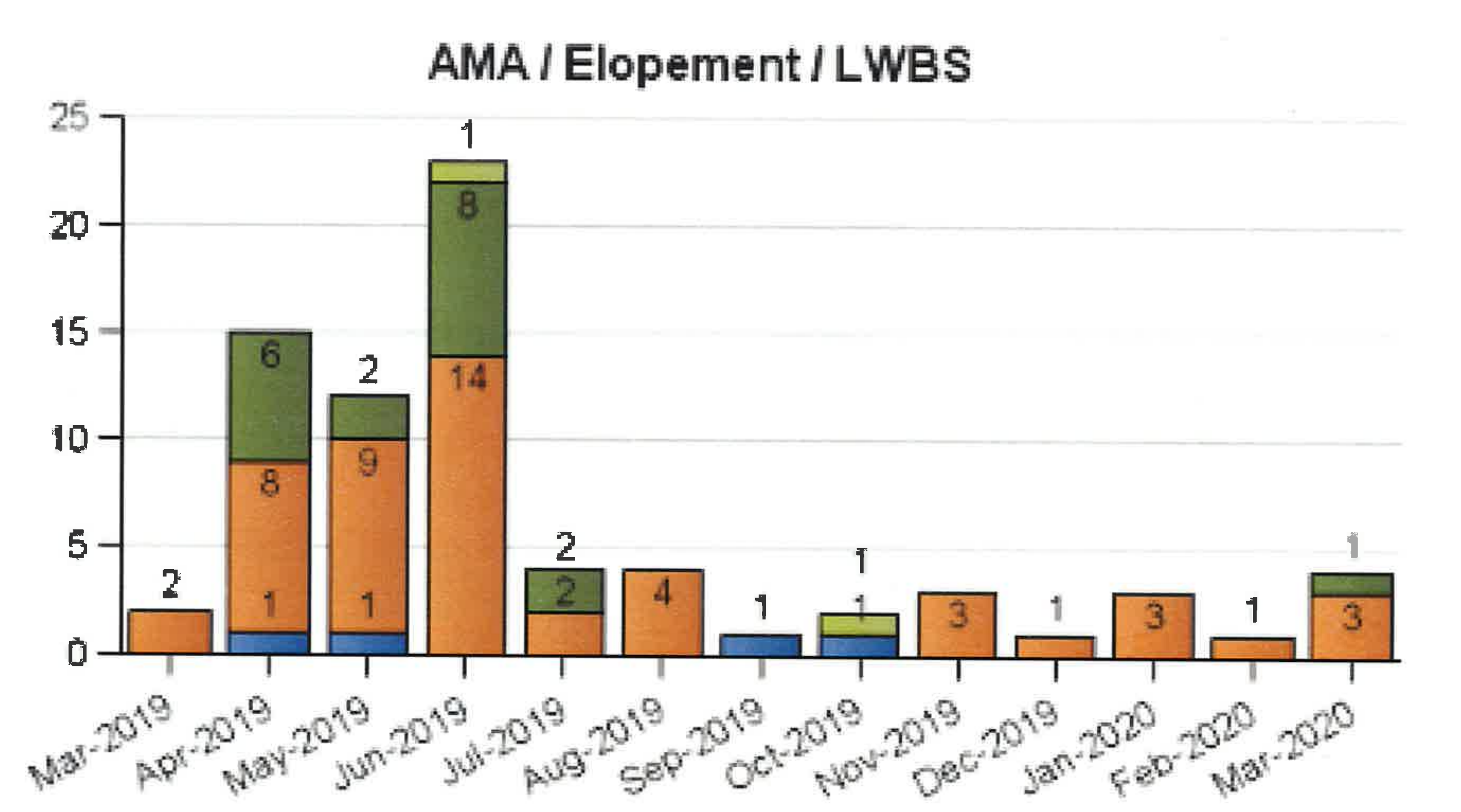
	Dec-2013	Jul-2018	Oct-2018	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Oct-2019	Nov-2019	Dec-2019	Jan-2020	Feb-2020	Mar-2020	Apr-2020	Total
AMA/Elopement/LWBS								2	15	12	23	4	4	1	2	3	1	3	1	4		**75**
Anesthesia										2												**2**
Codes - Rapid Response, Blue, Deescalation							1	1	4	1		1	4	2		2	2	1	1	1		**21**
Communication									8	4	5	4	10	3	6	4	7	4	4	3	1	**63**
Complaints/review request		1			1	1	1	4	7	16	16	13	8	12	13	11	8	8	8	8	5	**141**
Confidentiality/PHI Breach/HIPAA violation						1			7	7	11	11	5	6	8	4	6	8	9	4	6	**93**
Critical Indicator											1				4	1			2			**8**
ED									3	3		1					1	2		2	1	**13**
EMTALA																	1					**1**
Equipment/Supply/Devices									1	2	3	3	1	3	7	3	1	2	4	1		**31**
Falls/Slips			1						3	6	1		3	6	6		4	1	2	1		**34**
IV issues/Blood transfusion issues								1		5			1	1	2			1	2	1		**14**
Med Surg										1	1					1	2	2		1		**8**
Medication Occurrence/Error									4	4							1	1				**10**
Mishandled Sharps						1				3	1	1	1	1	2			1	2			**13**
OB/Nursery									2	2	2	1	1	2			3	2	4	3	1	**23**
Procedure/Test/Specimen problem	1			1	1			4	9	16	15	9	7	13	16	11	8	17	21	5	4	**158**
Safety/Security									4	7	3	2	2	3	2	2	2	2	4	8	1	**42**
Skin integrity concern											2								1	3		**6**
Surgery								1	1	2	1								1			**6**
Transfer - Internal or External									1			1	1		1	2		1				**7**
Transportation											1	1	1				1				1	**5**
Workplace Violence									7		2			7	1	7	1	4	4	1	1	**35**
Total	**1**	**1**	**1**	**1**	**2**	**3**	**2**	**13**	**76**	**93**	**88**	**52**	**49**	**60**	**70**	**51**	**49**	**60**	**70**	**46**	**21**	**809**

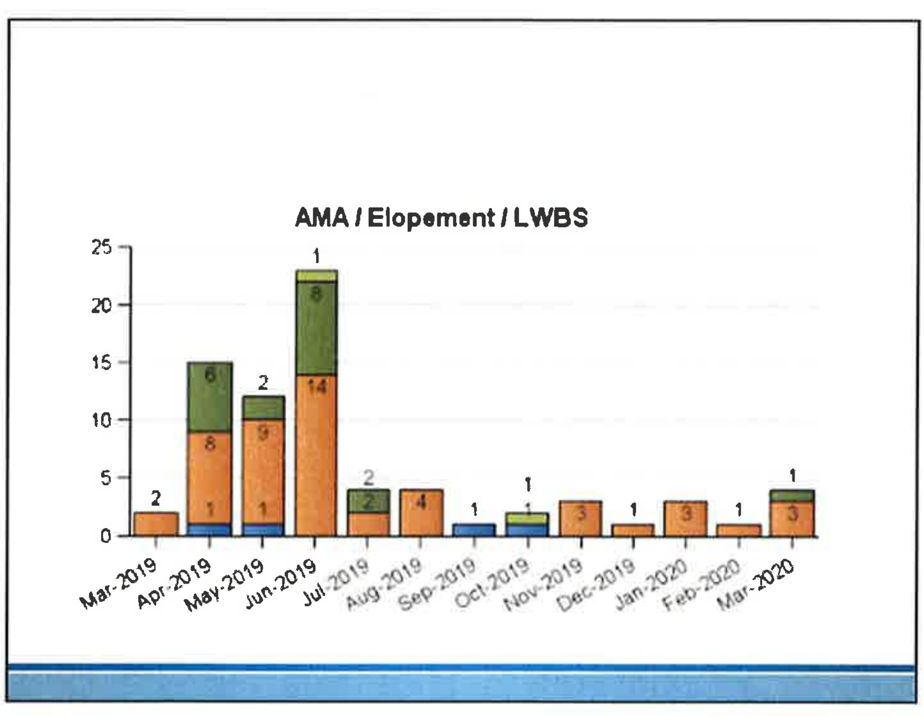


	Dec-2013	Jul-2018	Oct-2018	Nov-2018	Dec-2018	Jan-2019	Feb-2019	Mar-2019	Apr-2019	May-2019	Jun-2019	Jul-2019	Aug-2019	Sep-2019	Oct-2019	Nov-2019	Dec-2019	Jan-2020	Feb-2020	Mar-2020	Apr-2020	Total
AMA/Elopement/LWBS								2	15	12	23	4	4	1	2	3	1	3	1	4		75
Anesthesia										2												2
Codes - Rapid Response, Blue, Deescalation							1	1	4	1		1	4	2		2	2	1	1	1		21
Communication									8	4	5	4	10	3	6	4	7	4	4	3	1	63
Complaints/review request		1			1	1	1	4	7	16	16	13	8	12	13	11	8	8	8	8	5	141
Confidentiality/PHI Breach/HIPAA violation						1			7	7	11	11	5	6	8	4	6	8	9	4	6	93
Critical Indicator											1				4	1			2			8
ED									3	3		1					1	2		2	1	13
EMTALA																	1					1
Equipment/Supply/Devices									1	2	3	3	1	3	7	3	1	2	4	1		31
Falls/Slips			1						3	6	1		3	6	6		4	1	2	1		34
IV issues/Blood transfusion issues								1		5			1	1	2			1	2	1		14
Med Surg										1	1					1	2	2		1		8
Medication Occurrence/Error									4	4							1	1				10
Mishandled Sharps						1				3	1	1	1	1	2			1	2			13
OB/Nursery									2	2	2	1	1	2			3	3	4	3	1	23
Procedure/Test/Specimen problem	1			1	1			4	9	16	15	9	7	13	16	11	8	17	21	5	4	158
Safety/Security									4	7	3	2	2	3	2	2	2	2	4	8	1	42
Skin integrity concern											2								1	3		6
Surgery								1	1	2	1								1			6
Transfer - internal or External									1			1	1		1	2		1				7
Transportation											1	1	1				1				1	5
Workplace Violence									7		2			7	1	7	1	4	4	1	1	35
Total	1	1	1	1	2	3	2	13	76	93	88	52	49	60	70	51	49	60	70	46	21	809

The data reflected in the graph on the previous slide. (April 15, 2019 through April 30, 2020)

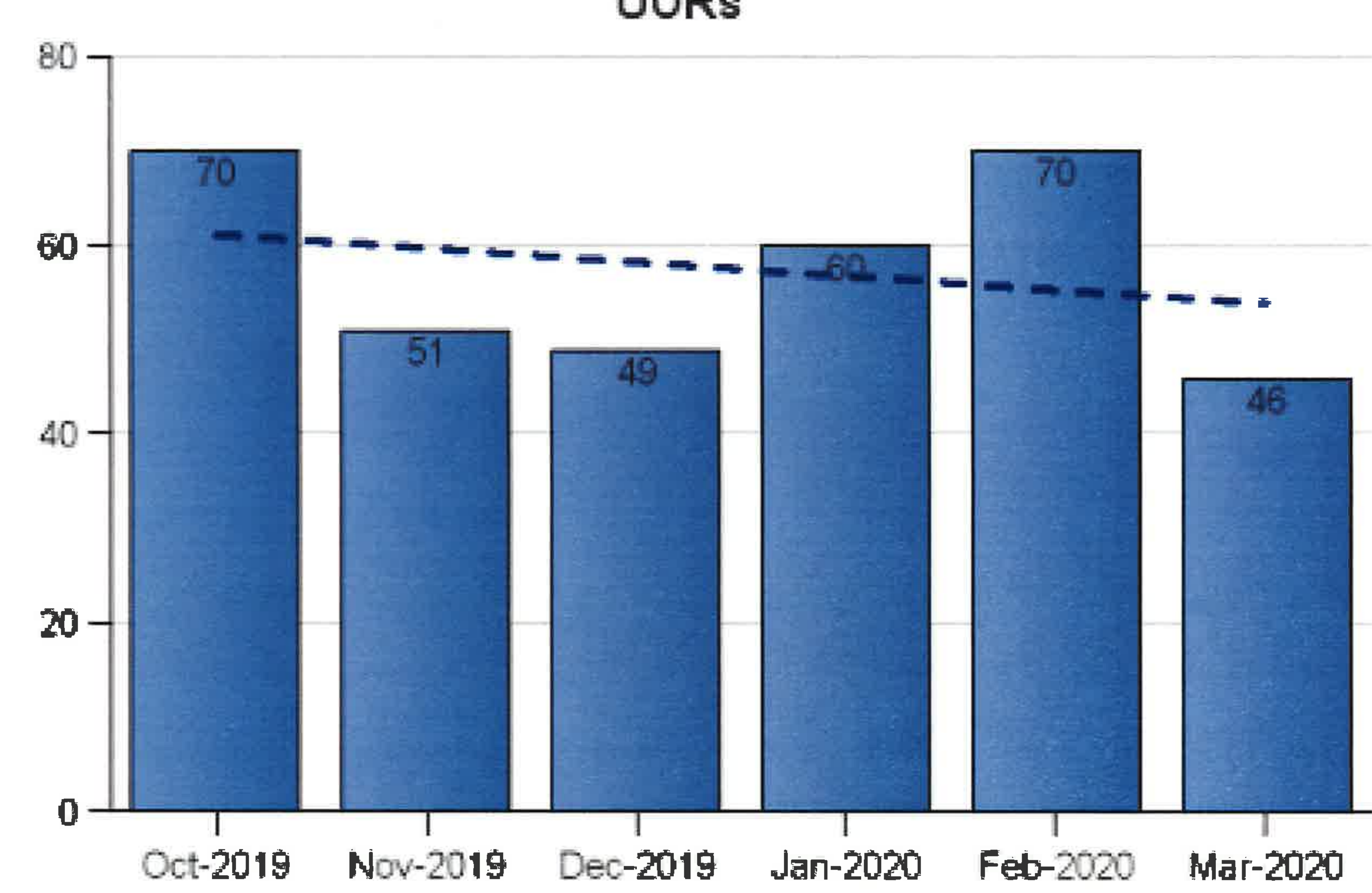
1 OCT 2019 – 31 Mar 2020


AMA / Elopement / LWBS
25
20
15
10
5
0
2
6
8
1
2
9
1
1
8
14
2
2
4
1
1
1
3
1
3
1
1
3
Mar-2019
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Sep-2019
Oct-2019
Nov-2019
Dec-2019
Jan-2020
Feb-2020
Mar-2020



First year of Complytrack data. AMA/LWBS/elopement – Again, the large decrease, as discussed on a prior slide, is due to the change in critical indicators for the ED.

1 OCT 2019 – 31 Mar 2020

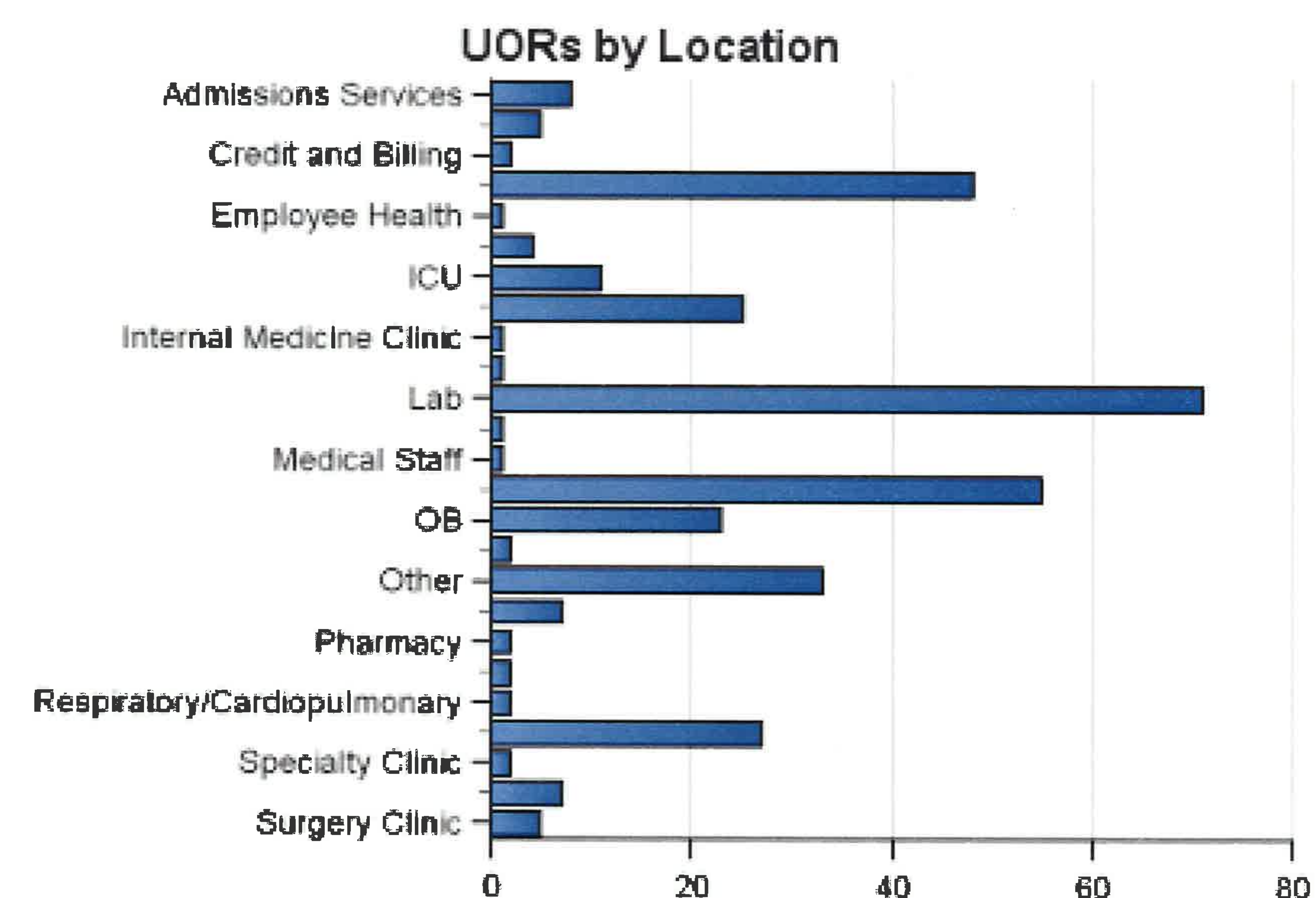


Total UORs entered April 2019-2020

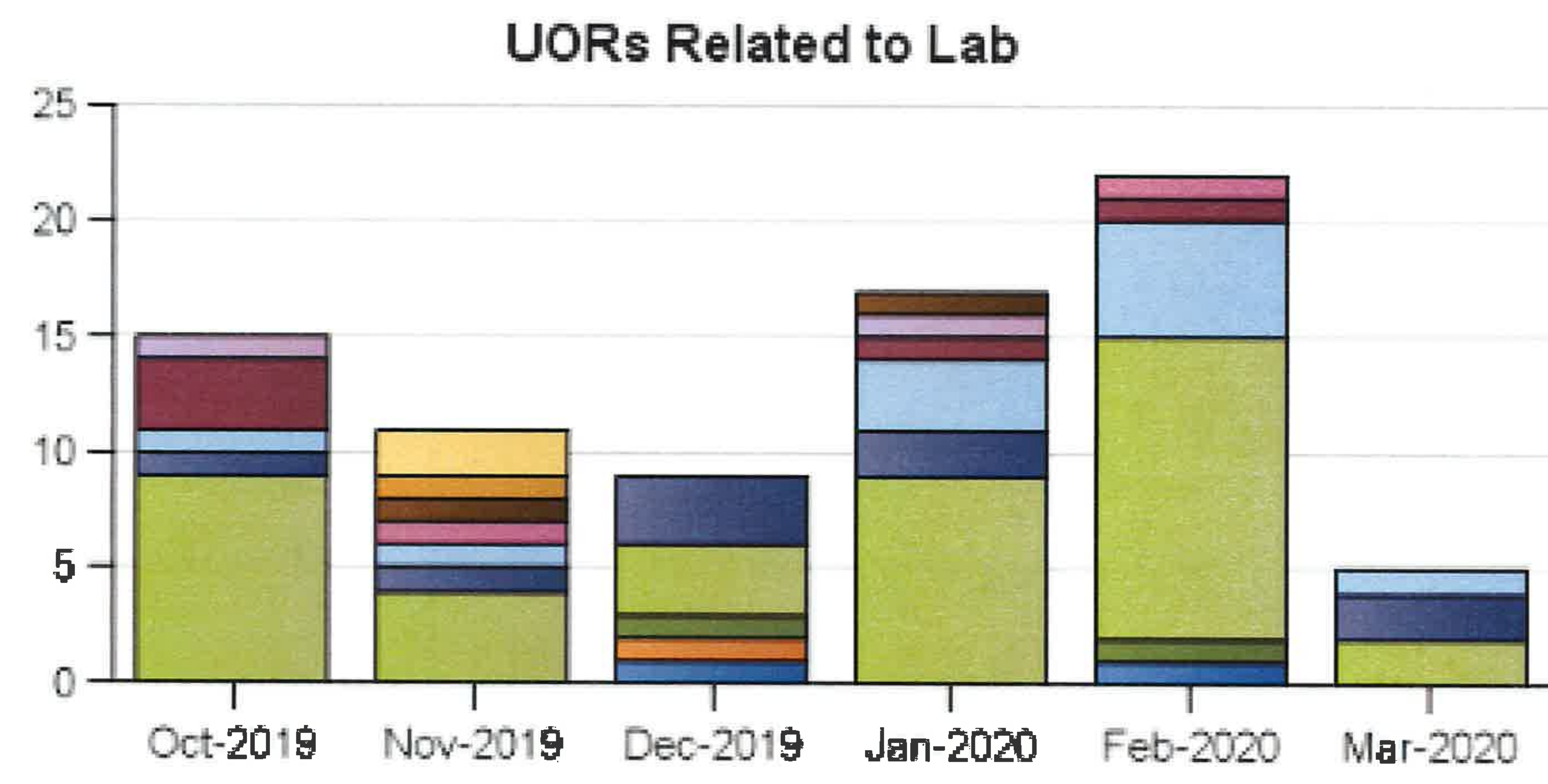
UORs

Month	UORs
Dec-2013	1
Jul-2018	1
Oct-2018	1
Nov-2018	1
Dec-2018	2
Jan-2019	3
Feb-2019	2
Mar-2019	13
Apr-2019	76
May-2019	93
Jun-2019	88
Jul-2019	52
Aug-2019	49
Sep-2019	60
Oct-2019	70
Nov-2019	51
Dec-2019	49
Jan-2020	60
Feb-2020	70
Mar-2020	46
Apr-2020	21

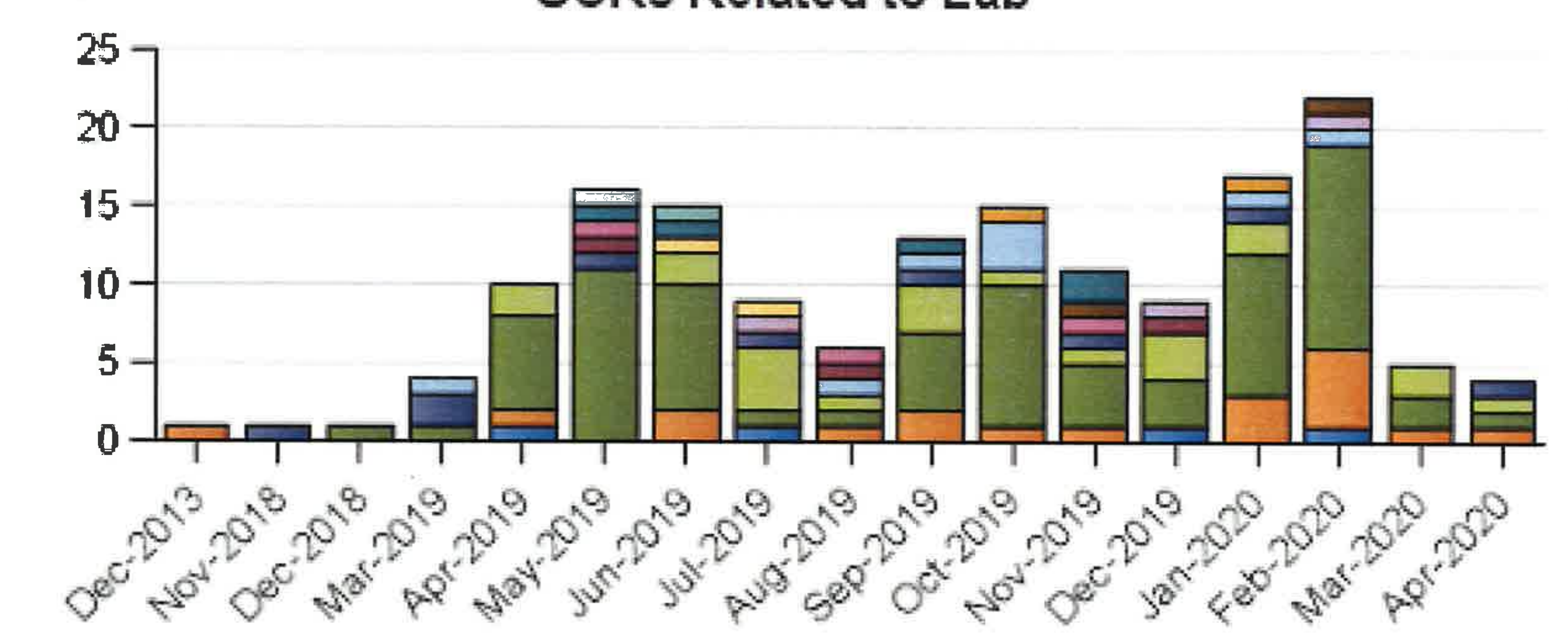
1 OCT 2019 – 31 Mar 2020



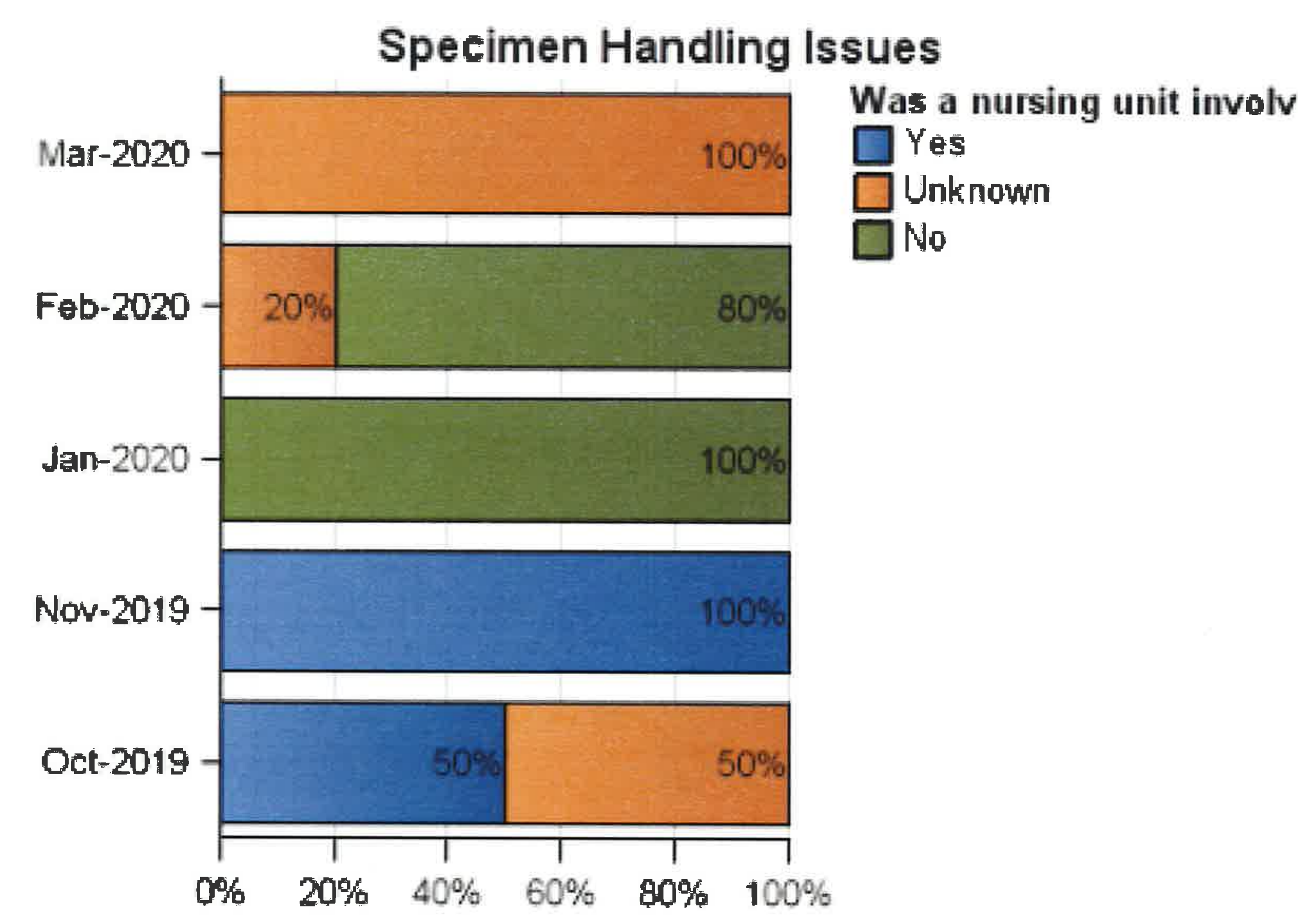
Lab related UORs   1 OCT 2019 – 31 Mar 2020

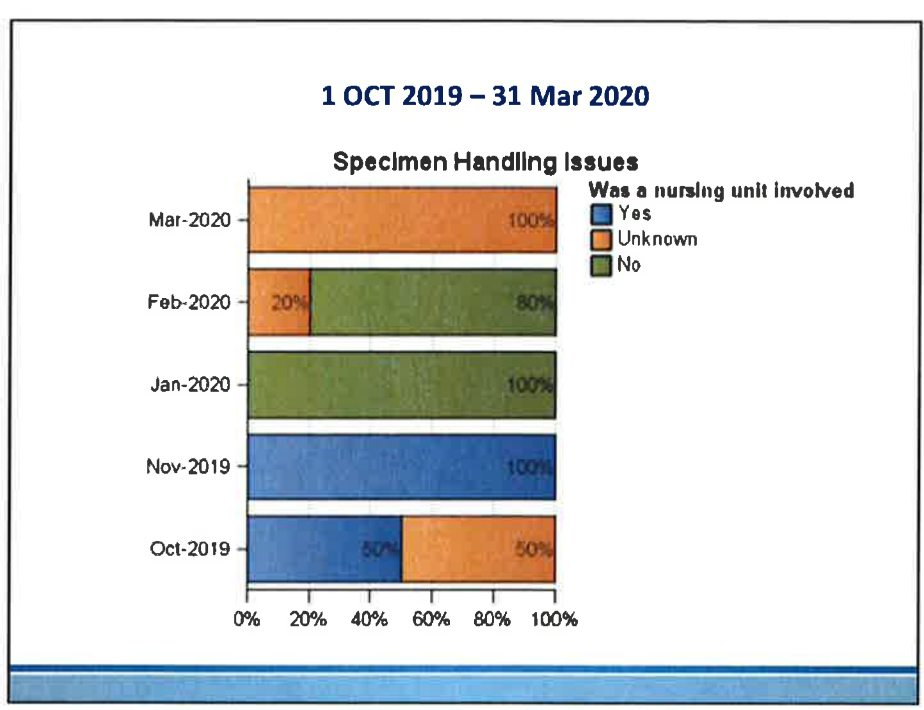


Northern Inyo Healthcare District
One Team. One Goal. Your Health.

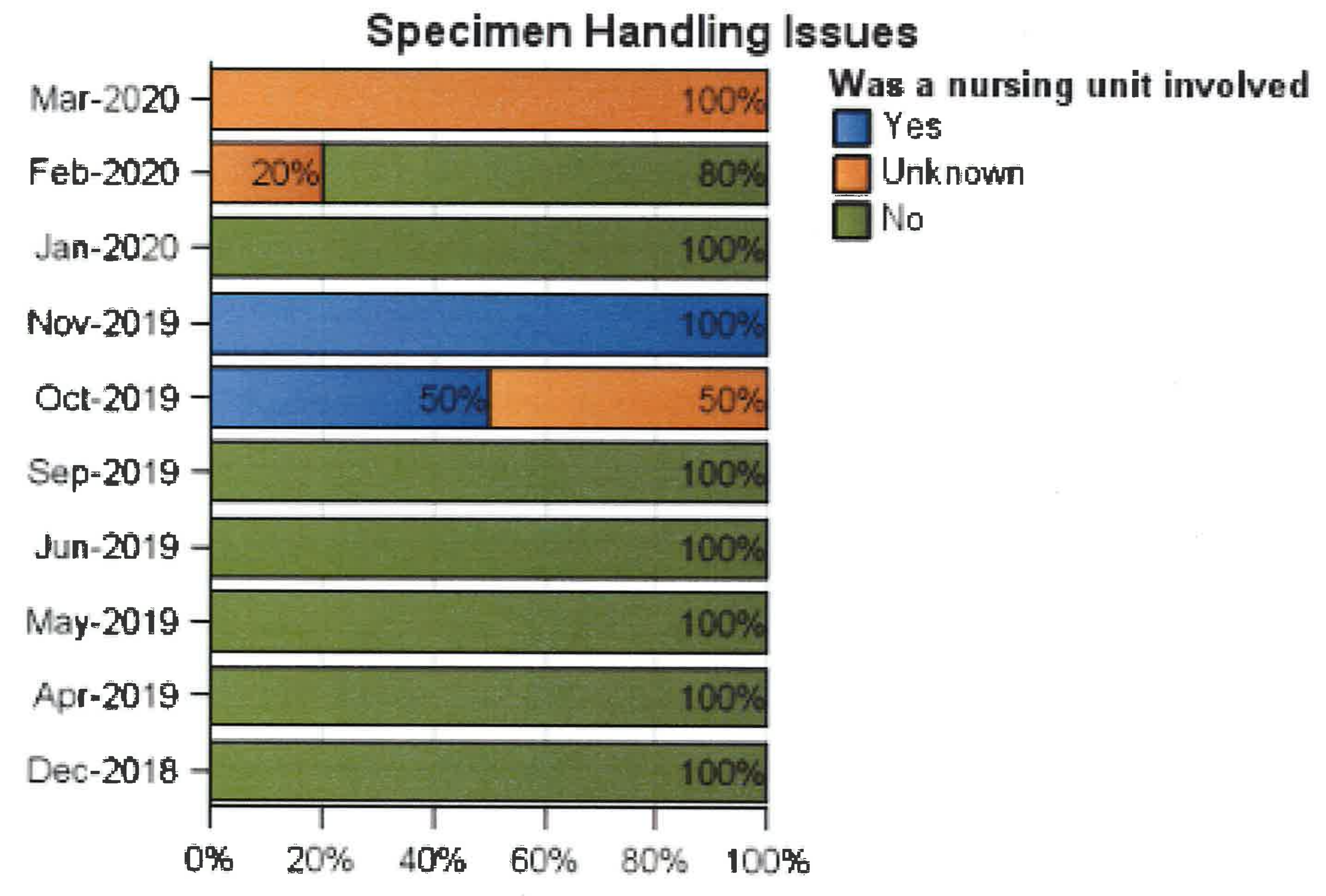

UORs Related to Lab
25
20
15
10
5
0
Dec-2013
Nov-2018
Dec-2018
Mar-2019
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Sep-2019
Oct-2019
Nov-2019
Dec-2019
Jan-2020
Feb-2020
Mar-2020
Apr-2020
Error reporting results
Other
Patient was not proper...
Improper technique oth...
Order Issue
Omitted a test or proc...
Delay
Consent issue
Unexpected complicati...
Reaction to Contrast
Specimen Problems
Delay due to Hospital/...
Performed on wrong p...
Performed wrong proc...
Incorrect Diagnostic R...

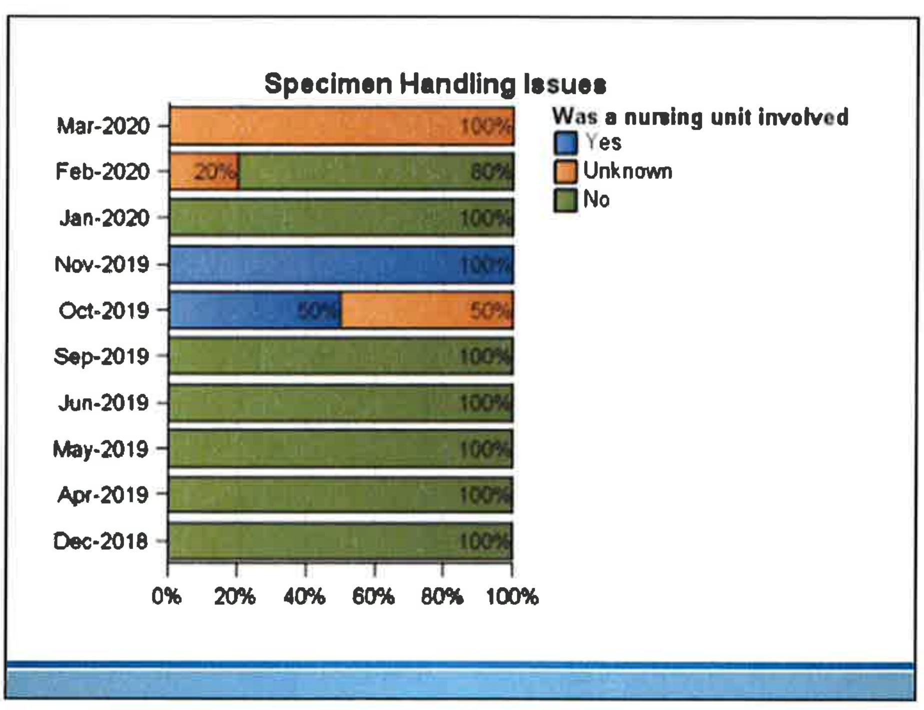
1 OCT 2019 – 31 Mar 2020



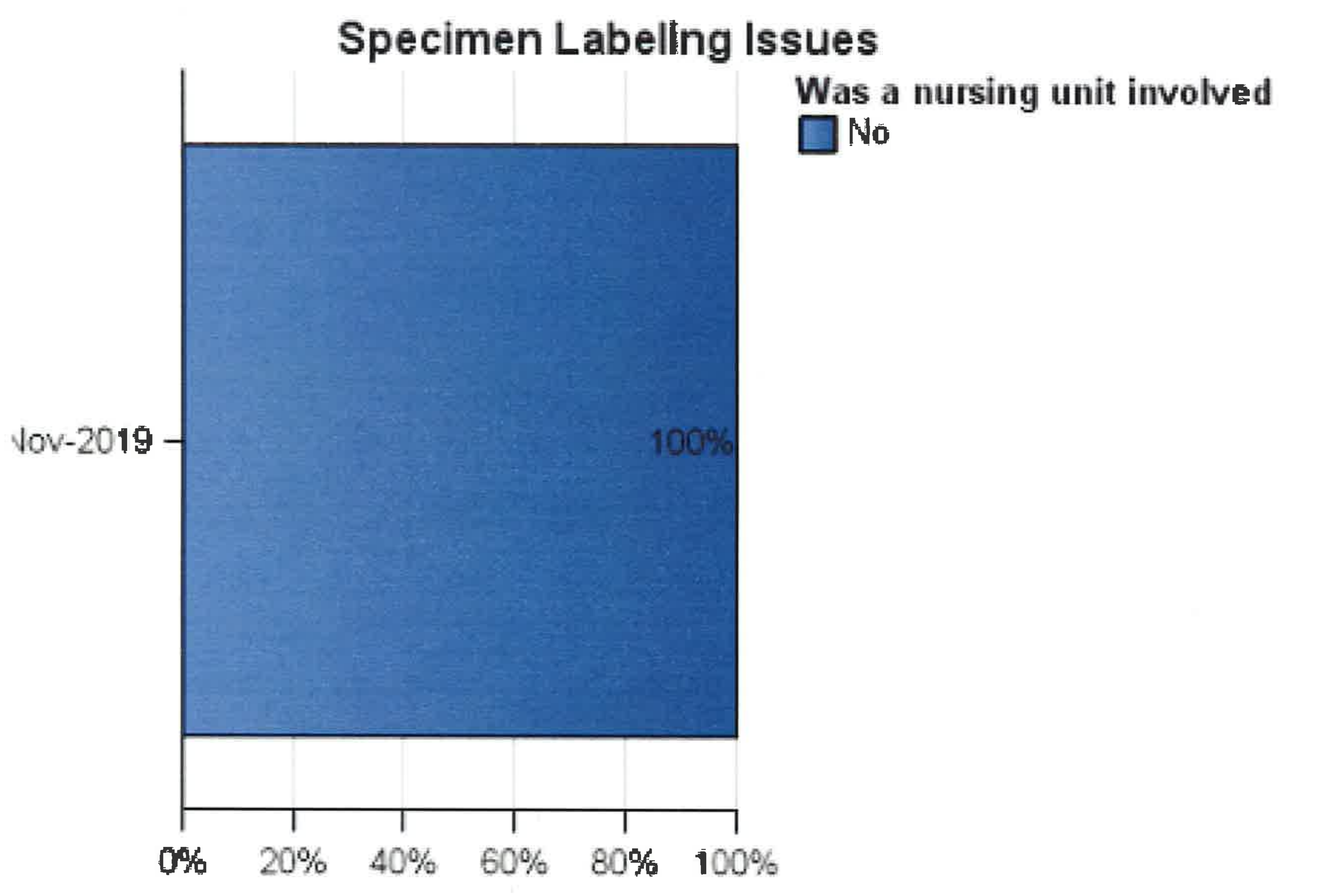


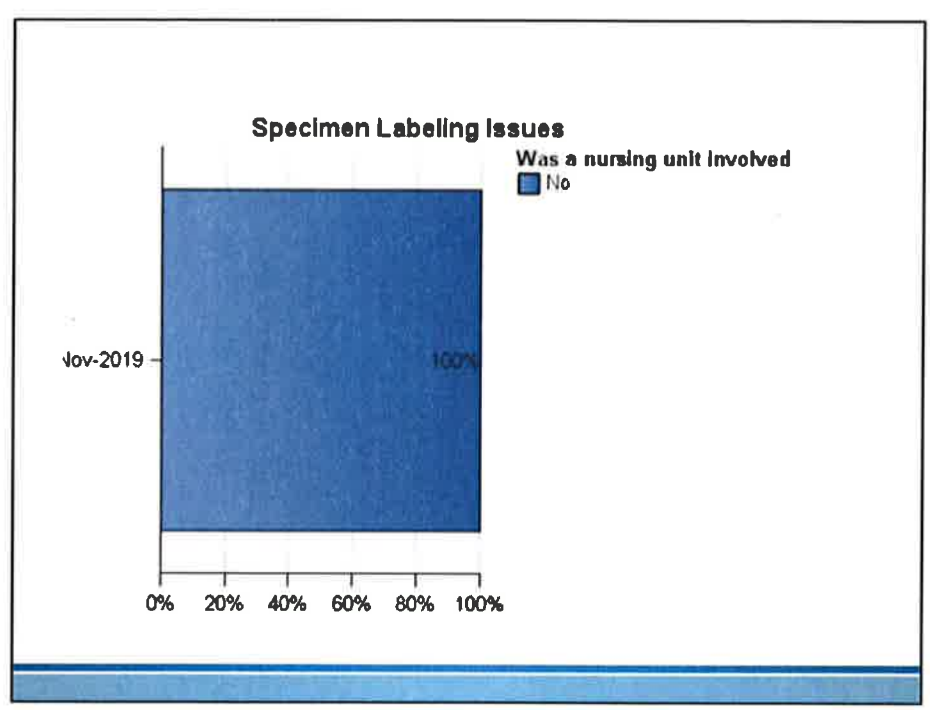
Specimen handling issues when a nursing unit was potentially involved – last 2 quarters


Specimen Handling Issues
Was a nursing unit involved
Yes
Unknown
No
Mar-2020
Feb-2020
Jan-2020
Nov-2019
Oct-2019
Sep-2019
Jun-2019
May-2019
Apr-2019
Dec-2018
100%
20%
80%
100%
100%
50%
50%
100%
100%
100%
100%
100%
0%
20%
40%
60%
80%
100%



The Professional Practice Council identified mishandled specimens and mislabeled specimens as a focus for improvement.

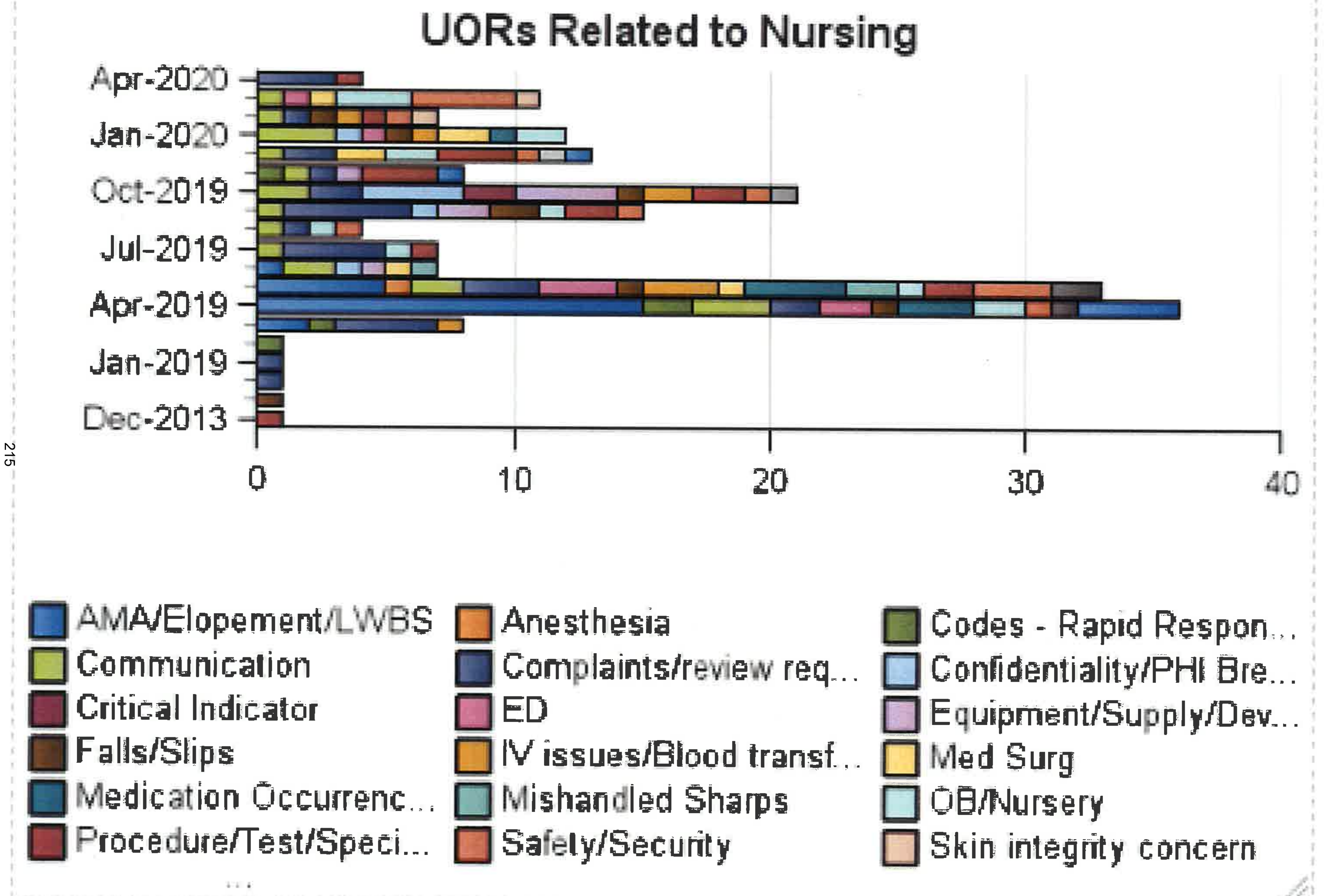

Specimen Labeling Issues
Was a nursing unit involved
No
Nov-2019
100%
0%
20%
40%
60%
80%
100%



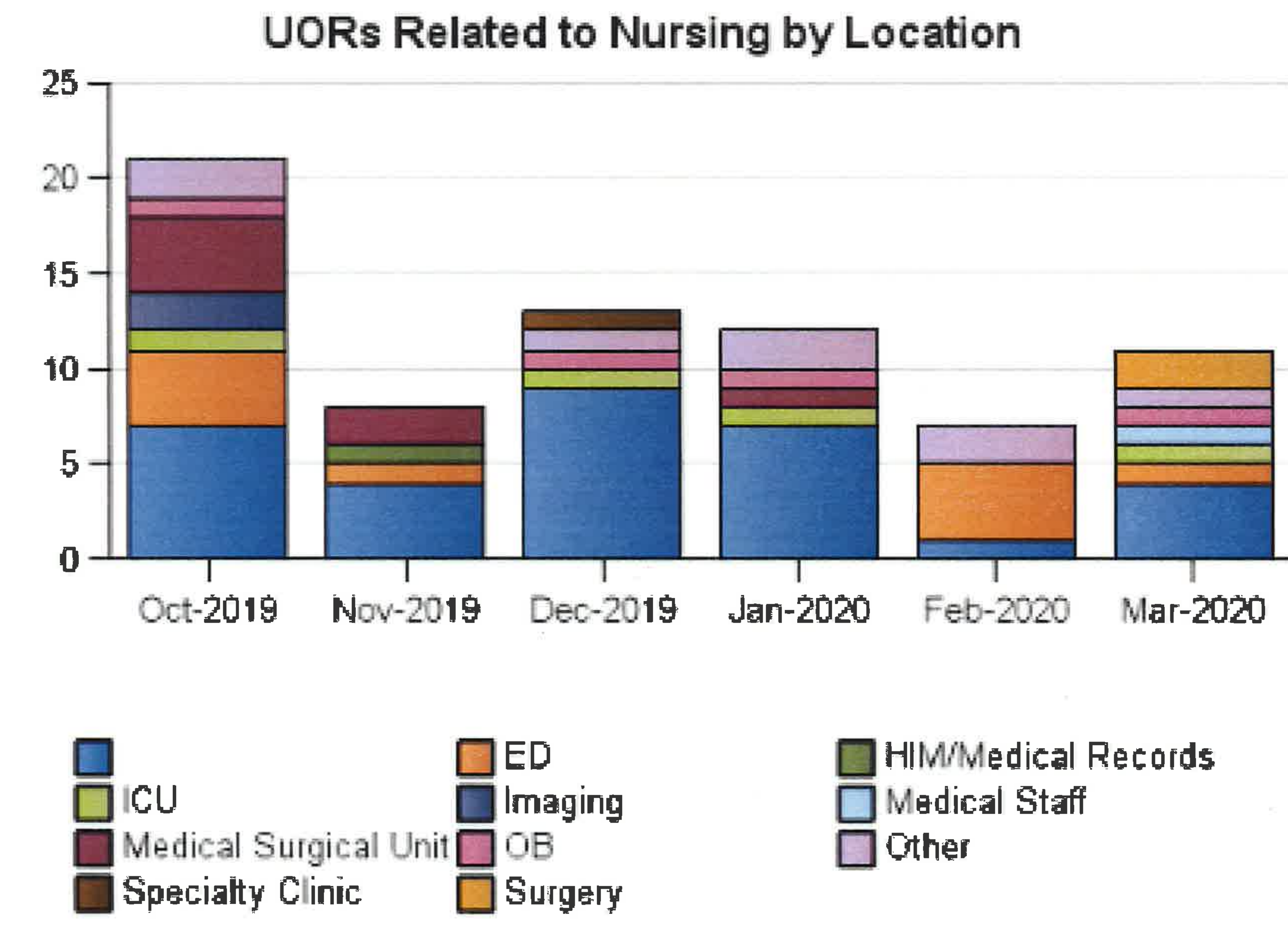
There was one UOR entered for a specimen labeling issue and it did not involve a nursing unit. This was a focus area for the Professional Practice Council.

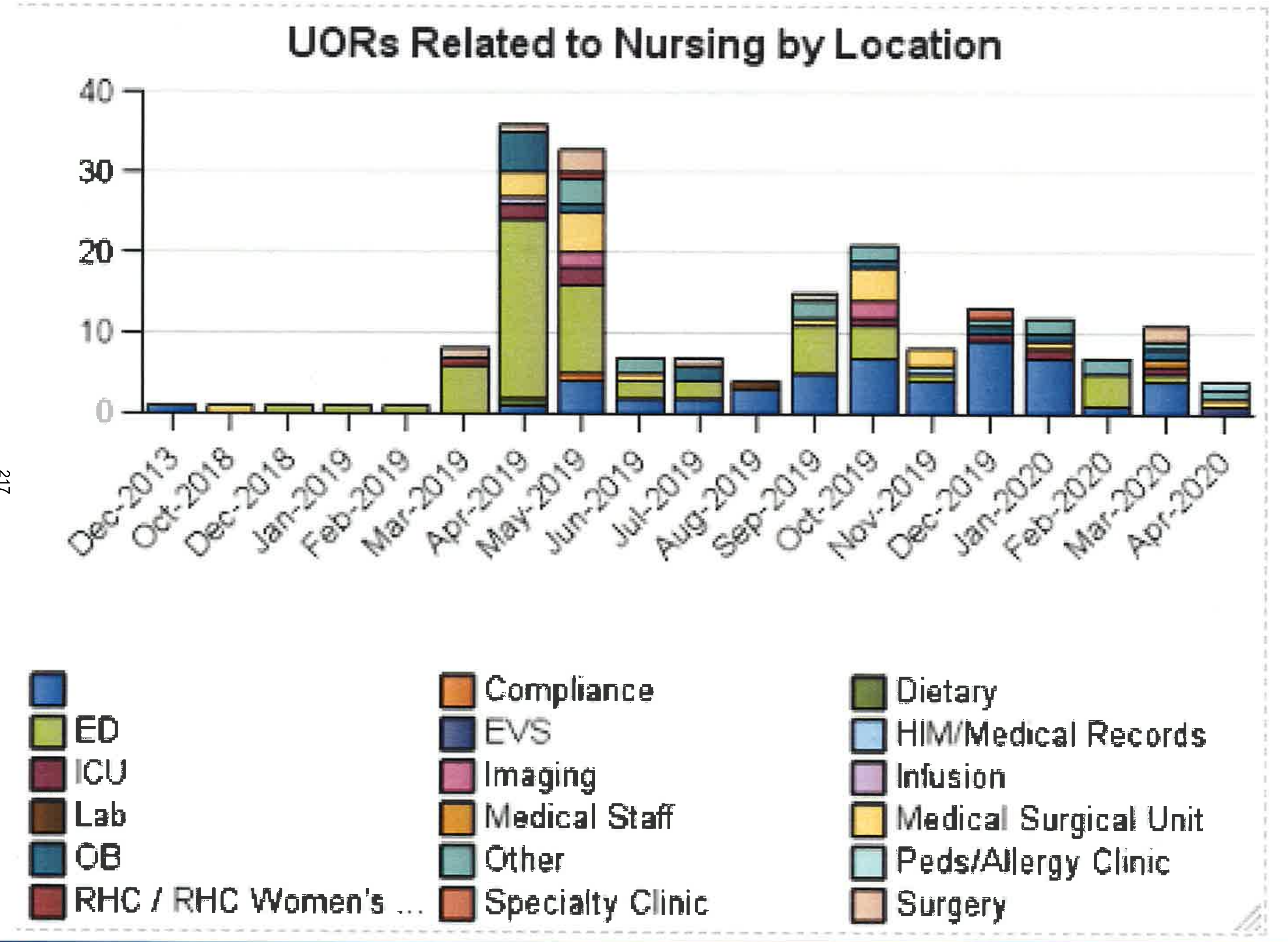
1 OCT 2019 – 31 Mar 2020

UORs Related to Nursing

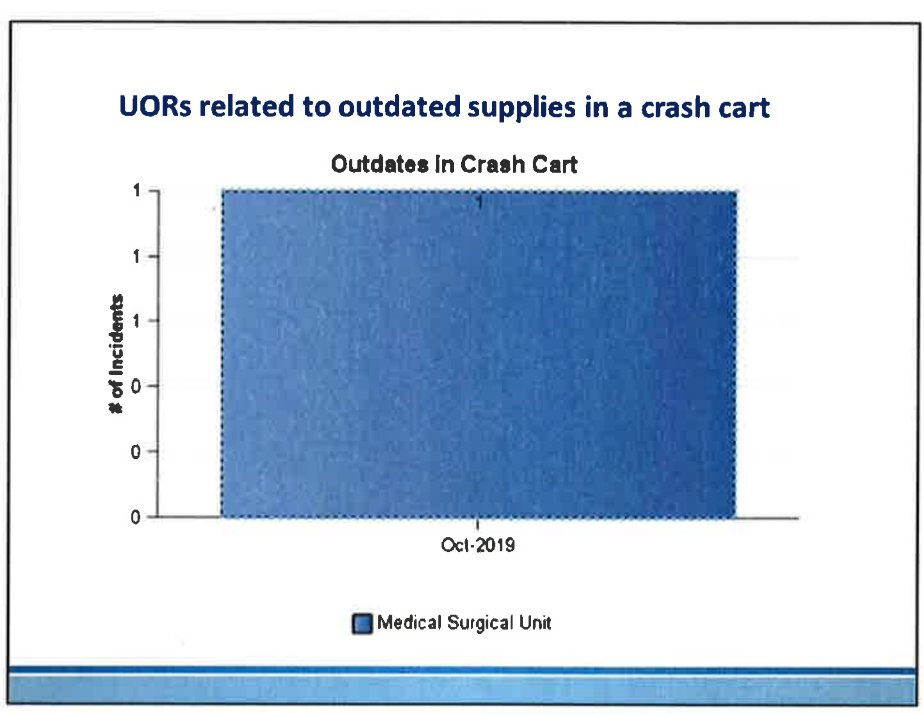

UORs Related to Nursing
Apr-2020
Jan-2020
Oct-2019
Jul-2019
Apr-2019
Jan-2019
Dec-2013
0
10
20
30
40
AMA/Elopement/LWBS
Communication
Critical Indicator
Falls/Slips
Medication Occurrenc...
Procedure/Test/Speci...
Anesthesia
Complaints/review req...
ED
IV issues/Blood transf...
Mishandled Sharps
Safety/Security
Codes - Rapid Respon...
Confidentiality/PHI Bre...
Equipment/Supply/Dev...
Med Surg
OB/Nursery
Skin integrity concern

1 OCT 2019 – 31 Mar 2020

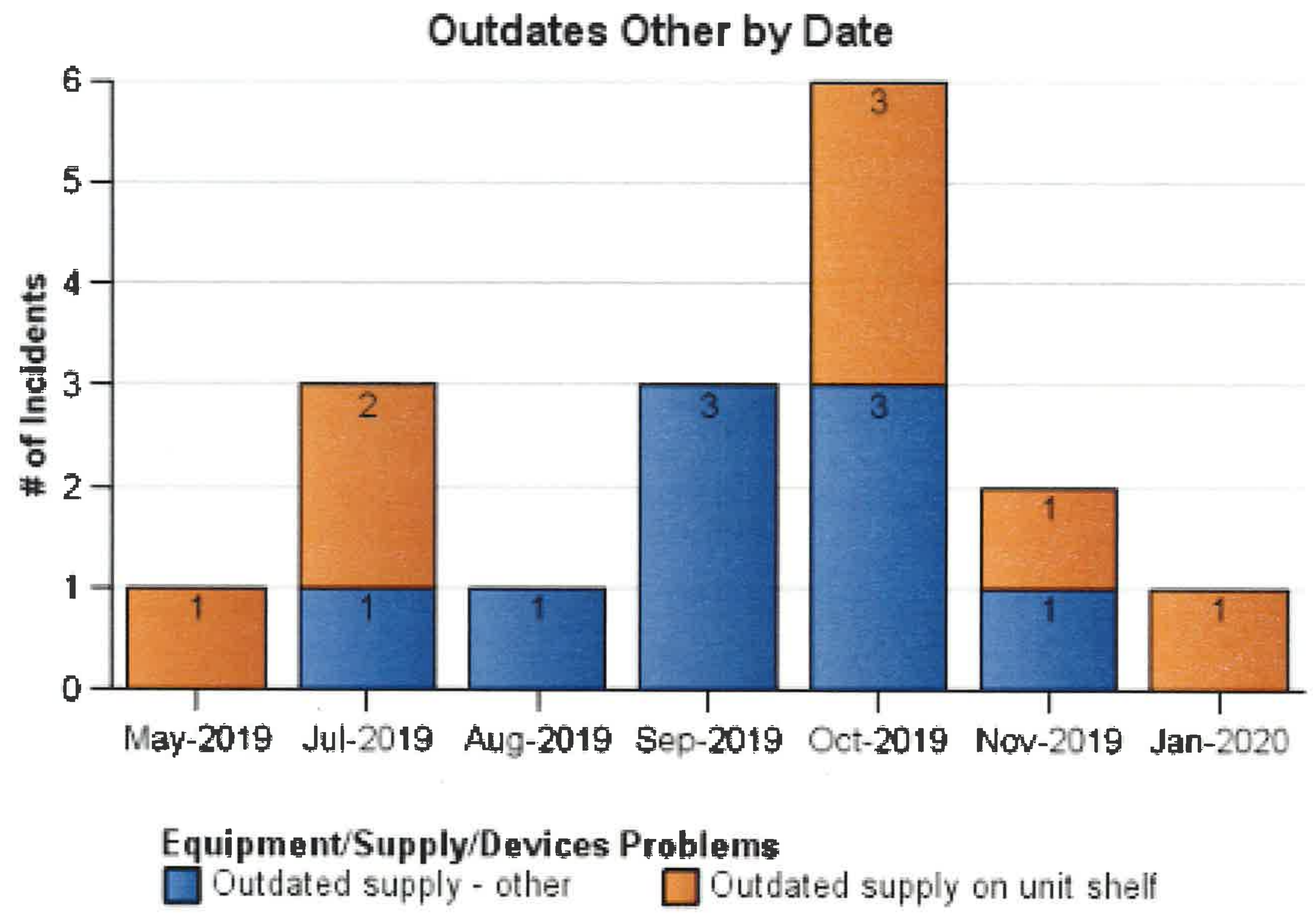



UORs Related to Nursing by Location
40
30
20
10
0
Dec-2013
Oct-2018
Dec-2018
Jan-2019
Feb-2019
Mar-2019
Apr-2019
May-2019
Jun-2019
Jul-2019
Aug-2019
Sep-2019
Oct-2019
Nov-2019
Dec-2019
Jan-2020
Feb-2020
Mar-2020
Apr-2020
ED
ICU
Lab
OB
RHC / RHC Women's ...
Compliance
EVS
Imaging
Medical Staff
Other
Specialty Clinic
Dietary
HIM/Medical Records
Infusion
Medical Surgical Unit
Peds/Allergy Clinic
Surgery

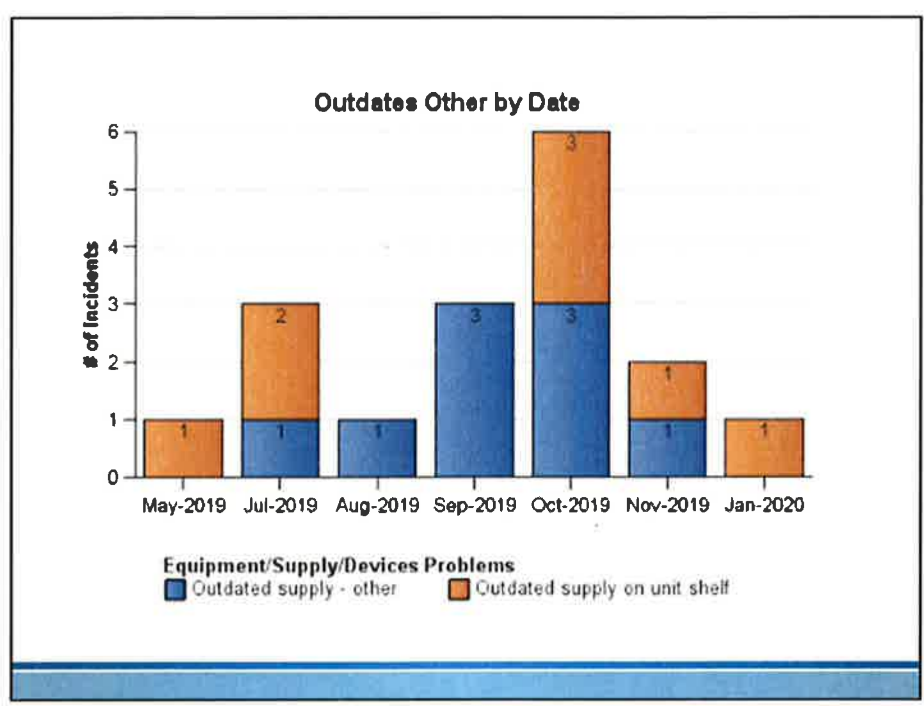
UORs related to outdated supplies in a crash cart



Only one instance of an outdated supply being located in a crash cart since tracking began in Complytrack. It occurred in October of 2019. Corrective actions were implemented and it has not recurred as of April 31, 2020.

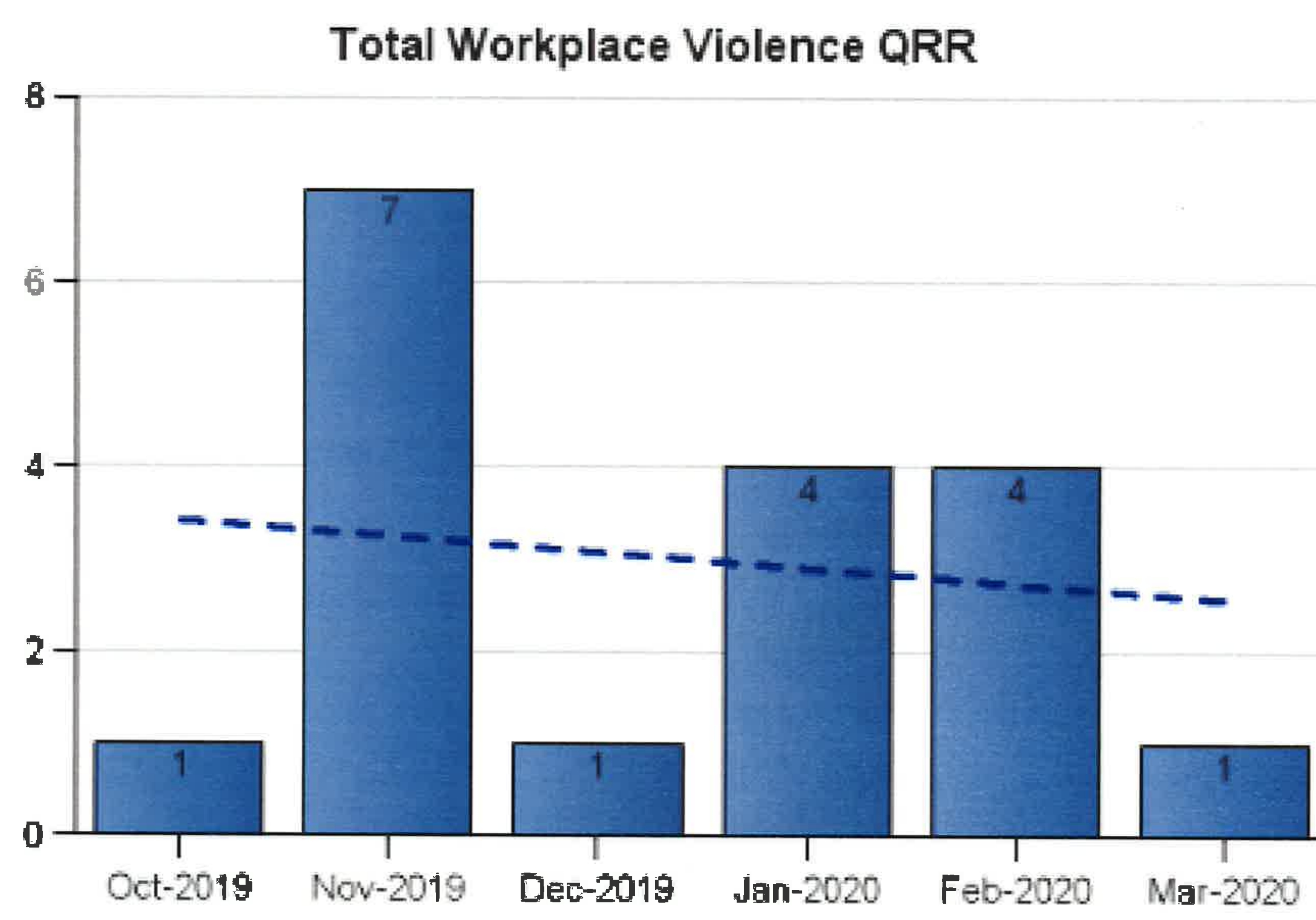


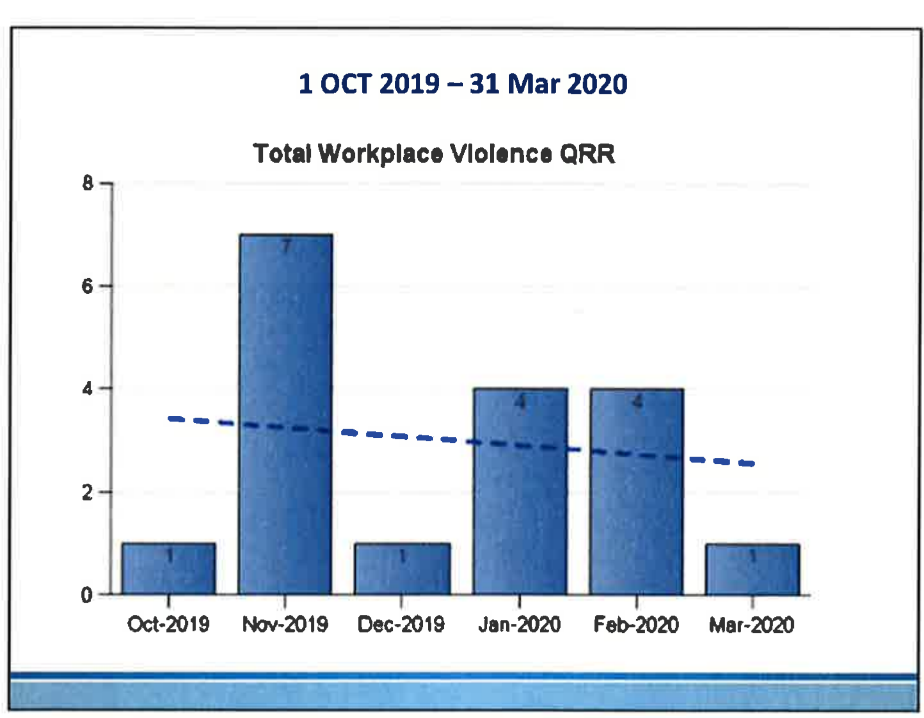
Outdates Other by Date
# of Incidents
0
1
2
3
4
5
6
1
2
1
1
3
3
3
1
1
1
May-2019
Jul-2019
Aug-2019
Sep-2019
Oct-2019
Nov-2019
Jan-2020
Equipment/Supply/Devices Problems
Outdated supply - other
Outdated supply on unit shelf



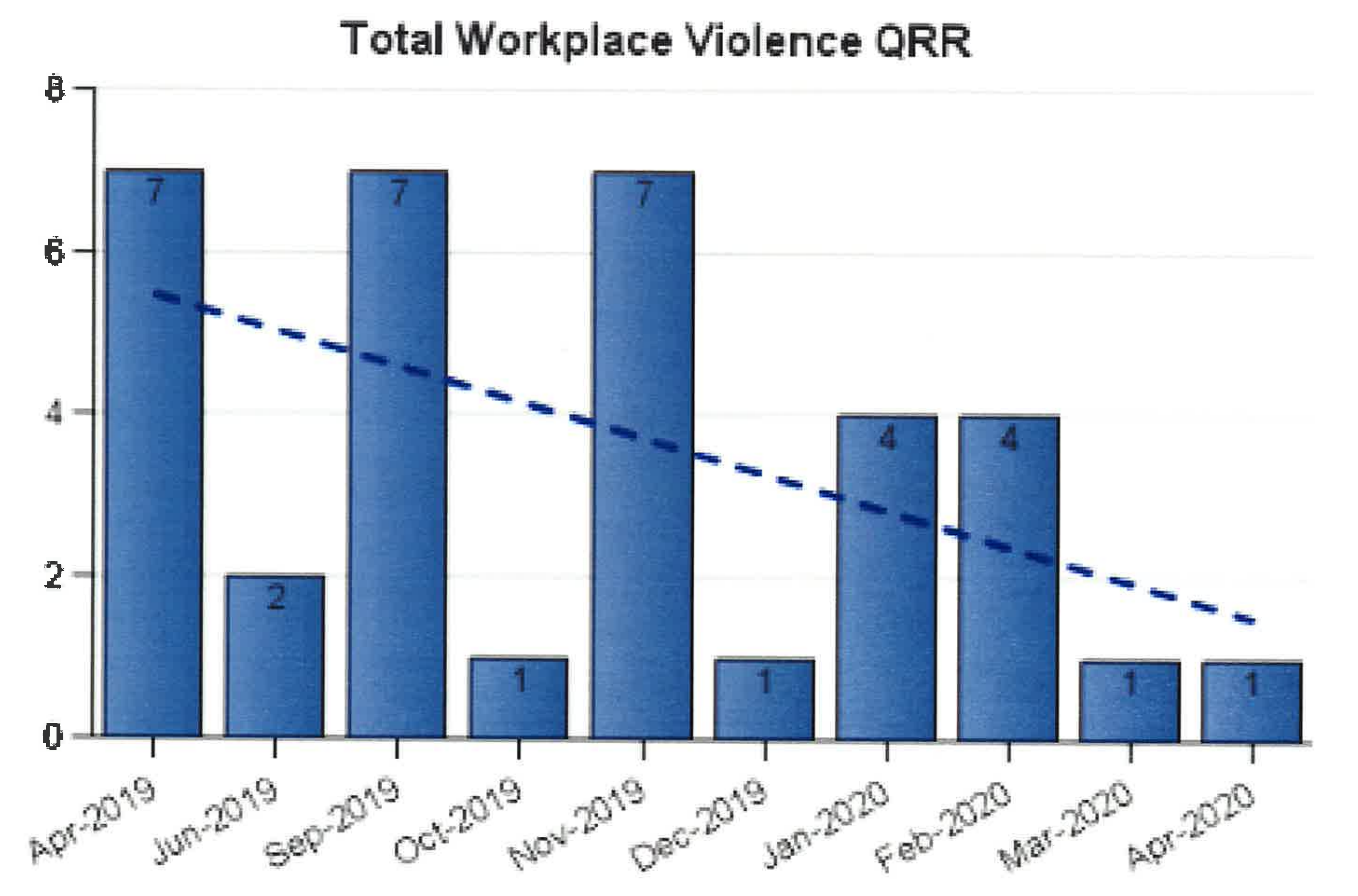
Outdated supplies, equipment, of medications since tracking in this system started in April 2019.

1 OCT 2019 – 31 Mar 2020

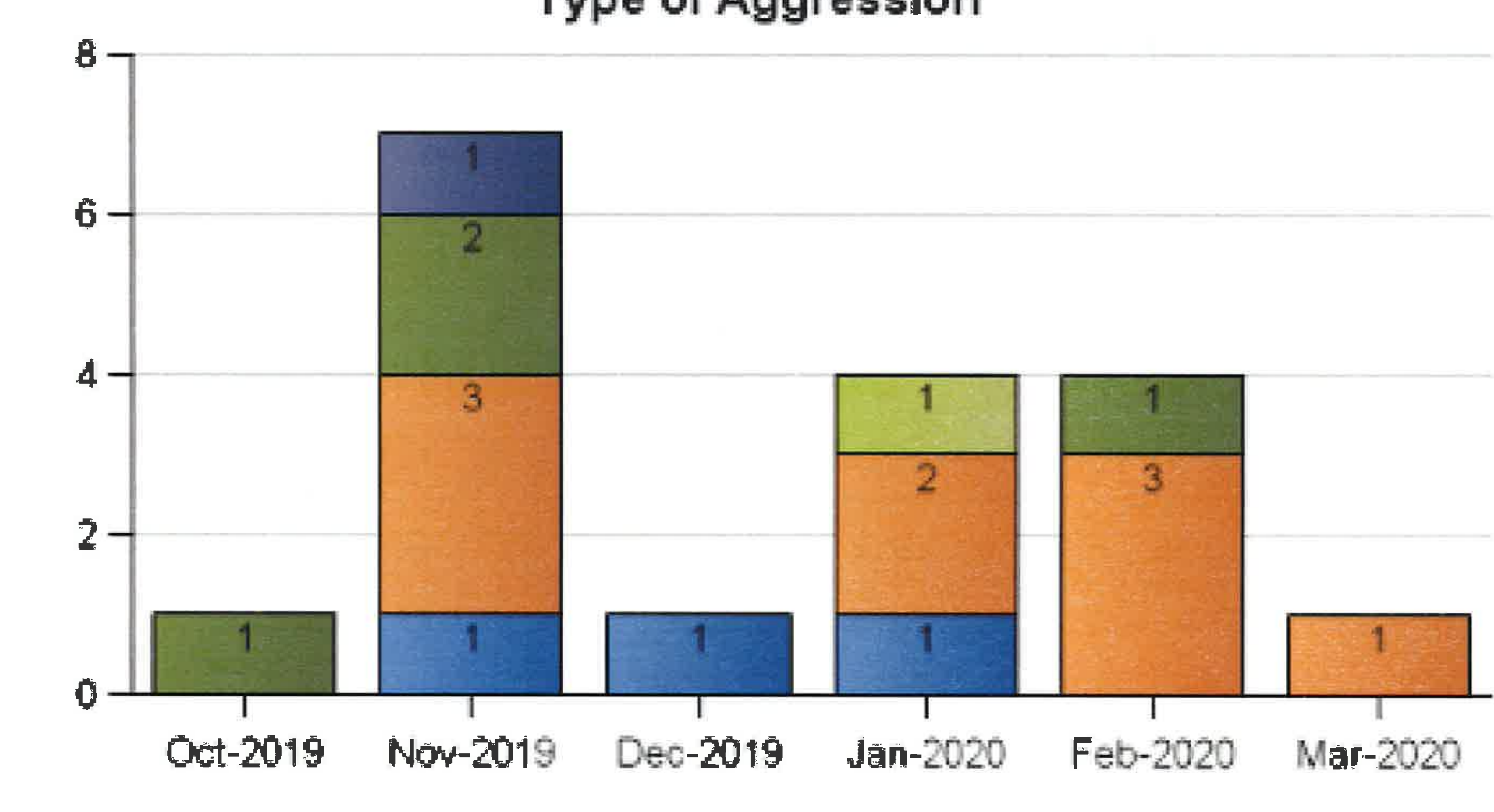




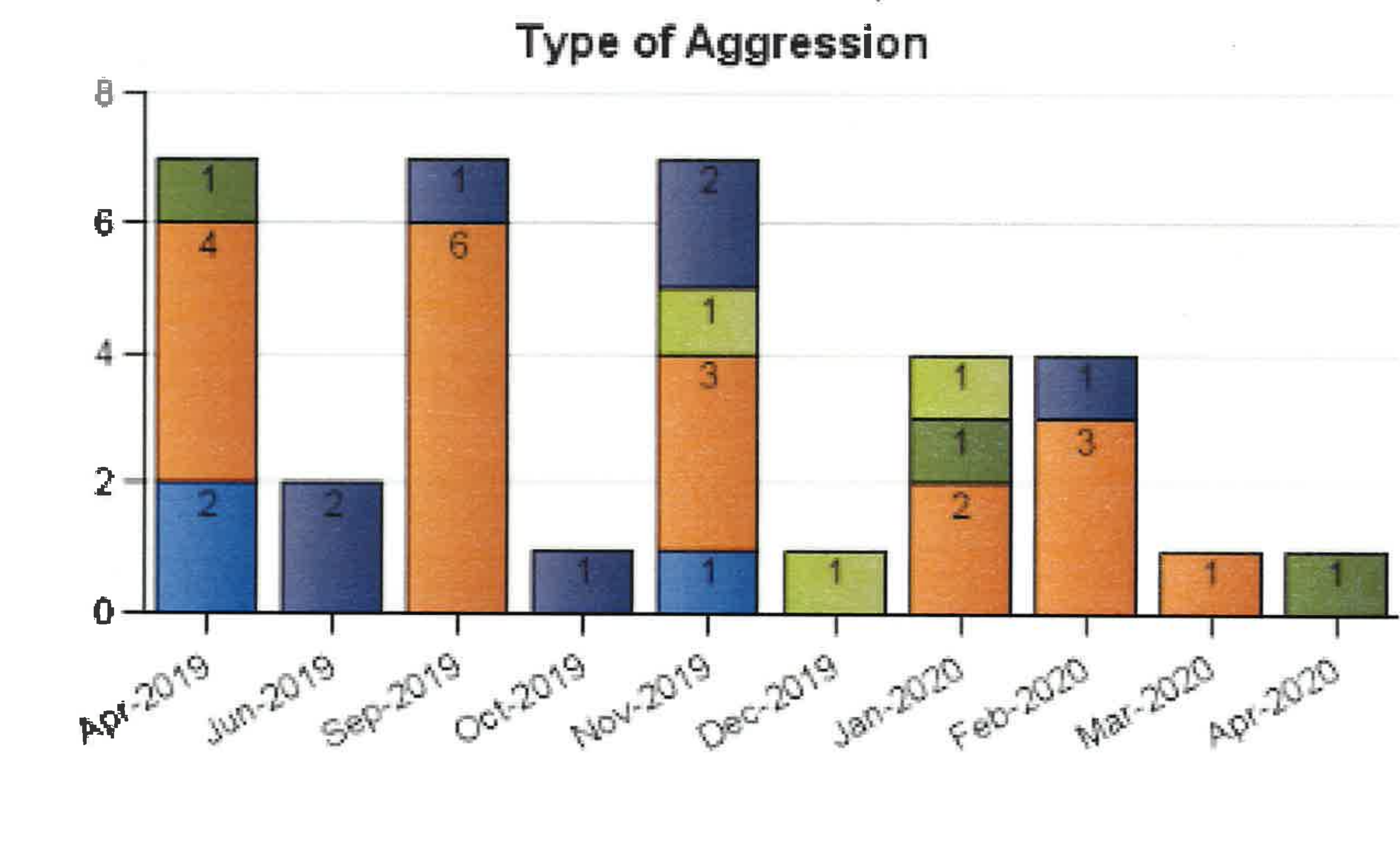
Workplace violence UORs –last 2 quarters
QRR is a reference to the older tracking document "Quality review report" and will be updated in the near future.


Total Workplace Violence QRR
8
6
4
2
0
7
2
7
1
7
1
4
4
1
1
Apr-2019
Jun-2019
Sep-2019
Oct-2019
Nov-2019
Dec-2019
Jan-2020
Feb-2020
Mar-2020
Apr-2020

Workplace Violence (WPV) - 1 OCT 2019 – 31 Mar 2020

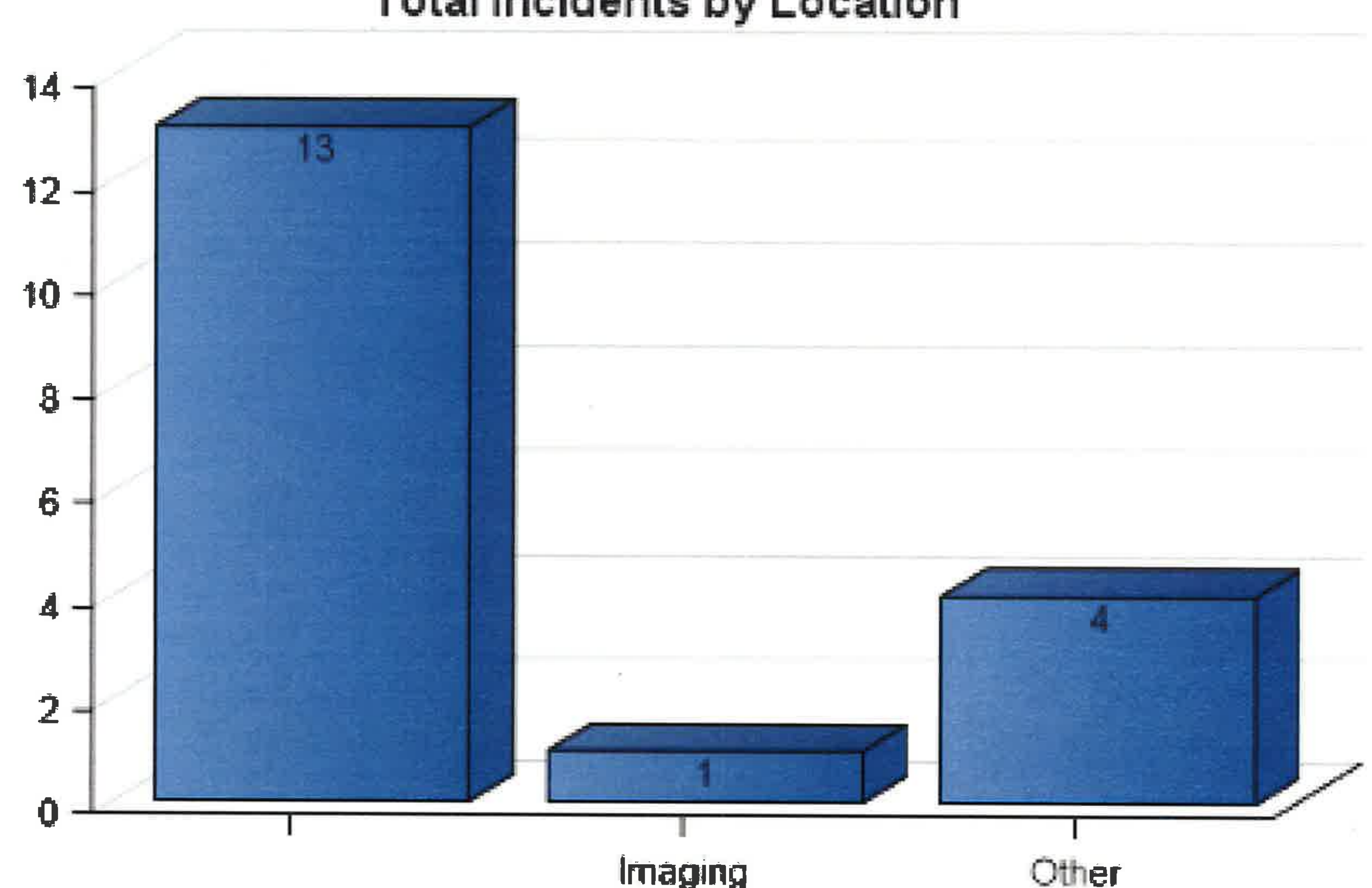


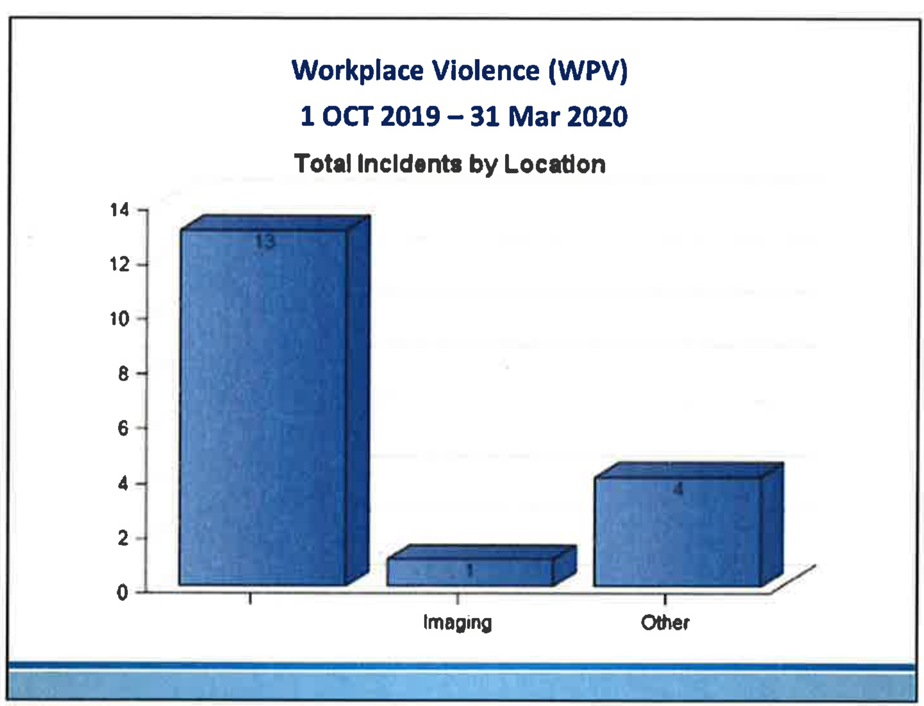
Workplace Violence (WPV)



Workplace Violence (WPV)

1 OCT 2019 – 31 Mar 2020





Total reported WPV by incident location – last 2 quarters
UOR report build to be corrected so that incident location is properly tracked.
Data is in the system, there is an error in the report build.

Workplace Violence (WPV)

Workplace Violence (WPV)

1 OCT 2019 – 31 Mar 2020

Total Incidents by Day of the Week

Sunday
1
6%

Thursday
2
11%

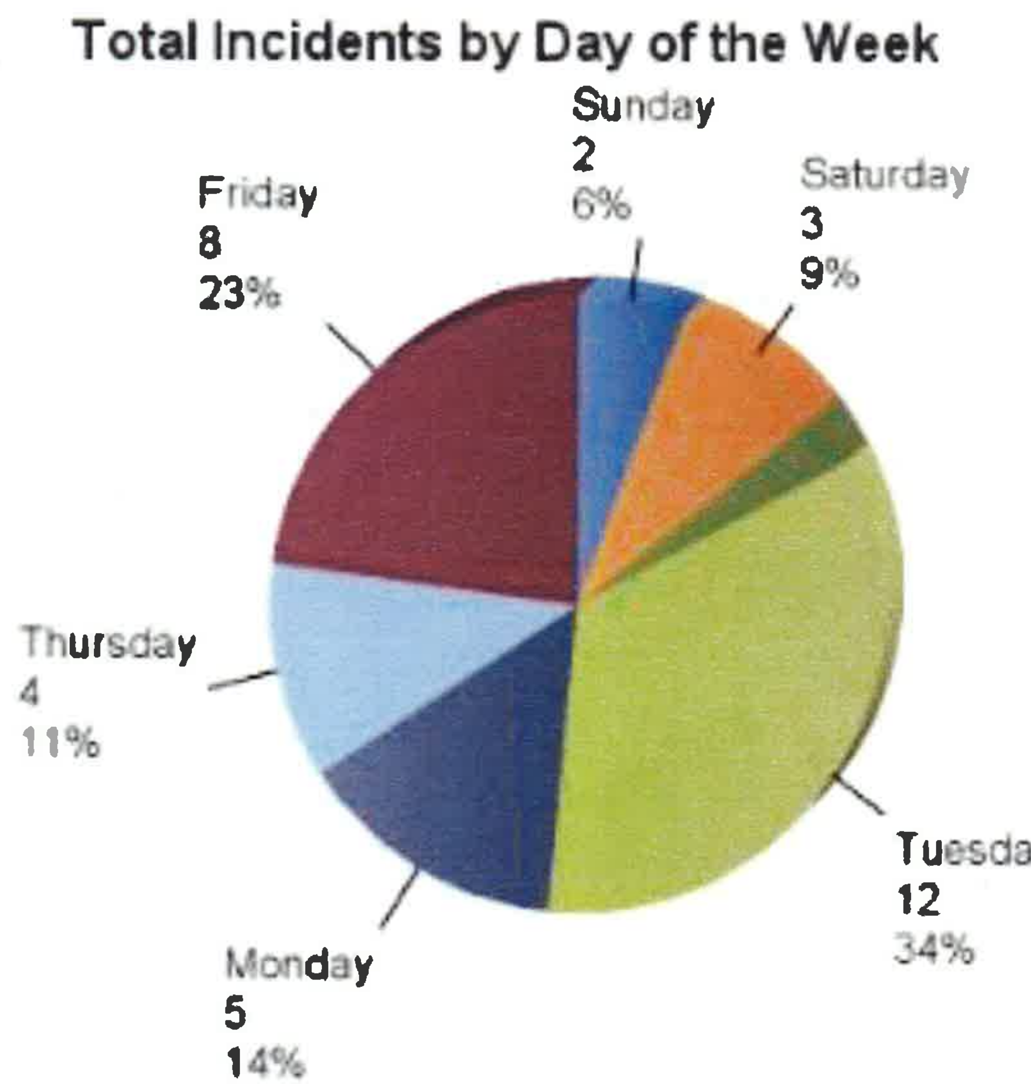
Saturday
2
11%

Wednesday
1
6%

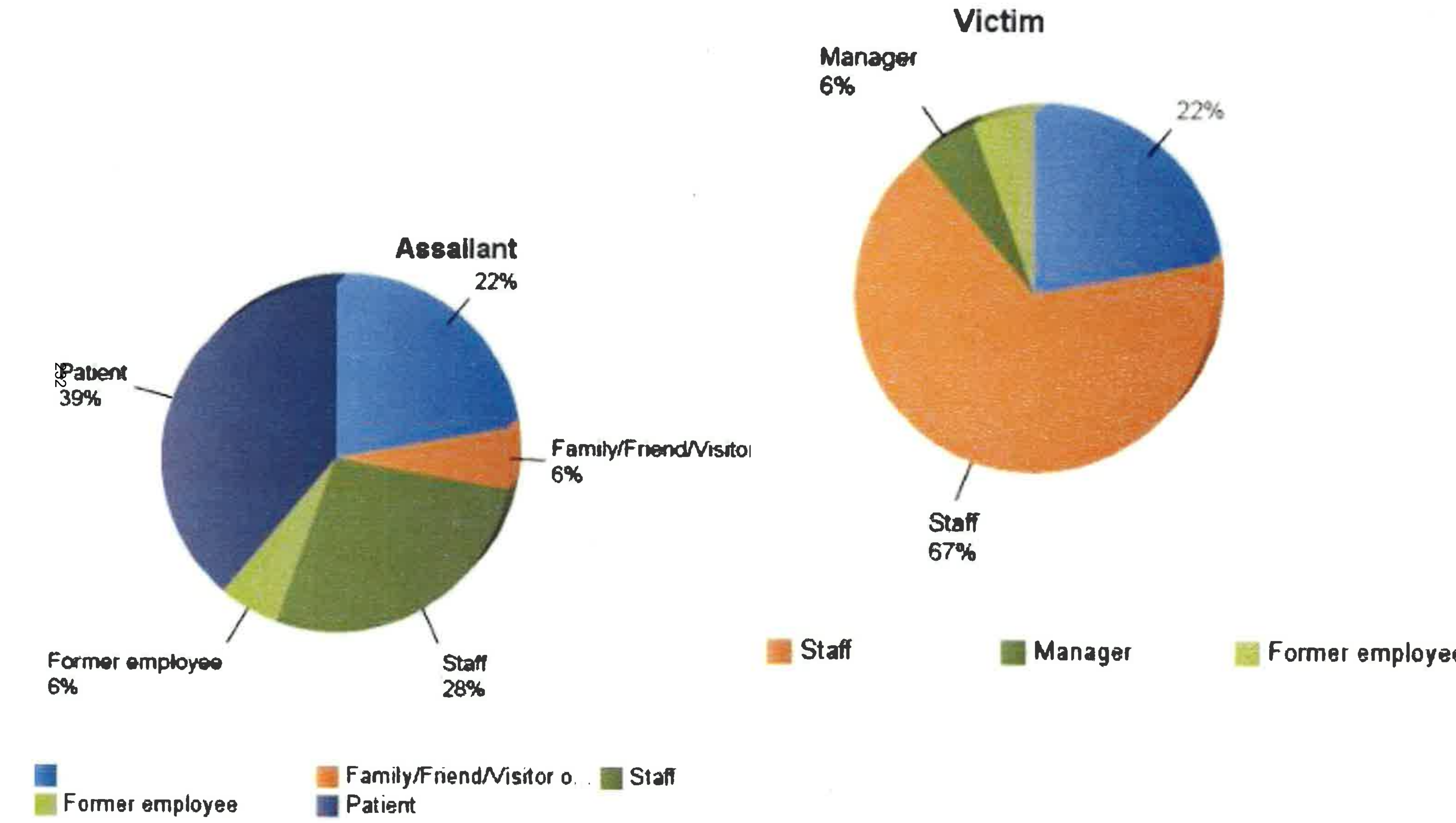
Monday
2
11%

Tuesday
9
50%

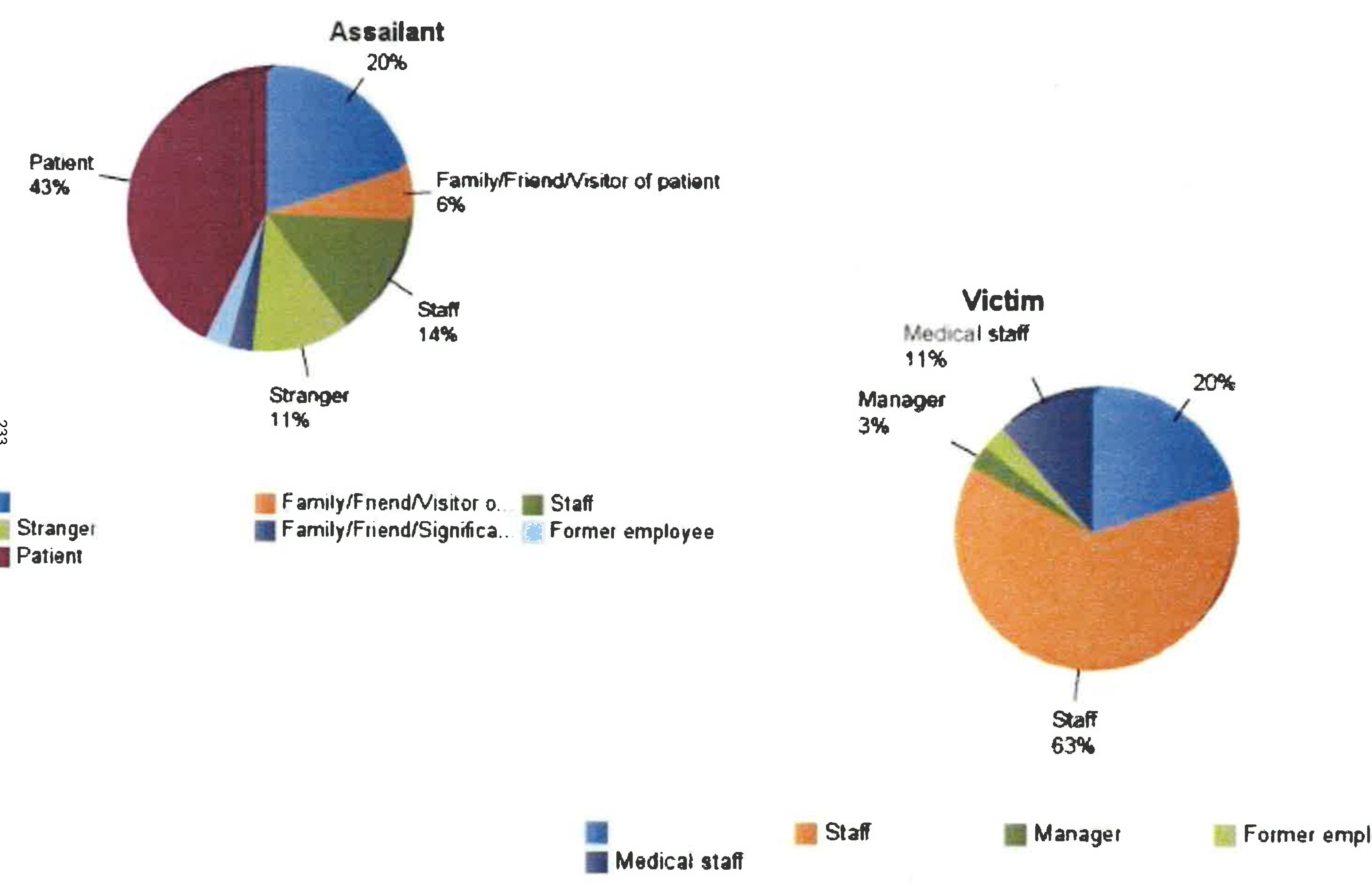
Workplace Violence (WPV)



Workplace Violence (WPV)
1 OCT 2019 – 31 Mar 2020

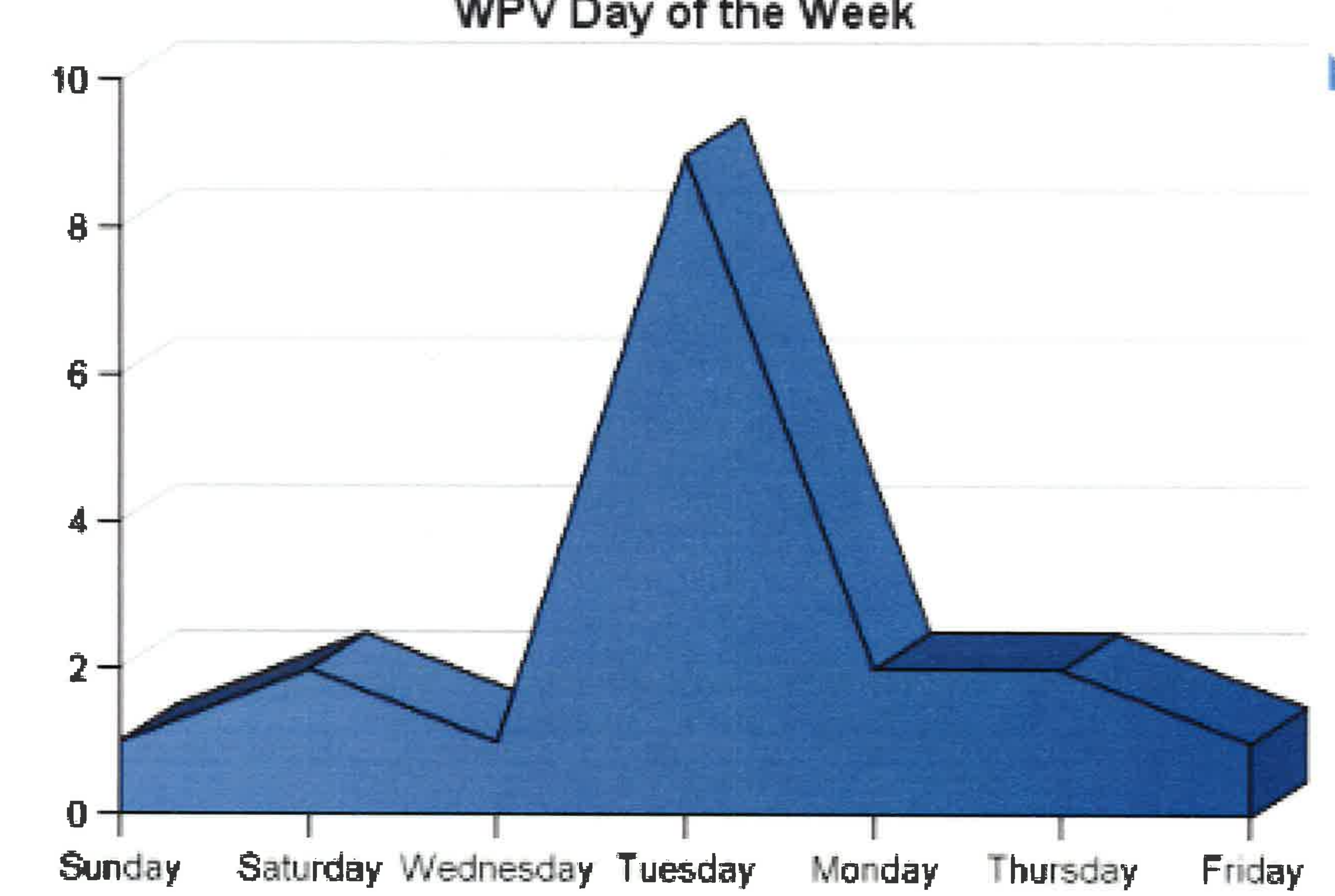


Workplace Violence (WPV)

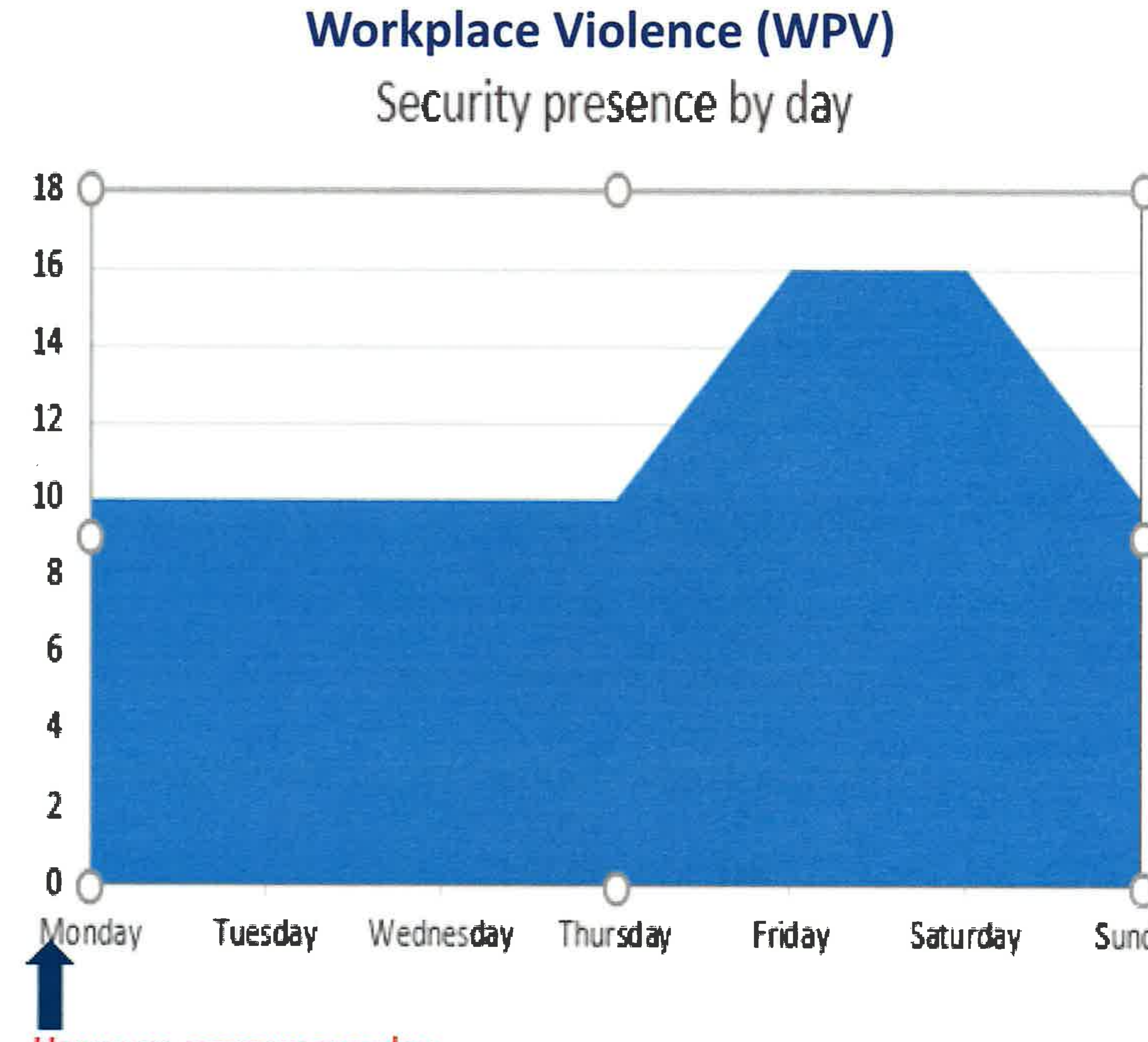


Workplace Violence (WPV)

1 OCT 2019 – 31 Mar 2020



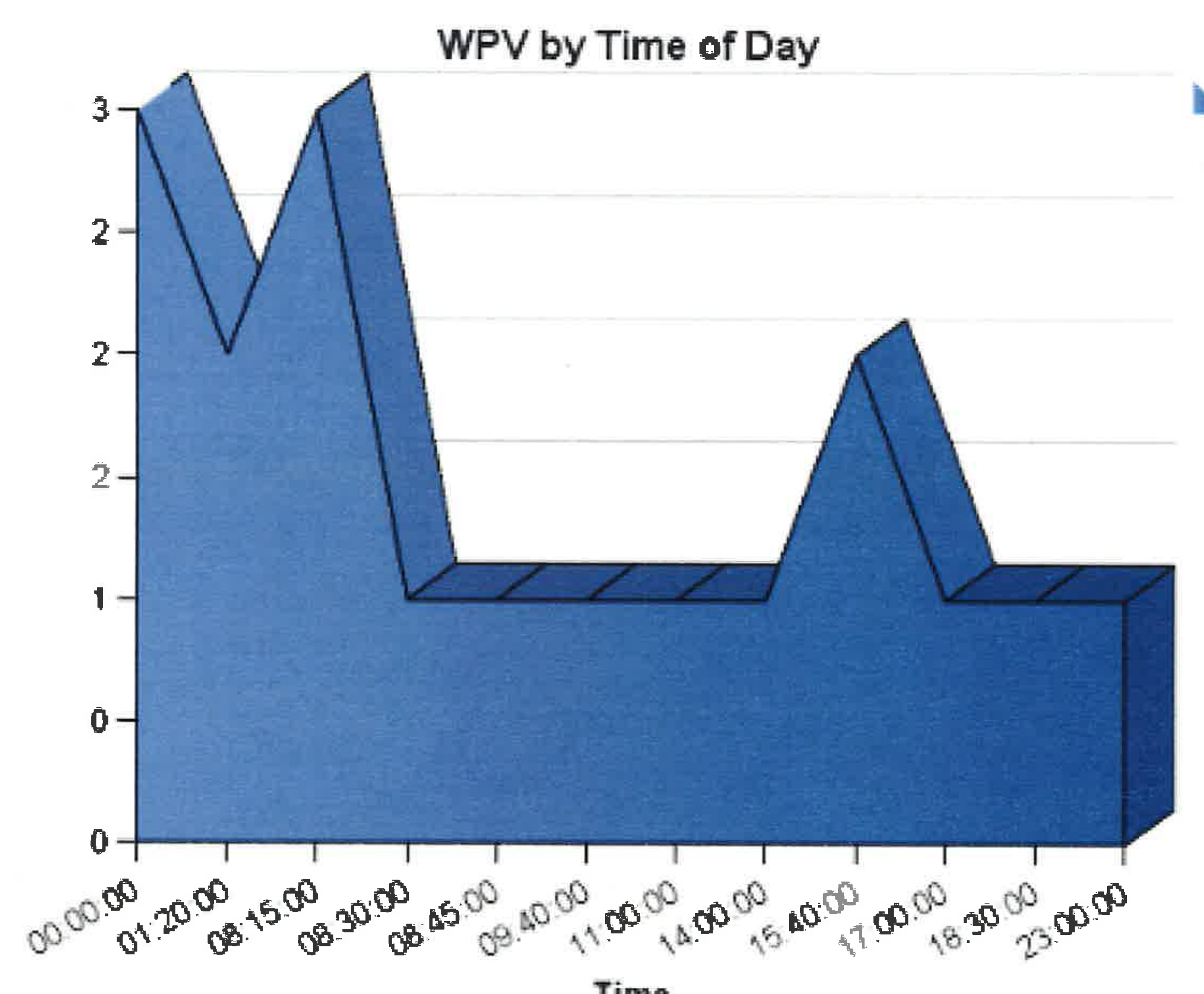
Workplace Violence (WPV)



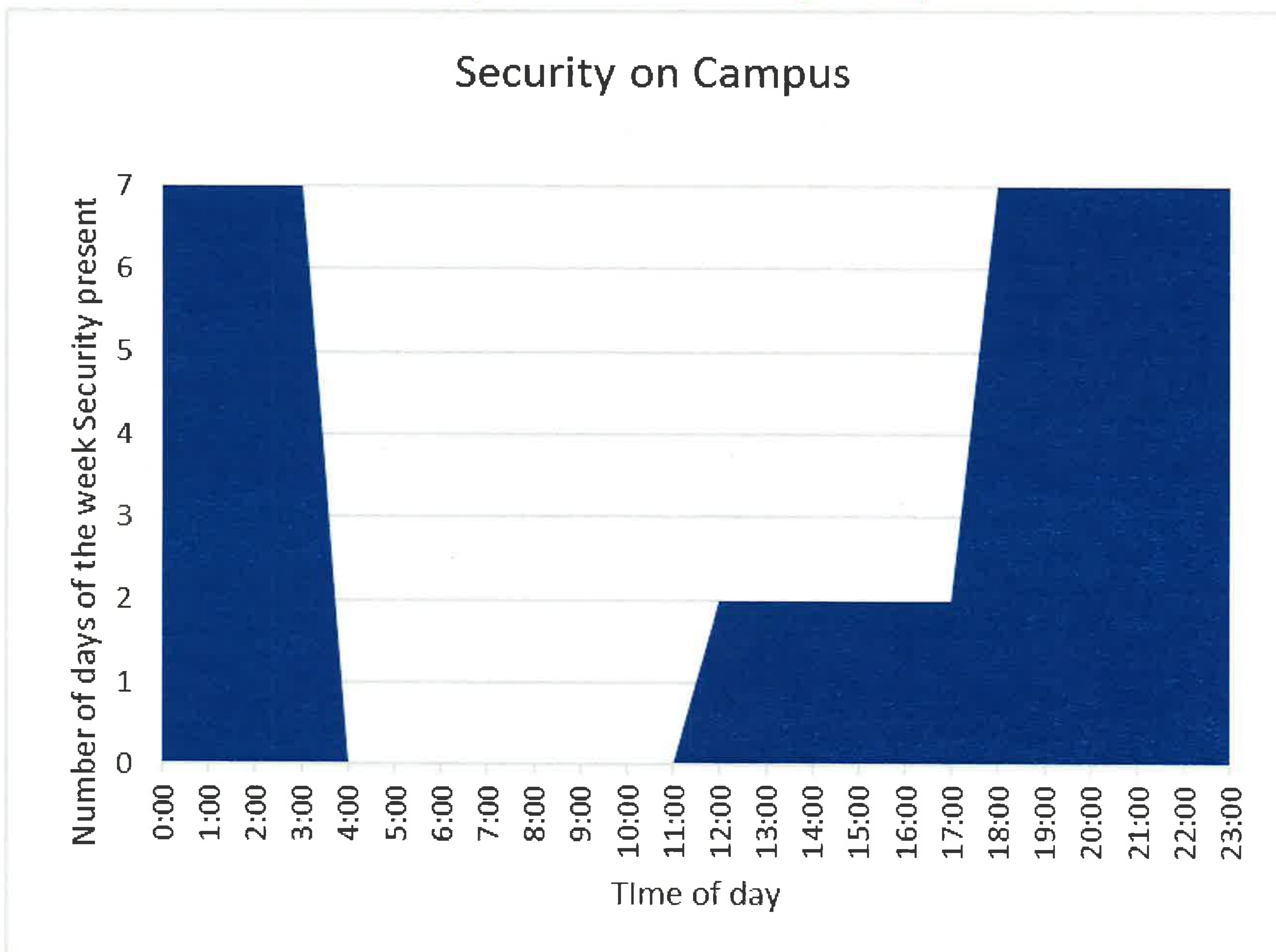
Workplace Violence (WPV)

Workplace Violence (WPV)

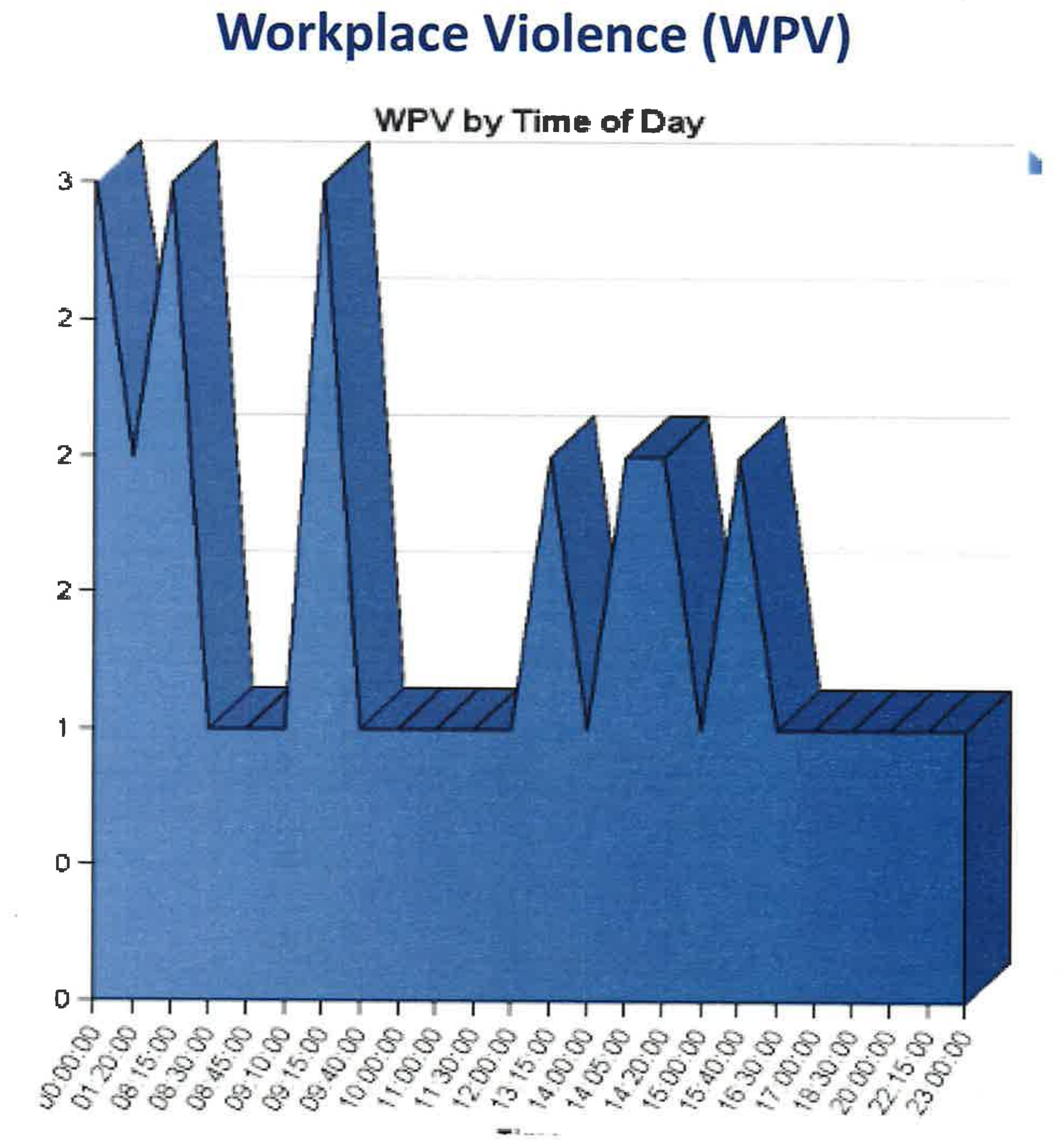
1 OCT 2019 – 31 Mar 2020



Workplace Violence (WPV)

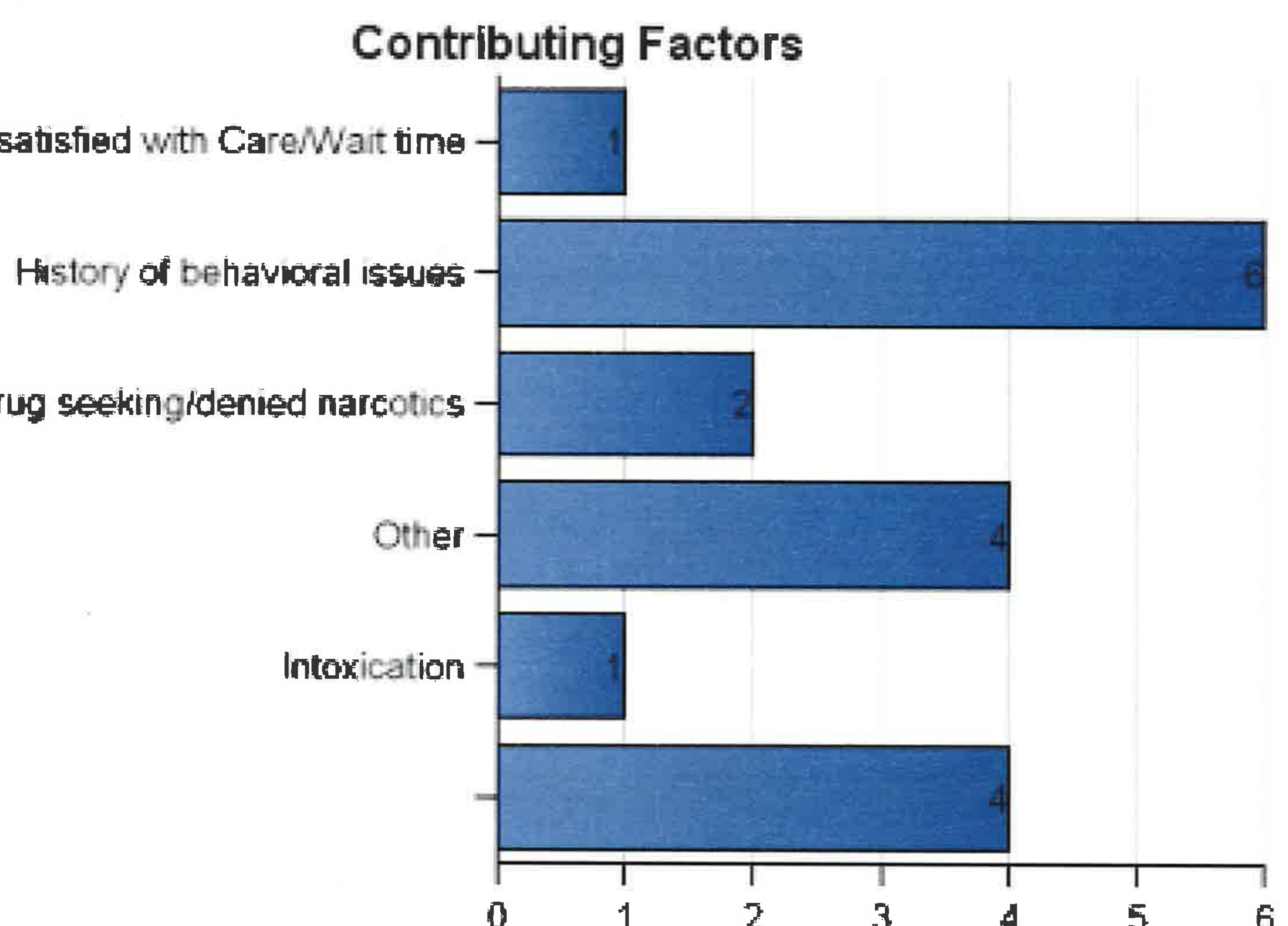


Workplace Violence (WPV)

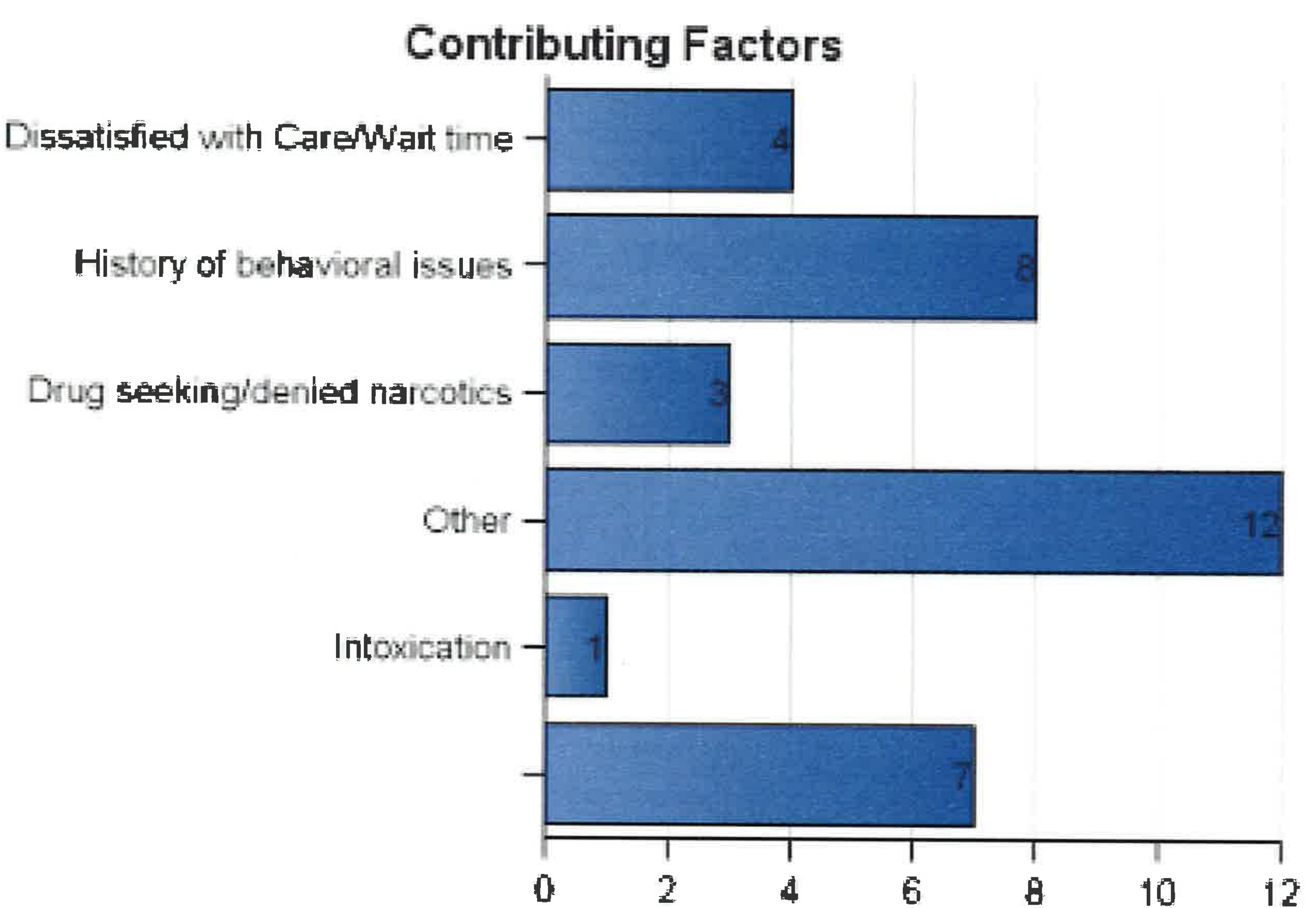


1 OCT 2019 – 31 Mar 2020

Workplace Violence (WPV)

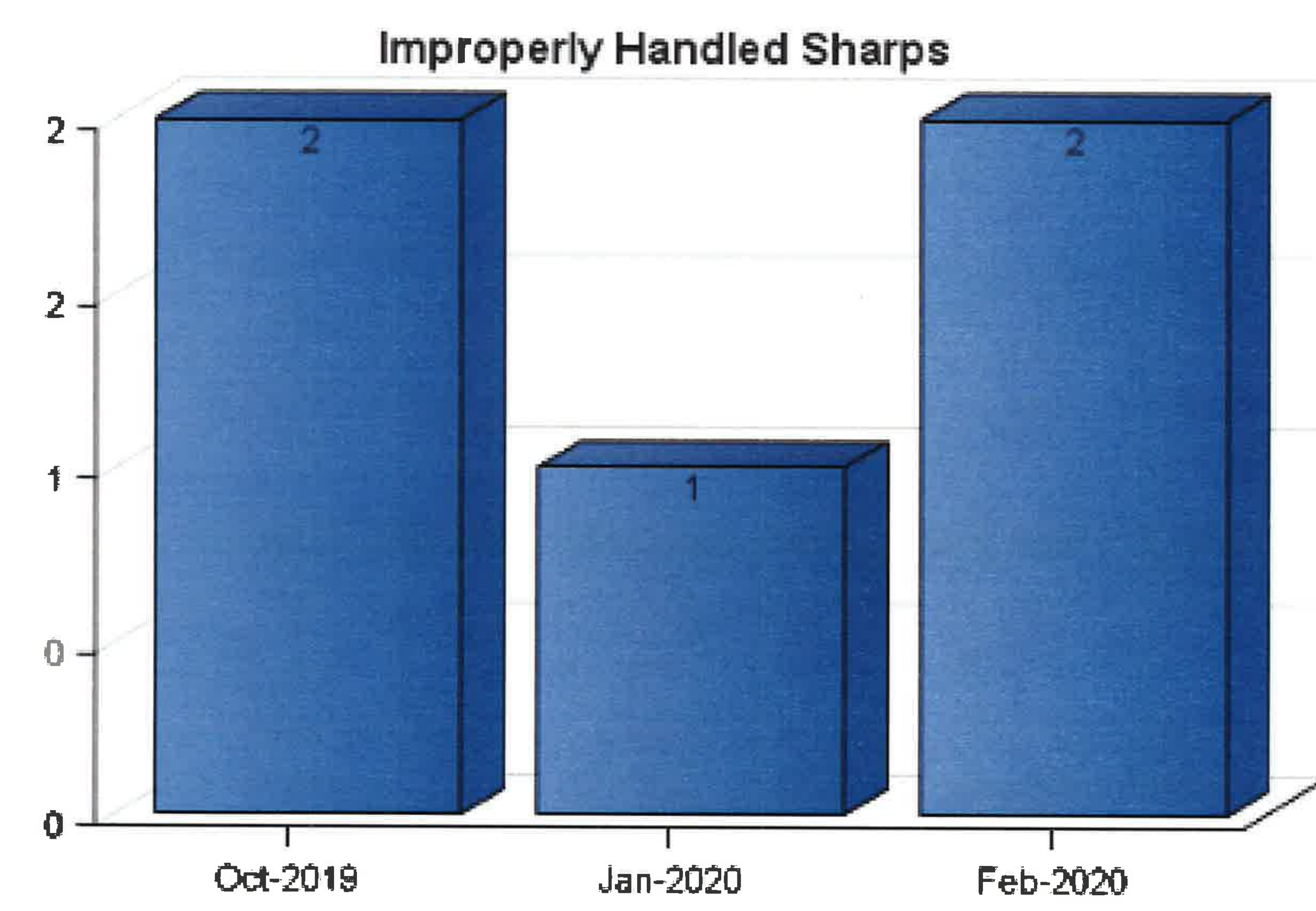


Workplace Violence (WPV)



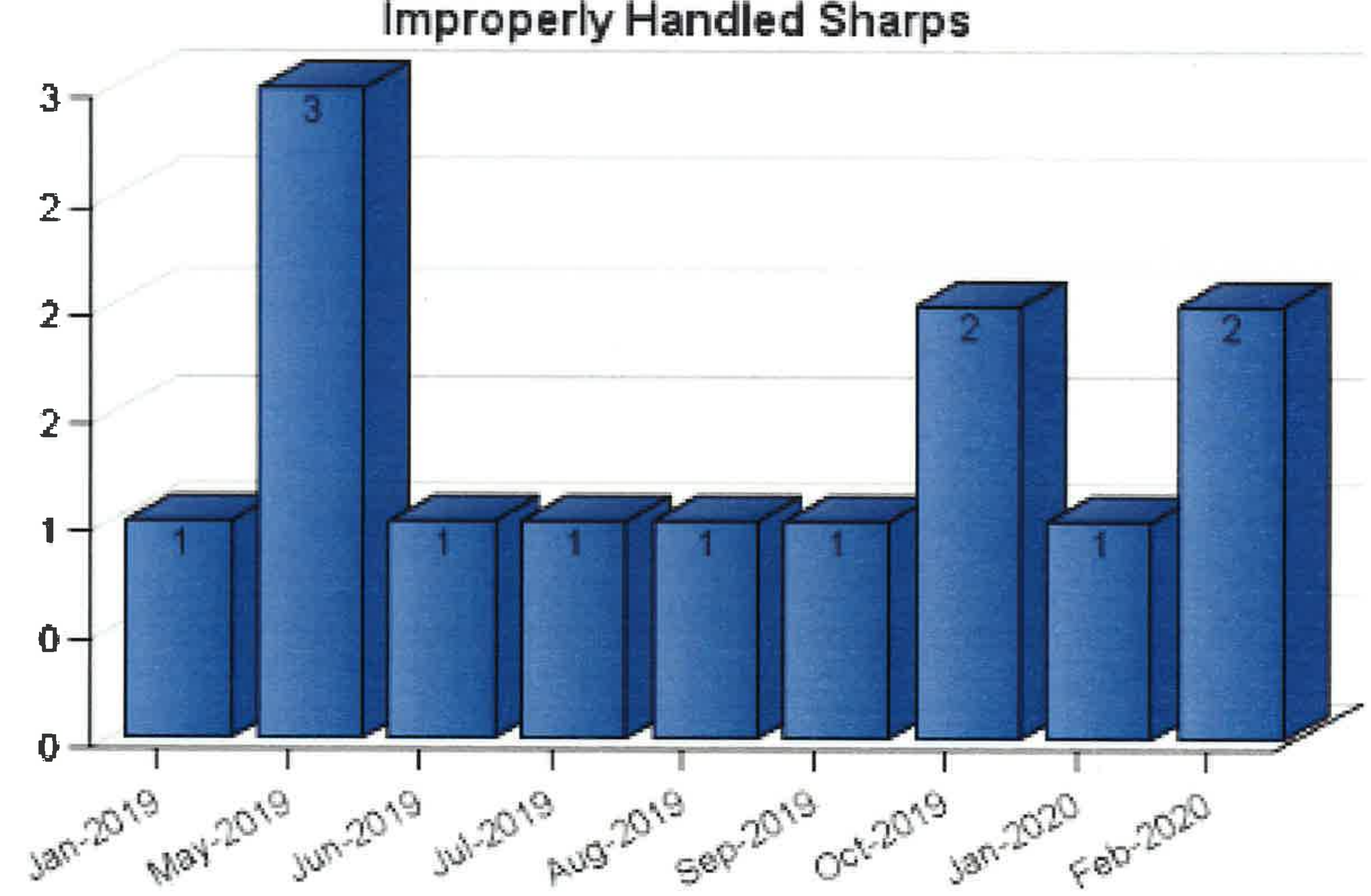
Sharps handling

1 OCT 2019 – 31 Mar 2020

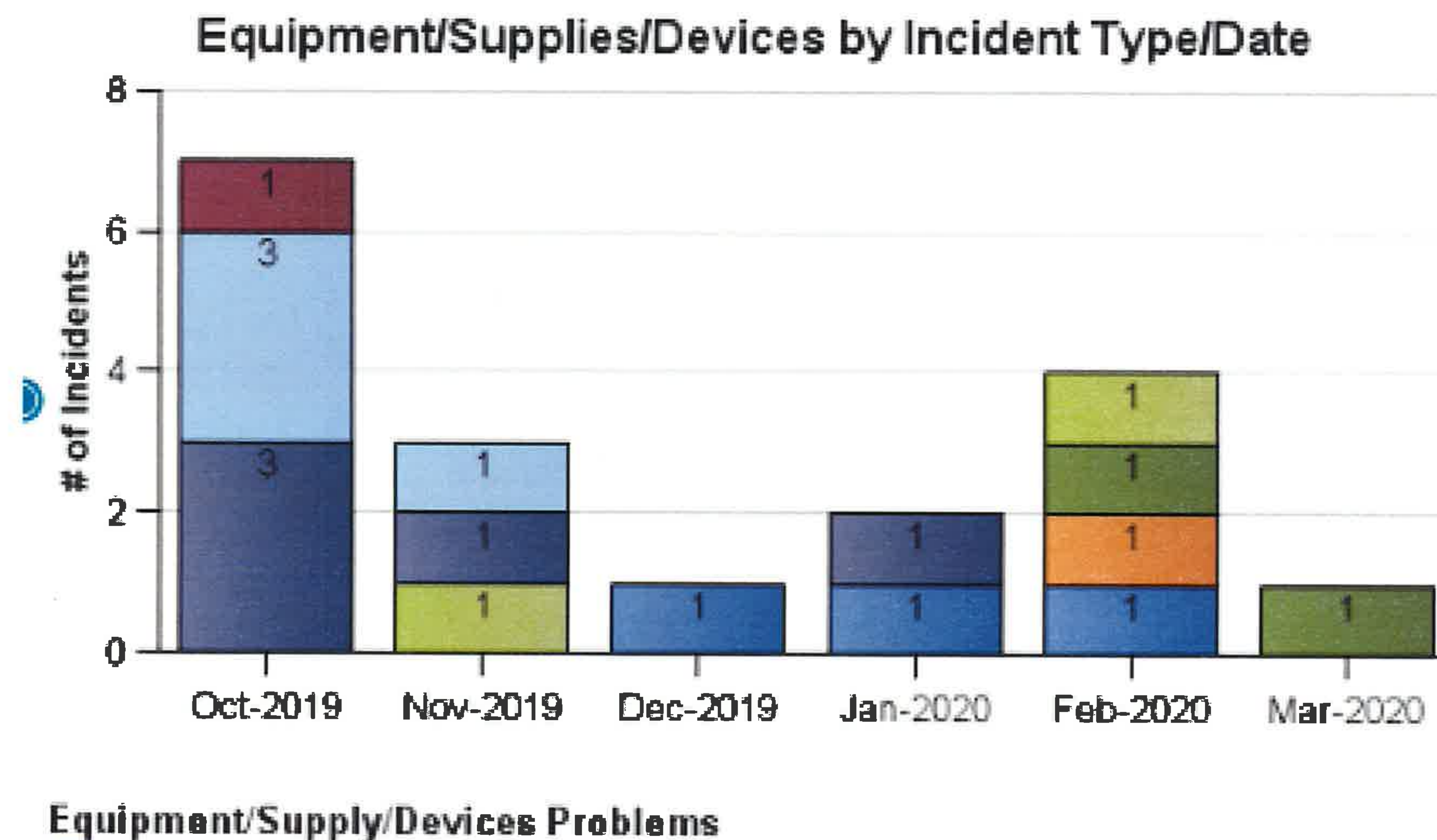


Sharps handling

1 OCT 2019 – 31 Mar 2020



1 OCT 2019 – 31 Mar 2020



1 OCT 2019 – 31 Mar 2020

Equipment/Supplies/Devices by Incident Type/Location

\# of Incidents

5
4
3
2
1
0

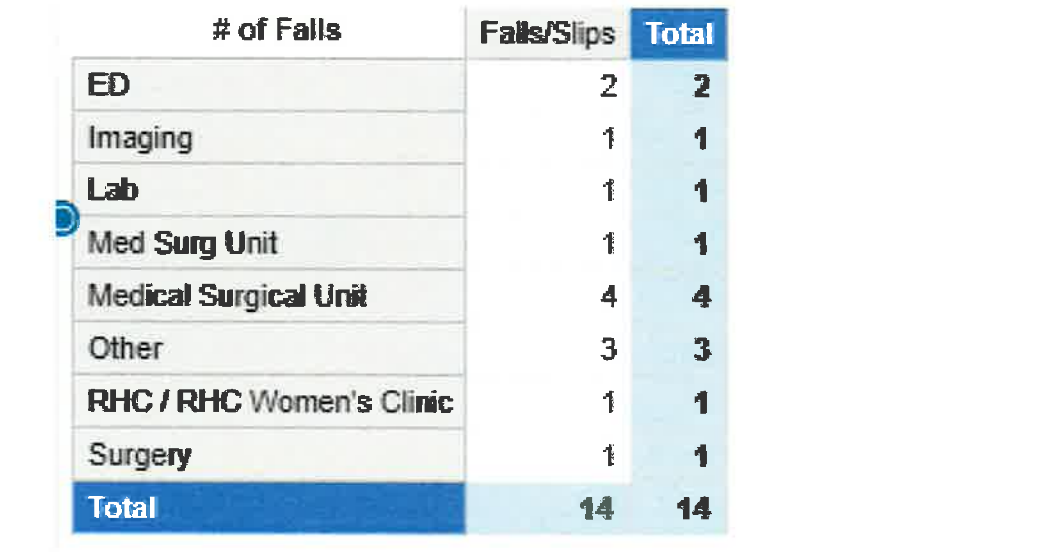
1
1
1
2
2
1
1
1
1
2
2
1
1
1

Other
Imaging
Medical Surgical Unit
ED
OB
Peds/Allergy Clinic
RHC / RHC Women's Clinic
Surgery

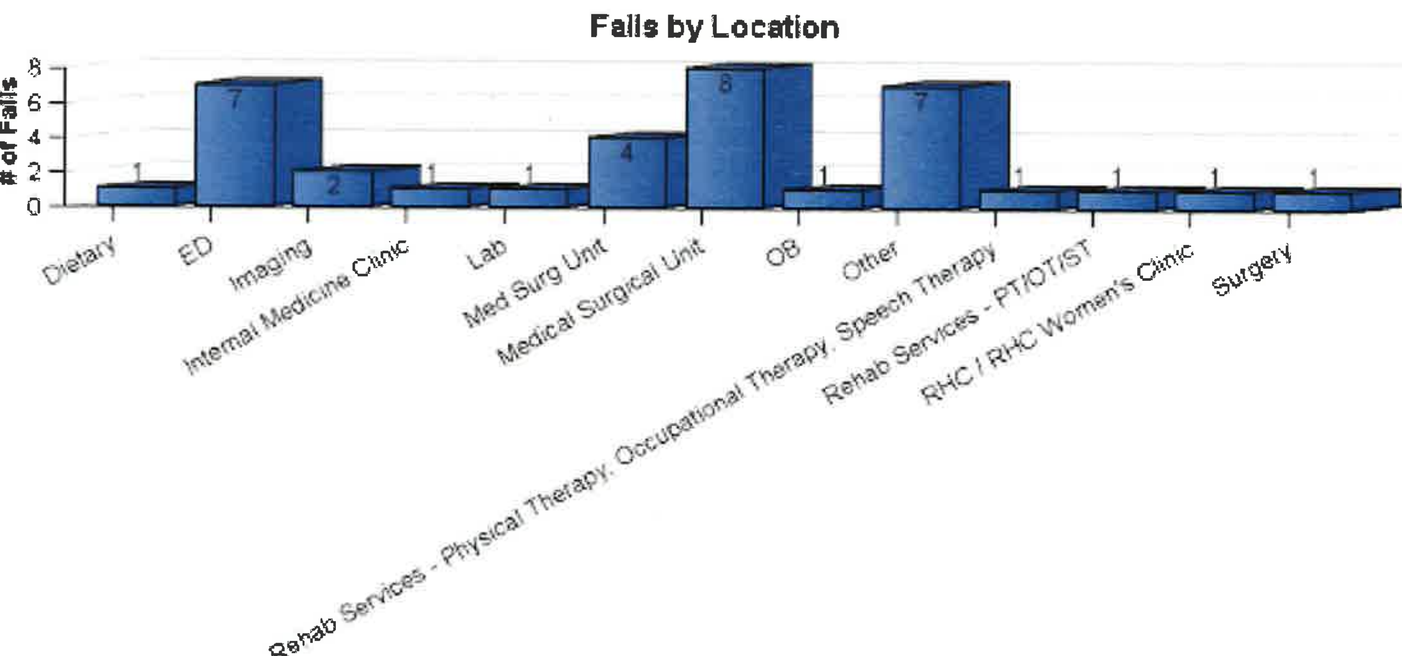
Equipment/Supply/Devices Problems

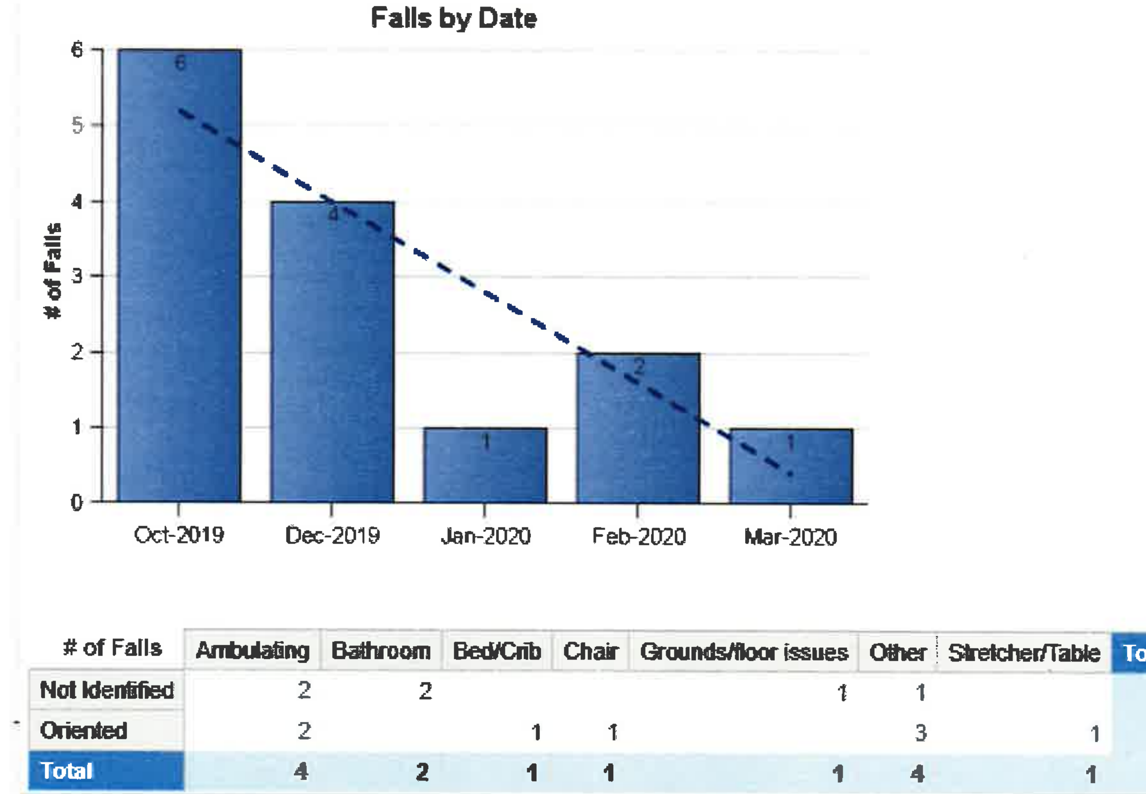
Electrical shock or burn
Malfunction
Missing - all or part of ...
Other
Outdated supply - other
Outdated supply in cra ..
Outdated supply on un...

# of Falls	Falls/Slips	Total
ED	2	2
Imaging	1	1
Lab	1	1
Med Surg Unit	1	1
Medical Surgical Unit	4	4
Other	3	3
RHC / RHC Women's Clinic	1	1
Surgery	1	1
Total	14	14

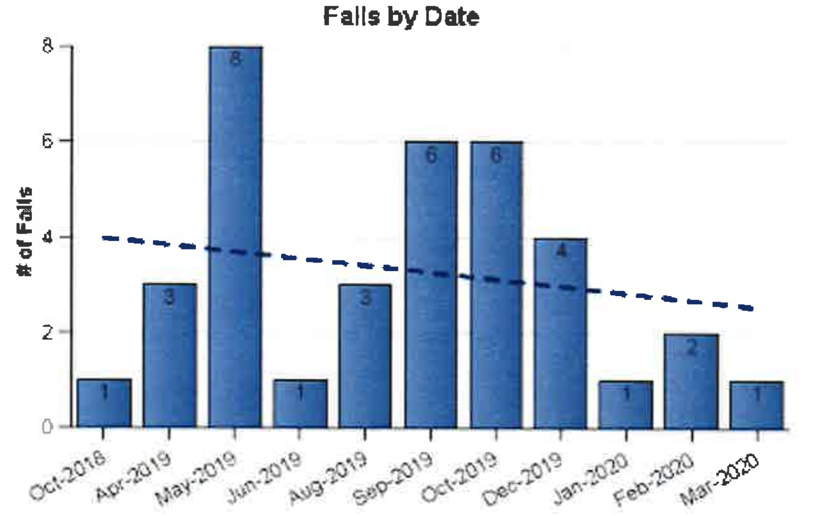


# of Falls	Falls/Slips	Total
Dietary	1	1
ED	7	7
Imaging	2	2
Internal Medicine Clinic	1	1
Lab	1	1
Med Surg Unit	4	4
Medical Surgical Unit	8	8
OB	1	1
Other	7	7
Rehab Services - Physical Therapy, Occupational Therapy, Speech Therapy	1	1
Rehab Services - PT/OT/ST	1	1
RHC / RHC Women's Clinic	1	1
Surgery	1	1
Total	36	36





# of Falls	Ambulating	Bathroom	Bed/Crib	Chair	Grounds/floor issues	Other	Stretcher/Table	Total
Not Identified	2	2			1	1		6
Oriented	2		1	1		3	1	8
Total	4	2	1	1	1	4	1	14



# of Falls	Ambulating	Bathroom	Bed/Crib	Chair	Grounds/floor issues	Ice/weather related	Other	Stretcher/Table	Total
Not Identified	4	3			3	1	4	1	16
Confused	1	1	1						3
Oriented	6	1	1	2			6	1	17
Total	**11**	**5**	**2**	**2**	**3**	**1**	**10**	**2**	**36**

- Non- compliance UORS are transitioning to Quality and Informatics – Michelle Garcia
- Michelle has been reviewing the training material to create/fix reports
- There is much more data in the UOR system, we just have to determine the best ways to report on it to enable our teams successfully create and implement corrective actions!

Patty Dickson, Compliance Officer

760 – 873 - 2022

Patty.Dickson@NIH.org

Attachment F

STANDARD	EP	Ensuring Sustained Compliance	Data	Reported to:	Accountability	Time frame for monitoring	Comment
EC.02.01.01	EP1	Monitor for items beyond BEST USED by DATE (BUD) for sterile supplies processed by NIHD	# of items beyond BUD	NEC quarterly	DON Perioperative Services	Monthly X 12, then Quarterly X 4	Completed
EC.02.02.01	EP5	a. Eye wash stations function, b. solution bottles in date	pass/fail	Safety Committee quarterly	Director of Facilities	Quarterly X 4	Completed
EC.02.02.01	EP12	a. permanent fuel tank label installed, b. Daily monitoring of contaminated item transport	a. none; b. containers with appropriate labels/total number of trays	a. one time report to safety committee (3/2019); b. NEC monthly x 2	Director of Facilities	a. none; b. daily x 2 months	a. Completed b. Completed
EC.02.02.01	EP19	UOR for spent bulbs found outside the recycling box in storage area	UOR summary data	Safety Committee x 3 months	Director of Facilities	3 months	Completed
EC.02.03.03	EP2	Fire drills in all buildings will be completed on a quarterly basis and all data from the fire drill will logged/analyzed monthly	Completed Fire drill matrix sheet	Safety Committee, Monthly x 1 year	Director of Facilities	12 months	Completed
EC.02.03.03	EP3	Fire drills in all buildings will be completed, timely, on a quarterly basis and all data from the fire drill will logged/analyzed monthly	Completed Fire drill matrix sheet	Safety Committee, quarterly x 1 year	Director of Facilities	Quarterly	Completed
EC.02.03.05	EP3	Event calendared with reminder to ensure all testing of Fire and life Safety equipment	Aggregate data for testing of all fire and life safety equipment and devices.	Safety Committee. Monthly X 6	Director of Facilities	Monthly	Completed
EC.02.03.05	EP4	Event calendared with reminder to ensure all testing of Fire and life Safety equipment	Aggregate data for testing of all fire and life safety equipment and devices.	Safety Committee. Monthly X 6	Director of Facilities	Monthly	Completed

STANDARD	EP	Ensuring Sustained Compliance	Data	Reported to:	Accountability	Time frame for monitoring	Comment
EC.02.03.05	EP5	Event calendared with reminder to ensure all testing of Fire and life Safety equipment	Aggregate data for testing of all fire and life safety equipment and devices.	Safety Committee. Monthly X 6	Director of Facilities	Monthly	Completed
EC.02.03.05	EP19	Review vendor written report to ensure complete HVAC shutdown.	Aggregate data for testing of all fire and life safety equipment and devices.	Safety Committee. Monthly X 6	Director of Facilities	Annually	Completed
EC.02.03.05	EP28	Review all tamper and flow documents include accurate/approved NFPA numbers	Aggregate data for testing of all fire and life safety equipment and devices.	Safety Committee. Monthly X 6	Director of Facilities	Quarterly	Completed
EC.02.05.01	EP9	Breaker painted. No ongoing monitoring needed	None	Safety committee - one-time	Director of Facilities	None	Completed
EC.02.05.01	EP15	Pressure levels will be tested/recorded on quarterly basis X 1 year	Aggregate positive pressure level data will be shared with	Safety committee - one-time	Director of Facilities	quarterly x 4	Completed
EC.02.05.01	EP16	Pressure levels will be tested/recorded on quarterly basis X 1 year	Aggregate positive pressure level data will be shared with	Safety committee - one-time	Director of Facilities	quarterly x 4	Completed
EC.02.05.03	EP1	(1) The creation of required documents/project plans are underway with the architects on record with a deadline submission to OSHPD by 5/21/19. The review, acceptance and approval of the plans by OSHPD will act as evidence in our compliance with this EP.	Bi-weekly updates until Breaker moved.	CEO	Director of Facilities	Bi-weekly	Completed

STANDARD	EP	Ensuring Sustained Compliance	Data	Reported to:	Accountability	Time frame for monitoring	Comment
EC.02.05.03	EP11	(11) Maintenance staff have been educated on the installation of the Emergency "Stop" Button outside of the generator room 1 & 2. Monitoring of compliance with this EP is not required on an ongoing basis.	None	(11) Maintenance Coordinator to provide one update on the installation of Emergency "Stop" Button installation outside generators 1 & 2 to be provided at the monthly Safety Committee Meeting.	Director of Facilities	None	Completed
EC.02.05.05	EP4	Damper inspections every 5 years; repair of dampers not fuctioning	Damper inspection data; damper repair data	One-time report to Safety Committee	Director of Facilities	one time	Completed
EC.02.05.05	EP6	Monthly rounding to ensure access to electrical panels if free from obstruction	Reported on Monthly EOC reports	Safety Committee?	Director of Facilities	Monthly	Completed
EC.02.05.07	EP8	The test report observations for due dates will be occur on a bi-monthly basis to ensure all testing is current and next test due dates are reviewed for timely scheduling needs.	Data on compliance with diesel fuel and generator 1, 2 & 3 testing will be collected by analyzing the test reports in the binders.	The diesel fuel and generator testing will be shared once with the Safety Committee at the monthly meeting upon completion of testing.	Director of Facilities	bi-monthly until annual testing is completed	Completed
EC.02.05.07	EP9	The test report observations for due dates will be occur on a bi-monthly basis to ensure all testing is current and next test due dates are reviewed for timely scheduling needs.	Data on compliance with diesel fuel and generator 1, 2 & 3 testing will be collected by analyzing the test reports in the binders.	The diesel fuel and generator testing will be shared once with the Safety Committee at the monthly meeting upon completion of testing.	Director of Facilities	bi-monthly until annual testing is completed	Completed
EC.02.05.09	EP11	(11) Clear identification of the bulk oxygen main shut-off valve will be visible to onlookers at all times.	No further monitoring required	No further monitoring required	Director of Facilities	No further monitoring required	Completed

STANDARD	EP	Ensuring Sustained Compliance	Data	Reported to:	Accountability	Time frame for monitoring	Comment
EC.02.05.09	EP12	a) The Maintenance Coordinator will perform once weekly observations of the gas cylinder bracket to ensure the gas cylinder is secure within the bracket. Any non-compliance will require a corrective action plan be submitted to the Director of Maintenance.	a) Ensuring compliance with gas cylinder security will be collected from these observations.	a) The gas cylinder compliance data will be shared once with the Safety Committee during the monthly meeting. After 3 consecutive months of compliance with this regulatory requirement, data will no longer be reported at the monthly Safety Committee Meeting.	Director of Facilities	a) The gas cylinder observations will occur once weekly for 2 months and any non-compliance will be addressed immediately.	Completed
		b) a spot check, to determine that the full and empty (including half used) oxygen containers are not comingle in the PACU. This will be performed by the PACU Manager, Nicole Eddy, BSN, RN.	b) Ensuring empty (including in-use cylinders) of oxygen is not comingled with full cylinders. If area is found with oxygen stored correctly will be compliant at 100%. If found comingled will be non-complaint at 0%. Numerator = compliant total number/Denominator = total number of audits.	b) Will be reported to Nurse Executive Committee monthly x 3. Data will be stored by compliance officer.		b) PACU monitoring will be done as a spot check 5 times per month x 3 months.	Completed
		c) Signage will be monitored to assure it remains posted by the Manager Med/Surg, Justin Nott, BSN, RN.	c) Ensuring signage remains posted on med/surg in the medication room. Compliance = number of times signage remains posted as numerator. Denominator = number of times audit was performed.	c) Will be reported to Nurse Executive Committee monthly x 2. Data will be stored by compliance officer.		c) Med/Surg monitoring will be done as a spot check 5 times per month x 2 months.	Completed

STANDARD	EP	Ensuring Sustained Compliance	Data	Reported to:	Accountability	Time frame for monitoring	Comment
EM.02.01.01	EP14	Emergency Management Plan will continue to be evaluated and updated as necessary annually by the ED Manager/Disaster Planning leader. It will be approved by medical staff committees when revised.	Annual monitoring to assure the CMS instruction of application for 1135 waiver will be updated if appropriate. This will be done in January each year as a part of the annual review of the emergency management plan.	Management Plan review, the Resuscitation & Disaster Committee (a sub-committee of the Emergency Services Medical Staff Committee)will note any update to the 1135	DON ED and IP services	Annually, January	Completed
EM.03.01.03	EP2	A Multi-Casualty Incident drill is scheduled for the first week of May 2019. Participation of NIHD staff and use of incident command system will be utilized. Disaster drills will be planned by Disaster Planning stakeholders annually in February to assure one of the annual drills includes an influx of simulated patients.	Number of drill and at least one drill annually that includes influx of simulated patients or actual influx of patients associated with 'code triage' event.	Report to the Nurse Executive Team by ED/Disaster Manager Quarterly; NEC is lead by the Chief Nursing Officer. Quarterly report process via QA/PI process. Copies of the QA/PI data will be stored by Compliance Officer. Quarterly reports will occur through the Fiscal Year 2019-2020 (ending June 30, 2020)	DON ED and IP services	The ED/Disaster Manager completes quarterly quality report, which will include disaster drill information. This information will be reported for fiscal year 2019 and 2020. (FY = July 1 to June 30th)	Completed
HR.01.01.01	EP2	Employees with required licenses/certifications will have primary source documentation that renewal is completed prior to expiration.	Spot audits of 10 employee files will show that greater than 99% (or 100%) have verified renewal from primary source.	CEO and Compliance Officer	Director of HR	These will be done monthly x 6.	Completed

STANDARD	EP	Ensuring Sustained Compliance	Data	Reported to:	Accountability	Time frame for monitoring	Comment
LS.02.01.10	EP11	This cross corridor 1.5 hour fire rated door will be tested during scheduled fire life safety testing to ensure the shut/latch hardware is fully operational and functioning as required.	Data on fire rated door compliance with fully functioning hardware will be collected by the designated Maintenance personnel during the fire and life safety testing.	The cross corridor 1.5 hour rated fire door hardware compliance data will be reported and analyzed by the NIHD Safety Committee on a quarterly basis for one year.	Director of Facilities	Testing on this door will occur on a quarterly basis for one year and all data from the observations will collected and analyzed on a quarterly basis.	Completed
LS.02.01.20	EP13	Stairwells will continue to be inspected during Environment Of Care rounding to ensure that they are clear of any items.	Stairwells will remain clear of any items that might be obstructive.	Reported to the Safety Committee at last meeting; Med sleds have been relocated to a compliant location. EOC reports are reported to safety committee.	Director of Facilities	EOC rounds are done monthly.	Completed
LS.02.01.34	EP9	(9) Work Orders involving ceiling/ceiling tile work will be audited for compliance with the note being attached to the Work Order and that no ceiling tiles are left out once the work/repairs have ceased.	Data on compliance from the observations for EP (9) and (10) will be collected to ensure ceiling tiles are replaced and fire pull stations are not blocked by objects as required by regulatory guidelines.	Observation data for EP (9) will be reported quarterly to the Safety Committee. Upon successful compliance with this regulatory requirement for 6 months, data will no longer be reported to the Safety Committee.	Director of Facilities	(9) Review of Work Orders to ensure ceiling tile replacement note is attached will be done through the Work Order daily review process for 3 months.	Completed

STANDARD	EP	Ensuring Sustained Compliance	Data	Reported to:	Accountability	Time frame for monitoring	Comment
LS.02.01.34	EP10	10) Observation of areas in front of the fire pull station will be done to ensure compliance with keeping area free from objects blocking the pull station.	Data on compliance from the observations for EP (9) and (10) will be collected to ensure ceiling tiles are replaced and fire pull stations are not blocked by objects as required by regulatory guidelines.	Observation data for EP (10) will be reported quarterly to the Safety Committee. Upon successful compliance with this regulatory requirement for 6 months, data will no longer be reported to the Safety Committee.	Director of Facilities	(10) Fire pull station area observation will occur once daily for 10 days of the month in April, May & June 2019. Data from the observations will be analyzed on a monthly basis and address appropriately to ensure compliance.	Completed
LS.02.01.35	EP6	Inspection of the sterile processing shelving rack will be done monthly as a part of the environment of care rounding by the perioperative staff to assure no items are stored within the 18 inch restricted area. This data will be reviewed by the DON Perioperative services, prior to sending to Safety committee.	If all storage items within the sterile processing area are stored at least 18 inches from the ceiling, the audit will reflect 100% compliance. Any item found within the 18 inch restricted space below the ceiling will constitute 0% compliance.	The data will be reviewed at the monthly safety meeting.	DON Perioperative services	Monthly as ongoing part of environment of care rounding in the sterile processing area. Will be required for minimum of 1 year with 100% compliance.	Completed
LS.02.01.35	EP14	The area around the fire extinguisher in the Operating Room will be inspected by the DON PeriOperative Services or Surgery Manager to ensure compliance with not placing any items within the defined line area on the floor in front of the fire extinguisher.	The data on compliance with not blocking the fire extinguisher will be collected from these inspections. The data collected will show staff compliance with adherence to not placing any item(s) in front of the fire extinguisher.	The data collected from the inspections completed in April through June 2019 will be reported on a monthly basis to the NIHD Safety Committee for review and analysis.	Director of Facilities	The area surrounding the fire extinguisher will be inspected on 10 days per month in the months of April, May and June of 2019.	Completed

STANDARD	EP	Ensuring Sustained Compliance	Data	Reported to:	Accountability	Time frame for monitoring	Comment
LS.02.01.70	EP6	Audit to ensure compliance that old trash can is not moved back to prior location next to linen hamper. The audit will be performed by the EVS workers in the PACU. (Gail B. and Susan K.)	Audit will identify that the smaller trash receptacle and soiled linen containers remain in place in the PACU per requirement.	This will be reported to the Nurse Executive Team at the end of the three month audit. Data will be stored by the Compliance Officer.	Director of Facilities	Three spot check audit monthly for three months	Completed
MM.04.01.01	EP1	Audit of PACU charts to assure PRN medications are given within the pain parameters as specified by MD/APP order. PACU staff RNs will participate in the audit process.	Percentage of accuracy will be reported based upon each dosage of PRN pain medication administered. Numerator = number of doses given correctly. denominator = total number of does given.	This will be reported to the Nurse Executive Committee at the completion of the audit. Data will be stored by the Compliance Officer.	DON Perioperative Services	100% of PACU charts will be audited April 15 to 30th. Then 10 charts per month x 3 months.	Completed
MM.05.01.01	EP4	On an ongoing basis order sets are reviewed annually at Pharmacy and Therapeutics Committee. (Routine process in place for NIHD.) Education of PACU RNs, Surgeons and Anesthesia Providers on changes to familiarize them with new order set completed by DON Perioperative Services and PACU Manager.	Data is not collected, but rather each order set is reviewed and updated as necessary.	Annually to the P&T committee.	Director of Pharmacy	Annual order set review occurs for all order sets at NIHD via P&T committee, which meets every two months throughout the year.	Completed

STANDARD	EP	Ensuring Sustained Compliance	Data	Reported to:	Accountability	Time frame for monitoring	Comment
MS.06.01.05	EP9	The peer review files (green folders) will contain copies of the peer review conducted. This will then be available to medical staff leaders during the re-credentialing period. Three random files will be selected and surveyed at each mock survey. Success will be such that all three randomly selected files contain evidence of the peer review data conducted from the previous OPPE cycle and the current OPPE cycle (as given by the date the mock survey is conducted).	Data on peer review conducted over the prior year will be assessed by the medical staff office personnel.	This audit will be reviewed at the Medical Executive Committee as a part of closed session during the May and August meetings.	Medical Staff Coordinator	the auditing of Allied Health Professional files will occur. Each survey will contain 3 provider files. Monitoring will occur in April 2019 and June 2019. If all files audited at both mock surveys are accurate, monitoring will end. If any file does not contain evidence of the peer review conducted, it will be corrected and a third mock survey will be conducted in January 2020. Mock surveys will end when the randomly-selected files are accurate for two consecutive mock	Completed
PC.02.01.11	EP2	Audit process developed to check emergency equipment check list for documentation of the Broselow lock number.	Numerator will be the number of times the Broselow lock number is documented in the month. Denominator will equal 2 shifts per day x number of days in the month. The expectation is twice daily check by nursing team members in the Emergency Department. Audit will be continued until 3 months of 100% compliance is achieved.	Data will be reported to the ED Nursing team by the Manager at monthly meetings AND to the Nurse Executive Committee quarterly until audit has demonstrated compliance at 100% for 3 months.	CNO	Spot checking will be done by the Manager & Assistant Manager 2-3 times per week to assure staff is compliant with equipment checks. Monthly audit will be completed to determine ultimate compliance level.	Completed

STANDARD	EP	Ensuring Sustained Compliance	Data	Reported to:	Accountability	Time frame for monitoring	Comment
PC.02.02.01	EP29	the CAH coordinates the patient's care, treatment, and services based on the patient's needs	for CAH with swing beds: The CAH follows its policy identifying circumstances when loss of or damage to a resident's dentures is the CAHs responsibility and it may not charge a resident for the loss or damage of dentures.	This audit will be completed by the Clinical Informatics Department, under the leadership of Robin Christensen, BSN, RN. Results will be provided to the Nurse Executive Committee monthly until audit is completed, minimum of two months.	CNO	5 swing patients will be audited each month, for a minimum of two months and until 100% of swing patients audited for each one-month period prove to meet expectation of the acute admission and the swing admission being separate, independent charts under separate visit ID numbers.	Completed
RC.02.01.01	EP2	Audit of charts with acute care stay and swing stay to see if each is under separate visit numbers.	The numerator will be the number of swing visits that are separated visit ID number charts. The Denomenator will be the total number of swing visits audited.	This audit will be completed by the Clinical Informatics Department, under the leadership of Robin Christensen, BSN, RN. Results will be provided to the Nurse Executive Committee monthly until audit is completed, minimum of two months.	CNO	5 swing patients will be audited each month, for a minimum of two months and until 100% of swing patients audited for each one-month period prove to meet expectation of the acute admission and the swing admission being separate, independent charts under separate visit ID numbers.	Completed

STANDARD	EP	Ensuring Sustained Compliance	Data	Reported to:	Accountability	Time frame for monitoring	Comment
TS.03.02.01	EP3	Audit to ensure compliance . Monthly the tissue / bone graft log book will be reviewed by Danielle, Scrub Tech, and an assigned Surgery staff member to ensure the log entries are complete	Numerator will equal the number of tissues added or removed with each required item correctly entered. Denominator will equal the number of tissue added or removed in total. This data will be utilized to demonstrate staff compliance with the required process.	The data will be reported to the surgery staff monthly AND the Nurse Executive Committee quarterly. Upon meeting 3 consecutive months of 100% compliance audit will be discontinued.	DON Perioperative Services	Monthly audit will be done by Danielle Medeiros, Scrub Tech, and surgery staff member to assure log entries are complete. Data will be analyzed monthly.	Completed

Attachment G

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
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March 27, 2020

Jan Hami, District Manager
State of California, Department of Industrial Relations
Division of Occupational Safety and Health
Fresno District Office
2550 Mariposa Street, Room 4000
Fresno CA 93721

Complaint No. 1550735

Dear Ms. Hami,

Northern Inyo Hospital received notice of a complaint to the Division of Occupational Safety and Health on March 13, 2020. Northern Inyo Healthcare District (NIHD) takes this complaint very seriously. The safety of our workforce and workplace is of the utmost importance.

Due to the current COVID-19 pandemic, an email request was sent to Laboratory and other personnel regarding concerns with the incinerator "smell." We received several emails voicing concerns over the smell in the work areas of the Laboratory. The concern was originally brought to our attention in the March 4, 2020 daily safety huddle. We had also previously investigated the concern when brought to our attention by DOSH in 2018. The complaint investigated by the District, at that time, was found to be unsubstantiated.

While we have investigated the complaint and are providing documents to address the noted concern, NIHD has made the decision to stop using the incinerator. The incinerator use has always been consistently well below allowed amounts, and burned during times that are outlined by regulation (school not in session, no outdoor field areas in use by sports teams, etc.). However, following complaints voiced by employees, we requested, received, and executed a quote for the medical waste company that picks up other waste to retrieve the pathological waste for disposal off-site.

The complaint Code Section and Alleged Condition(s):

1. GISO: 3203 (a)(6) The fumes of the medical waste incinerator are entering the work areas when in use.

We have investigated the alleged condition.

1. The air intakes for both the Support Building and the Main Hospital are 33.8 meters and 45.7 meters, respectively, and any plume is well dispersed before reaching that distance.
2. NIHD incinerates between 10-50 pounds of pathological waste on the burn days, usually Saturdays or Sundays. This creates a rolling annual weight of approximately 0.45 tons, well below the annual limit of

Northern Inyo Healthcare District

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10 tons permitted by the Great Basin Unified Air Pollution Control District Permit to Operate Conditions (Condition 3).

3. NIHD has burned only pathological waste since October 2017.
    a. Email sent to approximately 50 employees resulted in 3 concerns raised regarding the smell in the Support Building – Lab.
4. GISO: 3203 (a)(6) Illness and Injury Prevention Program – "Include methods and/or procedures for correcting unsafe or unhealthy conditions, work practices and work procedures in a timely manner based on the severity of the hazard:"
    a. The attached NIHD Injury and Illness Prevention Program includes methods and procedures for timely correction of unsafe or unhealthy conditions, work practices and work procedures, based on severity.

Please see attached supporting documents.

1. Facility maps and architectural drawings demonstrating location of incinerator, Support Building air intake and air intake 2 (M2.3.1) on the Main Building, which are the two closest air intakes. (Attachment A, 3 pages)
2. Photographs of the incinerator exhaust stack relative to the air intake of the Support and Main buildings. (Attachment B, 3 pages)
3. State of California Department of Public Health, Medical Waste Management Program Permit for Medical Waste Management, Permit No. P-426, expires 11/16/2020. (Attachment C, 1 page)
4. County of Inyo CUPA (Certified Unified Program Agencies) permit to operate a Hazardous Materials facility in Inyo County, valid March 2020 (Attachment D, 2 pages)
5. Great Basin Unified Air Pollution Control District, Permit to Operate (229-00-06) and 4 pages of Conditions for Approval. This permit is issued upon inspection every three years, and is renewed upon payment of fees annually. (Attachment E, 7 pages)
6. Injury and Illness Prevention Plan (Attachment G, 7 pages)
7. Medical Waste Management Plan 2020 (Draft with incinerator references removed) (Attachment H, 17 pages)
8. Great Basin Annual Burn Report 2019 (Attachment I, 1 page)
9. Incinerator Burn Log through final burn on March 12, 2020. (Attachment J, 4 pages)
10. California Environmental Protection Agency Air Resources Board Certificate of Completion for Danny Webster, 270: Incinerators. (Attachment K, 1 page)
11. Mediwaste Disposal Service signed agreement (Attachment L)
12. Photo of locked outdoor area where locking freezer will be placed (Attachment M)

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NIHD will no longer use the incinerator; however, date of removal has not been determined due to the COVID-19 pandemic and associated restrictions.

Please let me know if I can be of any further assistance in this matter.

Sincerely,

Patty Dickson, *CHC, CHPC, BA - HCM, CNMT*
Compliance Officer
Office: 760-873-2022
Northern Inyo Healthcare District | 150 Pioneer Lane | Bishop, California 93514
Patty.Dickson@NIH.org

June – ED and Disaster (Gina/Jenny)
Policies for Board Review

Page 1 of 4 (78 items) « < 1 2 3 4 > »

Type	Title
W	Bite Guidelines, Animals
W	Code Blue (Cardiac Arrest) Documentation
W	Communicable Disease Prevention Of Pre Hospital Care Worker
W	Computer Downtime Emergency Department
W	Computer Interface Down Time Emergency Department
W	Consent for Medical Treatment
W	Coroner's Cases
W	Dead on Arrival*
W	Dental Emergencies in the Emergency Department
W	Disaster Management Committee
W	Discharge Instructions Emergency Department
W	Discharge Planning for Homeless Patients
W	ED: Initiation of Buprenorphine in the Emergency Department
W	Emergency Department Level of Care Assessment
W	Emergency Department Telephone Advice Information
W	Emergency Medical Screening of Patients on Hospital Property
W	Emergency Medication and Code Blue Crash Cart Policy
W	Emergency Medication Trays Policy
W	Emergency Room Overcrowding
W	EMTALA Policy

Page 2 of 4 (78 items) « < 1 2 3 4 > »

Type	Title
W	Entering an ED Admission (observation, surgery, inpatient status) into Health Information System
W	Evaluation and Medical Screening of Patients Presenting to the Emergency Department
W	Evaluation of Pregnant Patients in the Emergency Department
W	Handling of Infants/Fetus/Stillborns and Genetic Workup
W	In-House Transport of Ventilator Dependent Patients
W	Interfacility Transfer Guidelines
W	Intubation Tray Adult/Pediatric
W	Intubation Tray Infant
W	Iron Dextran (Imferon) Administration
W	Latex Precautions
W	Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
W	Legal Blood Alcohol Intake Form Completion of the
W	Lidocaine Anesthetic For Local Infiltration Prior To Peripheral Catheter Placement
W	Medication Reconciliation
W	Medications Emergency Department
W	Mentally Ill Patients Detention of
W	MICN Guidelines
W	Myocardial Perfusion Stress Test: Nuclear
W	Neupogen / Procrit Administration
W	NPO Guidelines

Page 3 of 4 (78 items) « < 1 2 3 4 > »

Type	Title
W	Nursing Care of Outpatient Interventional Radiology Patient
W	Nutritional IV
W	OmniCell Automated Dispensing Unit (ADU)
W	Oxygen Therapy
W	Pap Smear Specimen Handling and Collections
W	PAPR Respirator Inspection Record
W	Patient Valuables and Personal Effects in the Emergency Room
W	Patient Warmer (Warm Air Hyperthermia System)
W	Patients Under the Influence of Drugs Management of
W	Pediatric Order Verificaton Overnight
W	Pentax Emergency Bedside Intubating Laryngoscope
W	Photo Documentation Policy
W	Physician Orders Thrombolytic Therapy for Acute Ischemic Stroke with Alteplase
W	Physician Request for Consult
W	Poison and Drug Overdose Information
W	Portacath Vascular Access System
W	Potassium Intravenous Administration
W	Pregnancy Loss Specimens
W	Pre-Hospital Care Policy
W	Propofol Use In Critical Care Areas

Page 4 of 4 (78 items) « < 1 2 3 4 > »

Type	Title
W	Quality Assurance Review Daily Chart Review
W	Quality Improvement Program Pre-Hospital
W	Quality Management Program Emergency Service
W	Radiation Policy for Management of Patients with Excessive Exposure
W	Recommendation for Prophylaxis After Occupational Exposure to HIV
W	Removal of Placenta from Hospital per Patient's Request
W	Responding to Ventilator, BiPAP, Vapotherm, EtCO2 and SpO2 Alarms
W	Resuscitation Quality Improvement (RQI)
W	Safely Surrendered Baby Policy and Procedure
W	Saline Lock For Blood Draw
W	Scope of Service for the Emergency Department
W	Sexual Assault Exam Policy*
W	Standardized Procedures for Medical Functions in the Emergency Department
W	Thrombolytic Therapy Focus Review
W	Thrombolytic Therapy for Acute Myocardial Infarction
W	Transfer of Evidence
W	Trauma Patient Care in the Emergency Department
W	Warming Cabinet for Blankets/Solutions