Northern Inyo Hospital

June 16 Regular Meeting

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AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
June 16th, 2021 at 5:30 p.m.

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***: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. New Business:

   A. NIHD and Inyo County Covid-19 update (*information item*).

   B. Cerner Project Update *(information item)*

   C. Colombo Construction Project Update *(information item)*

   D. 2021 NIHD Strategic Plan Presentation *(action item)*

   E. Policy and Procedure approval, *Password Policy (action item)*

   F. Policy and Procedure approval, *Cell Phone Procurement and Issuance (action item)*

   G. Policy and Procedure approval, *Lost and Found Items (action item)*

H. Policy and Procedure approval*, Environmental Services Radio Procedure (action item)*

I. Policy and Procedure approval*, Development Review and Revision of Policies and Procedures (action item)*

J. Compliance Department Quarterly Report, *(action item)*

K. Approval of District Board Resolution 21-05, Appropriations Limit (action item)

L. Board Meeting Venue Discussion *(discussion item)*

4. Chief of Staff Report, Sierra Bourne MD:

A. Medical Staff Appointments *(action item)*
1. Kevin Efros, MD (*anesthesiology*) – Active Staff
2. Michael Santomauro, MD (*urology*) – Courtesy Staff
3. Andrew Tang, MD (*internal medicine/hospitalist*) – Courtesy Staff

B. Change in Staff Category (*action item*)
1. Michael Phillips, MD (*emergency medicine*) – change from Active Staff to Honorary Staff

C. Policies and Procedures (*action items*)
1. *Dilation and Curettage or modified suction curettage procedures in the Emergency Department*
2. *Bloodborne Pathogen Exposure Control Plan*
3. *Nursing Care Guidelines in the PACU*
4. *Local Anesthesia in Surgery*
5. *PACU Discharge Criteria*
6. *Pathology Specimens in the Operating room*
7. *Patient Warmer (Warm Air Hyperthermia System)*
8. *Standards of Care in the Perioperative Unit: Pediatric Patient*
9. *Preoperative Preparation and Teaching*
10. *Scheduling Surgical Procedures*
11. *Scope of Service PACU*
12. *Sponge, Sharps, and Instrument Counts*
13. *Surgery Equipment and Routine Supplies*

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

Consent Agenda (action items)

5. Approval of minutes of the May 19 2021 regular meeting
6. Financial and Statistical reports as of April 30 2021

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7. NIHD Committee updates from Board members (*information items*).
8. Reports from Board members (*information items*).
9. Adjournment to Closed Session to/for:

6/11/2021, 1:44 PM

A. Conference with legal counsel, existing litigation (*pursuant to Gov. Code 54956.9(d)(1)*). One case: NIHD v. SMHD.

B. Conference with legal counsel, anticipated litigation. Significant exposure to litigation (*pursuant to paragraph (2) of subdivision (d) of Government Code Section 54956.9*) three cases.

C. Conference with legal counsel, existing litigation (*pursuant to Gov. Code Section 54956.9 (d)(1).*

10. Return to Open Session and report of any action taken (*information item*).
11. 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.

6/11/2021, 1:44 PM

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Password Policy**	
Scope: District Wide	Department: **District Information Security**
Source: Director of Information Technology Services	Effective Date: 4/14/2021

PURPOSE:

Passwords are an important aspect of computer security. They are the front line of protection for user accounts. A poorly chosen password may result in the compromise of NIHD's entire network. As such, all NIHD workforce members including but not limited to- employees, members of the Board of Directors, contractors and vendors with access to NIHD systems are responsible for taking the appropriate steps, as outlined below, to select and secure their passwords.

The purpose of this policy is as follows:

1. To establish a standard for creation of strong passwords
2. To establish a standard for the protection of those passwords
3. To establish a standard for the frequency of change of those passwords.

SCOPE:

The scope of this policy includes all NIHD workforce members (as described above) who have or are responsible for an account (or any form of access that supports or requires a password) on any system that resides at any NIHD facility, has access to the NIHD network, or stores any non-public NIHD information.

POLICY:

1. All passwords must be changed every 90 days.
2. Password history will remember the last 3 passwords that cannot be reused.
3. Accounts will be locked out after 8 failed attempts to prevent password spraying attempts.
4. Passwords must not be inserted into email messages or other forms of electronic communication.
5. All user-level and system-level passwords must conform to the guidelines described below.
    a. Password must contain a minimum of 8 characters and maximum of 15 characters
    b. Passwords must contain a combination of capital and lowercase letters ,numbers and symbols
    c. Passwords should not contain easily recognizable words (i.e. Bishop, Inyo, NIH)
    d. ***Password exception for DMS***– Passwords can **only** contain capital or lowercase and not in combination. Example – "TgAgm487&" the password would have to be "tgagm4878&" or "TGAGM4878&"
6. Passwords are not to be shared with anyone, including administrative assistants.
7. If a password is suspected to have been compromised, report the incident immediately to the Information Technology Services Department or the District Information Security Officer.
8. NIHD workforce members cannot use the same password for NIHD accounts as they use for other non-NIHD access (e.g., personal ISP account, shopping sites, benefits, etc.).
    a.) If an employee's NIHD account(s) is compromised the ITS department will then investigate the public password breaches to verify that an employee's password(s) are not in the public domain.
    b.) During an investigation of a security breach an employee may be asked - do you use the same password for any other accounts whether private or public?
9. NIHD workforce members cannot use the "Remember Password" feature of applications (e.g., Internet, Outlook OWA, etc.).

REFERENCES:

1. HIPAA Security - Security Awareness and Training Standard 164.308(a)(5)(ii)(D)
   NIST SP: 800-118, 800-12, 800-82 Rev 2, 800-53 Rev 4, 800-63-2, 800-66 4.5.3

CROSS REFERENCE P&P:

1. Password Management

Committee Approval	Date
Executive Team	4/5/2021

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Password Policy**	
Scope: District Wide	Department: **District Information Security**
Source: Director of Information Technology Services	Effective Date: 4/14/2021

Board of Directors	5/20/2020
Board of Directors Last Review	5/20/2020

Developed: 1/1/2004
Reviewed:
Revised: 6/3/2019 bh
Supersedes: Password Policy
Responsibility for review and maintenance: District Information Security Officer
Index Listings:
NIST Guidelines- https://pages.nist.gov/800-63-3/sp800-63b.html

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Cell Phone Procurement and Issuance	
Scope: District Wide	Manual: Information Technology
Source: Information Technology	Effective Date:

PURPOSE: Northern Inyo Healthcare District obtains and manages cell phones for use by district staff members in order to maintain appropriate privacy for hospital communications. This policy is to outline the process for issuance of cell phones to meet the needs of the hospital team.

POLICY:

1. **Northern Inyo Healthcare District has outlined cell phone usage policies as defined in the referenced policies below. The purposes of this policy is to assure the compliance of all team members regarding the procurement and issuance of cell phones.**

PROCEDURE:

1. Approved Cell Phones are requested by the manager of the staff member by submitting an IT (Information Technology) Service Desk request.
2. IT orders, manages and configures all smart phones.
3. Accounting reconciles the new phone charge to the monthly statement and completes the Purchase Order process.
4. Managers or Human Resources returns all phones to IT for re-deployment and updating of cost center information through the Verizon management console by either suspending the service as required by the carrier or reissuing to a new user. All phones returned must have the screen lock pin disabled before returning.

REFERENCES:

1. N/A

CROSS REFERENCE P&P:

1. Hospital Cell Phone Use
2. Hospital Issued Cell Phone/Electronic Communication Device Use By Employees

Approval	Date
NCOC	6/2/2021
Executive Committee	6/7/2021
Board of Directors	
Board of Directors Last Review	

Developed: 5/21kp
Reviewed:
Revised:

draft

Title: Cell Phone Procurement and Issuance	
Scope: District Wide	Manual: Information Technology
Source: Information Technology	Effective Date:

draft

NORTHERN INYO HEALTHCARE DISTRICT
PROCEDURE

Title: Lost and Found Items	
Scope: District Wide	Manual: Admissions Services
Source: Admission Services Manager	Effective Date:

PURPOSE: Northern Inyo Healthcare District will make reasonable attempts to safeguard patient and staff personal belongings and to assist in their recovery when loss or misplacement claims are made in order to reunite lost and found items with their owners.

PROCEDURE:

1 Found Items

A. Attach identifying information to the article:
1. Name
2. Date
3. Location lost and found
4. Patient/visitor or employee information, if known
5. Other pertinent information

2. Items to be turned in
1. Give items to admitting office
2. Admitting staff will put in lost and found box
3. Admission Services Department will check box every day and pick up any item(s)
4. If Admission Services Department is out of the hospital an alternate will be assigned to pick up item(s) and log item(s) in

3. Item(s) logged in and ID Number Given
1. The Admission Services Department will attempt to contact the owner

4. The Admission Services Department will:
1. Hold the item for 90 days; if unclaimed then
2. Disposal would then be,
a. Donate to a Thrift store, or
b. Offer to finder

5. Reporting Lost Items

A. When a patient believes that the hospital has misplaced an item that needs replacing, the Community
Relations Department will:
1. Assess the hospital's responsibility with hospital administration and
2. Replace the item, if appropriate

B. Calls regarding lost item(s)
l. Take information about lost item from caller
2. Check lost and found, if not found
3. Do a search of the area were items was said to be lost
4. Found item(s) will be entered into log and owner contacted

DOCUMENTATION:

The Community Relations log of lost and found items shall document:

Draft

NORTHERN INYO HEALTHCARE DISTRICT
PROCEDURE

Title: Lost and Found Items	
Scope: District Wide	Manual: Admissions Services
Source: Admission Services Manager	Effective Date:

1. Name of person, if known
2. Description of Item(s)
3. Date found and /or date lost
4. Name of reporting party
5. Location item(s) lost/found
6. Actions taken to find item(s)owner
7. Final disposition

REFERENCES:
1. N/A

CROSS REFERENCE P&P:
1. N/A

RECORD RETENTION:
1. N/A

Approval	**Date**
NCOC	6/2/2021
Executive Committee	6/7/2021
Board of Directors	
Last Board of Directors Review	

Developed:
Reviewed:
Revised: 6/21ta
Supersedes:

draft

NORTHERN INYO HOSPITAL
PROCEDURE

Title: Environmental Services Radio Procedure	
Scope: Environmental Services	Manual: Environmental Services
Source: MANAGER OF ENVIRONMENTAL SERVICES	Effective Date:

PURPOSE:
To provide constant communication within the E.S. Department and between the E.S. Department and other departments.

PROCEDURE:

1. Each employee will carry a radio throughout their shift.
2. Staff should radio out to the team they are here when they come on shift.
3. All conversations must be brief and each call must be responded to with a brief response.
4. Conversations should be kept discreet, including only vital information, over the radio.
5. Staff will turn on the radio, turn dial to channel #2 for ES Department, press the button on the side of the radio and wait two seconds before speaking, release button to hear the response.
6. If using the earpiece, hook the piece to ear and clip microphone to shirt. To respond to calls, press button on microphone wait two seconds before speaking and release button for response. If the earpiece or radio is not working, report it to the coordinator or manager.
7. At the end of the shift, turn radio off, disconnect ear piece, and dock the radio in the provided charger.

Approval	**Date**
NCOC	**6/2/2021**
Executive Committee	**6/7/2021**
Board of Directors	

Developed: 2/18/2017 AD
Reviewed:
Revised: 4/27/21 AS
Supersedes:

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Development, Review and Revision of Policies and Procedures	
Scope: District Wide	Manual: Administration
Source: Policy Tech Project Analyst	Effective Date:

draft

PURPOSE:

1. Policies and Procedures are developed to create a framework that describe and guide workforce in meeting the standards and expected action which have been adopted and approved by the Board of Directors of Northern Inyo Healthcare District (NIHD).
2. To provide direction on the required elements of policies and procedures and the required approval process.
3. To assist with determination on when to create a policy and when not to; to determine when a policy is essential and when it isn't.
4. Policy helps NIHD to accomplish its mission; maintain accountability; provide workforce and students with clear, concise tools; and clarify how the District does business.

POLICY:

NIHD workforce will have access to well-articulated and understandable policies and related procedures. These policies and procedures will be:

1. Presented in common format,
2. Formally approved,
3. Centrally maintained,
4. Kept current within the framework of an organized system of change control, and
5. Distributed to all relevant units in a timely manner.

DEFINITIONS

1. Clinical Consistency Oversight Committee (CCOC) – Multidisciplinary team, represented by clinical staff that reviews all clinical policies and procedures, once approved by CCOC, sends to appropriate medical staff committees and board of directors for final approval.
2. Forms – approve documents that are utilized for operations at the District. Stored on the NIHD Intranet and as attachments to procedures when appropriate.
3. Guideline – Statements that include recommendations intended to optimize patient care that are informed by a systematic review of evidence and assessment of the benefits and harms of alternative care options.
4. Policy – The clear, concise statements of the parameters by which an organization conducts its business. Policies are the rules that workforce abide by as they carry out their various responsibilities.
    A. Must be approved by governing body (Board of Directors) every 2 years at minimum.
5. Non-Clinical Consistency Oversight Committee (NCOC) – Multidisciplinary team, represented by non-clinical staff, operations team and clinical workforce, who review non-clinical policies and procedures. NCOC reviews and once approved sends policy on to other committees as appropriate prior to final approval at the board of directors.
6. Policy and Procedure Management Software (PPM) – Repository for NIHD policies and procedures, excluding the procedures in Lippincott Procedures. PPM allows for tracking of current and past policies and procedures, while maintaining access for workforce review.
7. Procedures – The instructions or steps that describe how to complete a task or do a job.

Title: Development, Review and Revision of Policies and Procedures	
Scope: District Wide	Manual: Administration
Source: Policy Tech Project Analyst	Effective Date:

   A. Clinical procedures require approval via the medical staff committee process; ultimately approved by the Medical Executive Committee.
   B. Lippincott Procedure Manual is utilized by NIHD for Clinical Procedures.
8. Protocols – An algorithm or recipe for managing a disease or condition. This sets a specific standard for process. (Example – wrist x-ray = 3 views)
   A. Require approval via medical staff committee(s) of departments where the protocol is utilized; ultimately approved by the Medical Executive Committee.
   B. Protocols followed by RN staff that cross from nursing into medical process require a standardized procedure per the California Board of Registered Nursing. These must be approved by the Interdisciplinary Practice Committee, Medical Staff Committee with department oversight and ultimately by the Medical Executive Committee
9. Workforce - Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Advanced Practice Providers (APPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.
10. Board of Directors Policy – Policy designed for organizational governance that sets direction for the District, defines and guides appropriate relationships between the board and the chief executive, and sets the duties and responsibilities of the board. These documents do not go to the NCOC or CCOC committees and are managed by the Board Administrative Assistant.

PROCEDURE:

1. Establishing need for a new policy or procedure:

   A. Determine a policy or procedure is necessary;
      I. When the cost of a mistake is high. (High Risk, High Volume or Problem Prone)
      II. When process is outside of common sense and must be prescribed.
      III. When consistent poor results across a number of departments or employees is demonstrated.
      IV. When required by regulatory agencies, including but not limited to: California Department of Public Health (CDPH), The Joint Commission (TJC), Title 22, or Centers for Medicare/Medicaid Service (CMS) Condition of Participation.

   B. Determine a policy or procedure is not necessary.
      I. Simple tasks that are able to done a variety of ways to achieve the same outcome.
      II. Processes that are able to be resourced via other manuals, such as One Source, Lippincott Procedure, etc.
      III. Guidelines are recommendations and although they may be adopted by clinical teams, they do not need to be approved at the Board of Directors level. They are generally created after studies lead to conclusion of best practice. They are not mandated as a policy. Clinical

draft

Title: Development, Review and Revision of Policies and Procedures	
Scope: District Wide	Manual: Administration
Source: Policy Tech Project Analyst	Effective Date:

Guidelines must be adopted by the Medical Staff Committee with oversight of the area where the Guideline is being utilized; ultimately approved by the Medical Executive Committee.
IV. Clinical procedures that are separated from policy may be contained within the District's Procedure Resource (Lippincott Procedures), which is based on best practice and updated routinely. This precludes the necessity of duplicate procedures in most instances. Critical notes are added within the Lippincott procedure to customize for NIHD practices. These must be approved via Medical Staff Committee, but do NOT require Board of Directors review or approval. Included in this document type are Standard Operating Procedures.

2. Policy/Procedure Development or Review/Revision

A. Policy owner or their designee (writer within PPM) may develop or review and update existing policy.

B. New policy development is done in *document>draft* within PPM by policy owner.

I. Policy Wizard is utilized to input policy title, owner, and department by policy owner and Approver. NCOC or CCOC will review the Policy Wizard at the time of approval to support the Policy Owner in making correct build, including assignee (reader group) and frequency of policy review by workforce and owners.
   a. Template is chosen based upon type of document.
   b. Search features are tied to Owner, Department, Writer, Template, Approver and Category.
   c. Writers, Reviewers and approvers are assigned by the Owner, with support and review by the NCOC or CCOC.

II. Research is conducted. Collaboration with subject matter experts and team members impacted by the policy or procedure is best practice during development. Collaborators may include but is not limited to:
   a. Compliance Officer
   b. Legal Counsel (with approval of Executive)
   c. Director of Human Resources
   d. Director or Chief within chain of command

III. References from valid sources and/or regulatory agencies is generally required. Occasionally "not applicable" (N/A) will be appropriate.

IV. Cross Reference P&P – requires review of policies or procedures that may impact the new policy being developed. These are listed as a reference to the end user and to assure the documents are aligned. Other cross reference documents can be located by use of key words via the search feature within PPM.

C. Revision or Review of existing policy or procedure in PPM:

I. Published document within PPM is opened.

draft

Title: Development, Review and Revision of Policies and Procedures	
Scope: District Wide	Manual: Administration
Source: Policy Tech Project Analyst	Effective Date:

II. Create New Version (blue box/top of screen) drop down list allows:
   a. All assignees - A user given the Assignee role can see all documents and assessment they're assigned to plus all published documents whose security is set to All Users.
   b. Administrators will have exclusive ability to Edit in Current State within published documents.
   a. Owners to Submit for Periodic Review or determine No Revision Necessary
   b. Task Completion by Proxy (Allows policy owner to assign a proxy author to create a specific document, access and edit all draft documents for the owner, request review of edited or newly written document by the owner, can assign review and approval process and can revise owner's documents in review or approval status-placing them back into draft status.)

III. Create New Version (blue box/top of screen) may be checked to create draft of current policy for revision. This does the following:
   a. Automatically archives the current published version upon final approval of the revised version
   b. Maintains current Property Wizard settings, unless revision of these settings is required
   c. Allows for revisions within the draft version

3. Template development

A. Policy Steering Committee will have authority to develop and approve new templates.
   I. Owners and writers may present ideas for new templates to the Policy Steering Committee, but may not create templates.
   II. Templates will have standardized information contained within the header.

B. Templates will be developed for various document types
   I. Policy/Procedure
   II. Standards of Care
   III. Guidelines
   IV. Protocols
   V. Standardized Procedures
   VI. Standard Operating Procedures
   VII. Committee Charters
   VIII. Clinical Guidelines

C. Policy and or procedure templates will contain some or all of the following elements:
   I. Purpose
   II. Policy Statement (All documents that contain policy MUST be initially approved and reviewed every two years by the Board of Directors.)
   III. Definitions

draft

IV. Procedural steps

V. Record retention and destruction
   a. California Hospital Association reference may be found on the NIHD Intranet>Information>Compliance>Record Retention.
   b. If record retention is not applicable (N/A) must be inserted within this section.
   c. Destruction of record – Confidential records and those with PHI will be shredded or destroyed in compliance with Information Technology Services standards.

VI. References are required using the American Psychological Association (APA) format.

VII. Cross-referenced policies
   a. Use “search” function within PPM to find key words.
   b. Review policies identified by search for potential cross-reference.
   c. Assure policies align with new policy/procedure; if not determine if further revision is required of either or both policy/procedure.

VIII. Header will Contain:
   a. Northern Inyo Healthcare District
   b. Document Type
   c. Title of Document
   d. Source (What part of the Workforce will utilize the document- all departments where the document applies)
   e. Owner of the document (title of the role)
   f. Department (of the document Owner)
   g. Effective date and version number for the document

IX. Page numbers for each page in every document.

4. Committee Approval Process

A. Clinical Policies/Procedures:

I. Clinical Consistency Oversight Committee (CCOC) is the first committee to review and determine if a clinical Policy/Procedure document is ready for approval. They make the following determinations:
   a. Frequency of required review/revision (if necessary)
   b. Assignee by role (who needs to read the document and how often.)
   c. Effective date time line is established to allow workforce education on policy/procedure new documents and for revisions of significance.
   d. Medical Staff Committee(s) referral for approval (Medical Staff Office builds committees into Property Wizard, sequenced by upcoming meeting dates). Final Medical Staff Meeting is Medical Executive Committee (MEC).
   e. Board of Directors review approval is required on all policy and procedure documents prior to implementation.
   f. Final approver, generally at Chief Executive level (may be a designee of the Chief).
   g. Clinical documents recommended for archival by owner must be approved by CCOC prior to archival.

draft

h. After final required approval by Board of Directors or MEC, the Nursing Administrative Assistant is responsible to assure the document is published.

B. Non-Clinical Policies/Procedures

I. Non-Clinical Consistency Oversight Committee (NCOC) is the first committee to review and determine if a Non-Clinical Policy/Procedure document is ready for approval. They make the following determinations:

a. Frequency of required review/revision (if necessary)
b. Assignee by role (who needs to read the document, how often and in what timeframe)
c. Effective date time line is established to allow for workforce education on policy/procedure new documents and for revisions of significance.
d. What other committee(s) need to review and approve the document prior to sending to the Board of Directors.
e. Board of Directors review approval is required on all policy documents prior to implementation and every two years.
f. Executive Committee review/approval is required on all procedure documents prior to implementation and every two years.
g. Non-Clinical documents recommended for archival by owner must be approved by NCOC prior to archival.
h. After final required approval via committees, the COO Administrative Assistant is responsible to assure the document is published.

C. Clinical Guidelines tools developed as best practice (generally utilized for specific diagnosis or situations).

I. Medical Staff Committee will approve Clinical Guideline for use within their department and assure education of peers.
II. Medial Executive Committee approval is required prior to implementation
III. Board of Director approval is not required.
IV. Frequency of review of Clinical Guideline will be determined at Medical Department level.

D. Board of Director policy and procedure will be developed and approved at the Board level.

I. Board may request Board Legal Counsel or Compliance review
II. Board Policy/Procedure will be maintained within PPM and the following will be established:

a. Frequency of required review/revision (if necessary)
b. Assignee by role (who needs to read the document, how often and in what timeframe)
c. Effective date time line is established to allow for workforce education on policy/procedure new documents and for revisions of significance.

5. Periodic Review of documents:

A. This is the responsibility of the document owner, who may delegate by assigning writer(s)

draft

Title: Development, Review and Revision of Policies and Procedures	
Scope: District Wide	Manual: Administration
Source: Policy Tech Project Analyst	Effective Date:

B. The PPM will be set up to notify the owner of items due for review or revision via email and task list within PPM. This process will be under the direction of the Policy Steering Committee.

6. Implementation and effective dates:

A. Workforce education to the new processes and polices must be considered when determining the effective date for each document.

B. During CCOC or NCOC approval process the following decision will be documented:
I. Effective date in relationship to final approval date. (Last Committee or Board of Directors required to approve document)
II. Is workforce required to read the new document? If so, what roles are required to read the document and how often.
III. Will a different education process be utilized to train workforce to the new document?

7. Discarding of documents versus Archival of document

A. Published documents are moved to archives when revised or if they become obsolete. This does require NCOC or CCOC approval for obsolete documents.
B. Draft documents that are found to be unnecessary may be discarded; becoming irretrievable. This may only be done by the policy owner or their designee and does not require committee approval.

8. General Information for document development for PPM.

A. Acronyms must be spelled out prior to being utilized in all documents.
B. May/must are preferred to use of should/shall.

REFERENCES:

1. Center for Medicare/Medicaid Services- **§485.627 Condition of Participation: Organizational Structure C-0241; Interpretive Guidelines §485.635(a)(2) & (4); -§485.627(a) Standard: Governing Body or Responsible Individual;** (Rev. 200, 02-21-20**).** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf
2. American Psychological Association (APA) Format web site: https://owl.purdue.edu/owl/research_and_citation/apa_style/apa_formatting_and_style_guide/general_format.html
3. California Hospital Record and Data Retention Schedule, 2018.

CROSS REFERENCE P&P:

1. Pathways for development, Review and Revision of Nursing Standards

draft

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Development, Review and Revision of Policies and Procedures	
Scope: District Wide	Manual: Administration
Source: Policy Tech Project Analyst	Effective Date:

RECORD RETENTION:
All policy, procedure, scope of practice, standards of care, care guidelines and bylaw documents will be maintained for the life of the document, plus 6 years.

Approval	**Date**
NCOC	6/2/2021
CCOC	6/1/2021
Executive Committee	6/7/2021
Medical Executive Committee	6/1/2021
Board of Directors	
Board of Directors Last Review	

Developed: 5/2021ta
Reviewed:
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Index Listings:

https://www.pnwu.edu/inside-pnwu/about-us/policies-and-procedures/procedure-policy-development-and-approval

draft

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

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
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Compliance Report
June 2021

1. **Compliance Department Team**
    a. The Compliance team is pleased to announce that Paige Wagoner has moved from the RHC to the Compliance Team. She is fantastic to work with and is already making great contributions.
    b. The Compliance team is also pleased to announce that Tracy Aspel returned from retirement as the Compliance Policy Project Analyst. Tracy is making great progress preparing the new software, our policies, and training for our leadership team.
2. **Comprehensive Compliance Program review –** no update since Annual Compliance Report of November 2020.
3. **Potential Breaches** and privacy concerns
    a. The Compliance Department has investigated 12 privacy concerns between January 1, 2021 and May 31, 2021.
        i. Investigations closed with no external reporting required – 7
        ii. Investigations still active – 2
        iii. Reported to CDPH/OCR – 3
            1. No determinations received from CDPH
    b. The Compliance Department has investigated 69 alleged breaches in CY 2020.
        i. Investigations closed with no external reporting required – 50
        ii. Investigations still active – 0
        iii. Reported to CDPH/OCR – 19
            1. 3 CDPH cases closed as substantiated without deficiencies
            2. 16 are pending determination by CDPH
    c. Outstanding breaches reported to CDPH between 2016-2019
        i. 2016
            1. 1 case is still in progress
        ii. 2017
            1. 15 cases are in submitted status
            2. 1 case is still in progress
        iii. 2018
            1. 9 cases are in submitted status

iv. 2019
   1. 3 cases are in submitted status
   2. 1 case is in progress

4. Issues and Inquiries

a. The Compliance Team researches regulatory concerns, ever-changing COVID regulations and guidance, and internal policy as requested by NIHD workforce.
b. Compliance has assisted with more than 50 research requests since the beginning of January 2021.

5. Audits

a. Employee Access Audits
   i. The HIPAA and HITECH Acts imply that organizations must perform due diligence by actively auditing and monitoring for appropriate use of PHI. These audits are also required by the Joint Commission and are a component of the "Meaningful Use" requirements.
   ii. Access audits monitor who is accessing records by audit trails created in the systems. These audits allow us to detect unusual or unauthorized access of patient medical records.
      1. The Compliance Department Analyst manually completes audits for access of previous patient information systems (Athena, Centricity, Paragon, Redoc, Orchard, etc) to ensure employees' access records only on a work-related, "need to know," and "minimum necessary" basis.
         a. Compliance performs hundreds audits monthly. **This will continue for the legacy systems as long as they are accessed.**
         b. Each audit ranges from hundreds of lines of data to thousands of lines of data.
         c. A "flag" is created when any access appears unusual.
         d. Flags are reviewed and resolved by comparison audits, workflow review, discussions with workforce, and discussions with leadership.
         e. See attachment A
   iii. Cerner has a more automated system for auditing. Cerner has a dashboard that displays the data the program monitors on an on-going basis.
      1. Compliance has a dashboard and can review flags for the following event types regularly

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a. User ID matches patient name
b. User has same last name as patient
c. Chart access is unusual pattern for user.
d. Excessive printing or excessive charts being opened for job role.

2. We have only had the new auditing software for two months, and so are still working on how to incorporate executive overview style reports for the Board of Directors. See some sample data
   a. attachment B

b. Business Associates Agreements (BAA) audit
   i. We currently have approximately 160 Business Associates Agreements.
   ii. We have executed around 1 BAAs since January 1, 2021.
c. Vendor Contract reviews
   i. 39 contracts currently in the review process
   ii. More than 100 agreements or contracts have been reviewed and executed since January 2021
d. PACS (Picture Archival and Communication System) User Access Agreements - No update since previous quarterly report
e. HIMS scanning audit – Deferred to Q3 CY 2021 to include Cerner EHR
f. Language Access Services Audit – Deferred to Q3 to ensure documentation in Cerner
   i. Audits for Language Access Services to ensure Limited English Proficiency (LEP) patients are provided with the appropriate access to ensure safe, quality healthcare.
   ii. Audits review documentation of language assistance provided to LEP patients
   iii. Action items from audits allow the Compliance team to work with Language Access Services Manager, Jose Garcia, to develop tools for the workforce to ensure all proper steps are followed.
   iv. Language Access regulations are enforced by the HHS Office of Civil Rights.
g. HIPAA Security Risk Assessment – Due November 2021 (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.

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            1. Periodic update and assessment to be completed in Q3 of CY2021 with system changes of EHR, Time keeping system, Employee badge process, and other technological update.
        ii. NIHD is now using 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.
            1. We have over 70 Vendor Companies registered.
            2. We have over 127 Representatives registered.
    h. 340B audit – Annual external audit and response plan in progress
    i. An audit of NIHD Board of Directors Agendas, Minutes, and Resolutions is in progress.

6. **CPRA (California Public Records Act) Requests**
    a. The Compliance office has responded to two CPRA requests to date in 2021.
7. **Compliance Workplan** - – no update since previous quarterly report
8. **Unusual Occurrence Reports** (UOR) - UORs have transitioned to the Compliance Department. ** We continue to update the confusing or missing labeling on the reports.
    a. See attached 2020 Summary of Unusual Occurrence Reports (14 pages)
        i. attachment C
    b. See attached Q1 CY2021 Summary of Unusual Occurrence Reports (14 pages)
        i. Attachment D
9. **Compliance Committees**
    a. Business Compliance Team
        i. 2021 Conflict of Interest (COI) questionnaires were distributed approximately 2 weeks ago.
        ii. We have received greater than 40% of completed questionnaires from our workforce
        iii. Business Compliance Team will be meeting no less than monthly until all conflicts of interest have been addressed.
    b. Billing and Coding Compliance Committee
        i. Sporadic meetings during the Cerner build and go-live. Has now been set for weekly meetings to address coding, provider enrollment, billing, productivity, coding audit information, new services or service lines and similar information
    c. Compliance and Business Ethics

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   i. Members of committee have been reassessed. Update to Compliance Program to the Board anticipated in July and then we will re-establish regular quarterly meetings.

10. 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. Tracy Aspel has compiled all of this information and we are hoping to bring the steering policy to the Board either in June or July.
   c. Tracy, Policy Project Analyst, has reviewed and updated more than 600 policies, ensured the correct version in correct formats are in both the currently published version and the version to be released later this year.
   d. Tracy has also provided one-on-one training for the policy software and policy writing with many new and no-so-new members of the District leadership team.

11. Optimization, update, and audit of Contract Management software

   a. Approximately 75% of active contracts have been updated to utilize additional features available in the updated software.
   b. Paige, Compliance Clerk, is working to update all contracts, standardize entries and include key data for the end users of the system.
   c. All historic contracts in the system will still be available for review.