Northern Inyo Healthcare District

Board Meetings

August 21, 2024 Regular Board Meeting

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

AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

August 21, 2024 at 5:30 p.m.

Northern Inyo Healthcare District invites you to join this meeting:

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

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

The Board is again meeting in person at 2957 Birch Street Bishop, CA 93514. Members of the public will be allowed to attend in person or via zoom. Public comments can be made in person or via zoom.

Board Member, David McCoy Barrett, will attend from 61 Yorkville Ave, Toronto, ON M5R 3V6 Canada, Room 711, via zoom.

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are **limited to three (3) minutes per speaker**, with a total time limit of thirty (30) minutes for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. New Business:
   A. Chief Executive Officer Report *(Board will receive this report)*
      1. Medical recruiting; ophthalmology, orthopedics, pediatrics

2. Strategic plan
3. Pharmacy project
4. Public Outreach/Marketing

B. Chief Financial Officer Report

1. Financial & Statistical Reports *(Board will consider the approval of these reports*)
2. Intergovernmental Funds (IGT) and cash flow
3. Budget preliminary (information item)
4. Service line analysis

C. Chief of Staff Report, Sierra Bourne MD

1. Medical Staff Initial Appointments 2024-2025 *(action item)*
   a) Amr Elmaghraby, MD *(Neurology)* – Telemedicine Staff
   b) David Lichtenfeld, MD *(Internal Medicine)* – Active Staff
2. Medical Staff Reappointments 2024-2025 *(action item)*
   c) Wanda Lam, MD *(General Surgery)* – Courtesy Staff
3. Proposed Medical Staff Bylaws Amendments 07/16/2024 (*action item)*
4. Medical Executive Committee Report *(information item)*

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4. **Consent Agenda -** *All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.*

A. Approval of minutes of the July 17, 2024 Regular Board Meeting

B. CEO Credit Card Statements

C. Approval of Policies and Procedures

1. Bulk Oxygen Systems
2. Cell Phone Procurement and Issuance
3. Collective Bargaining Agreement Disclaimer
4. Computer Screen Lock
5. Consent for Medical Treatment
6. Hiring Anniversary Date
7. Hiring Background Screening
8. Involuntary Leave of Absence
9. ITS Service Desk Work Order
10. Managing Biological Agents
11. Medical Gas Storage Rooms
12. Paid Absence
13. Cleaning procedures: Room/Building Components: Floor Care
14. Employee Attendance
15. Environmental Service Dress Code Policy

16. Identification Badges
17. Introductory Period
18. Roles and Responsibilities – Competency
19. Sanctions for Breach of Patient Privacy Policies
20. Minimum Necessary Access, Use and Disclosure of Protected Health Information (PHI)

D. General Information from Board Members (*Board will provide this information*)

E. Public comments on closed session items.

F. Adjournment to closed session to/for:

   1. Conference with Legal Counsel – Existing Litigation (Government Code §54956.9(d)(1)) Salazar Godina V. NIHD
   2. Discussion of trade secrets – Health and Safety Code §32106 and Civil Code §3426.1 (Information item only)

G. Return to open session and report on any actions taken in closed session.

H. Adjournment

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

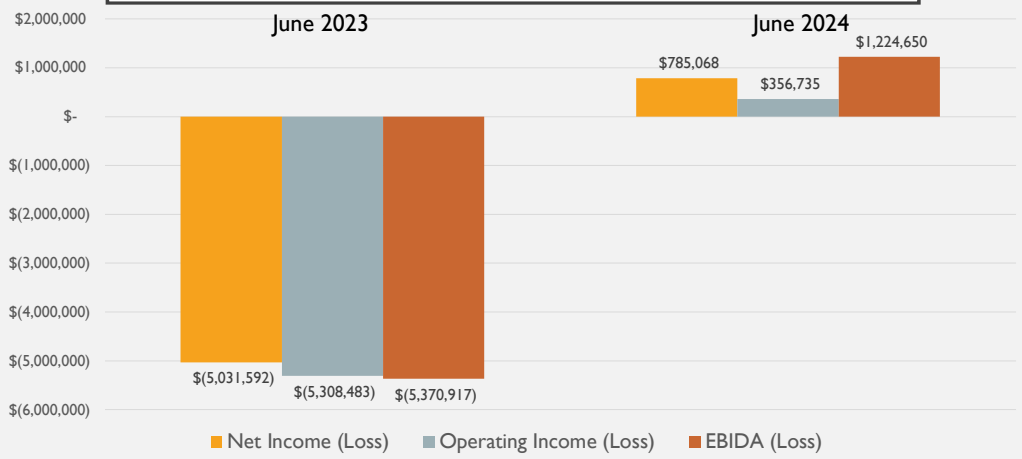
NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

NIHD FINANCIAL UPDATE

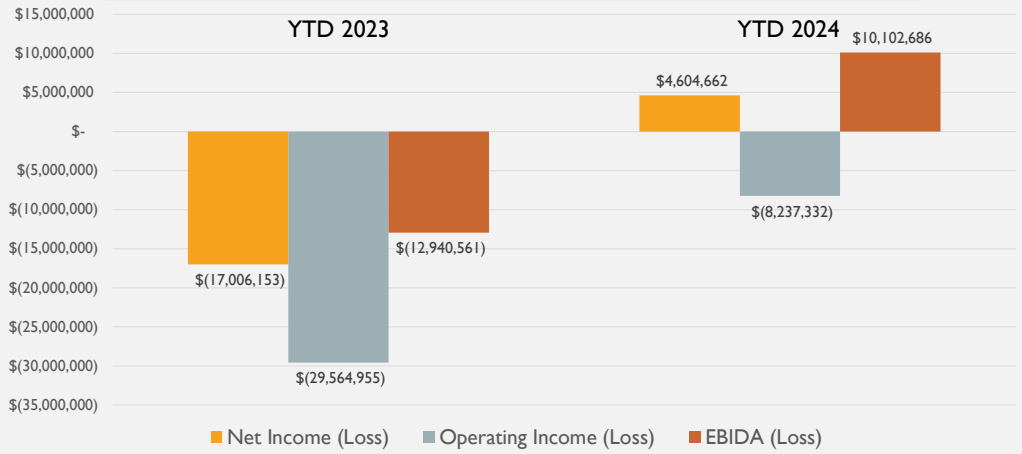
June 2024

INCOME

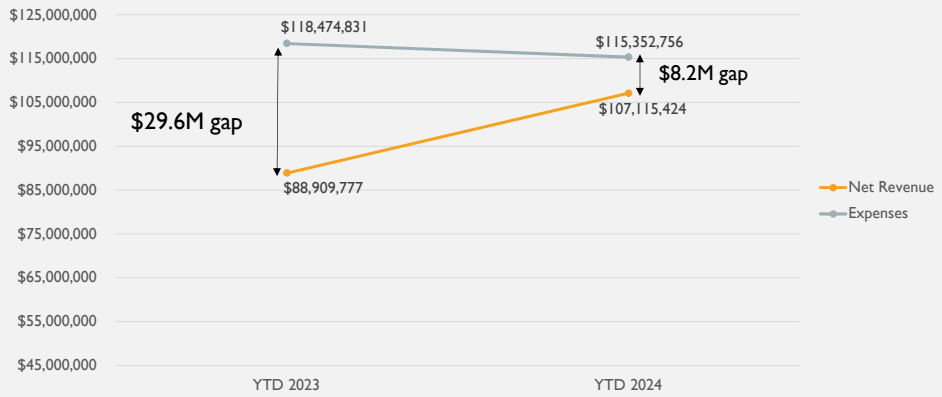
JUNE 2024 FINANCIAL PERFORMANCE



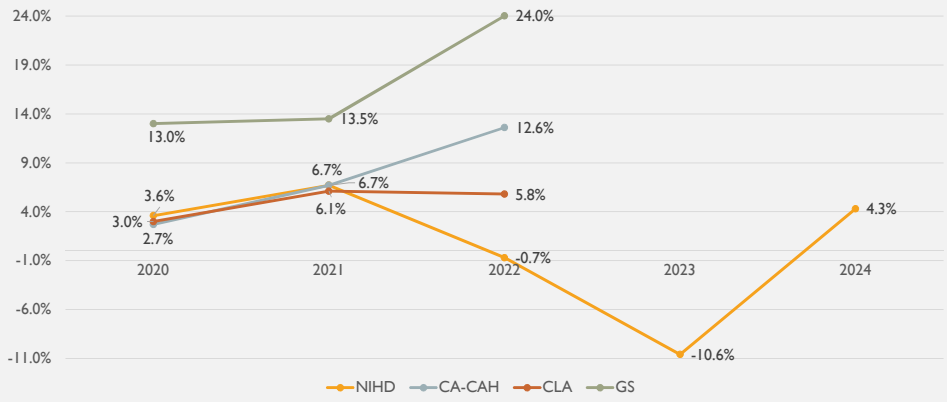
FYE 2024 FINANCIAL PERFORMANCE



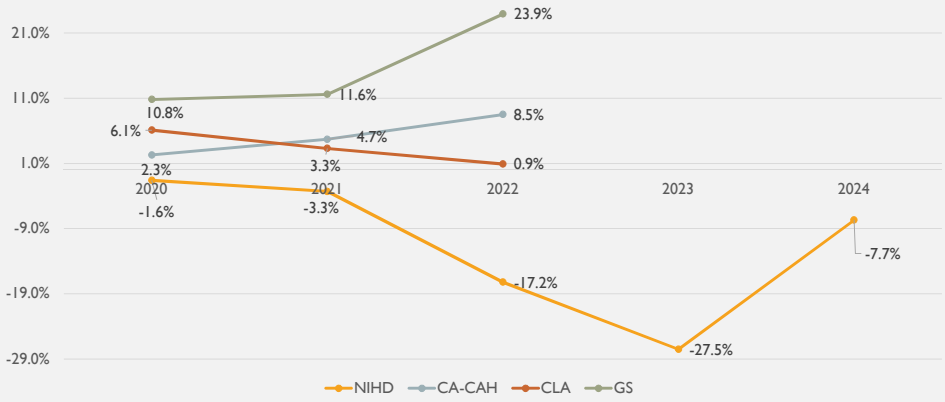
YTD OPERATING INCOME (LOSS) PERFORMANCE



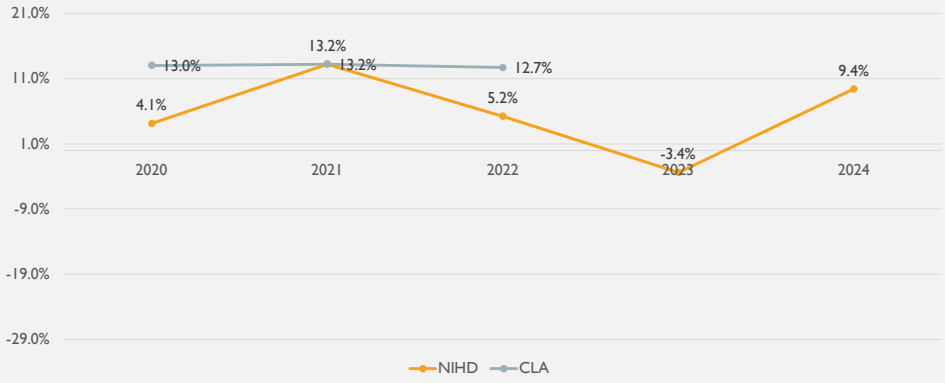
NET PROFIT MARGIN



OPERATING MARGIN

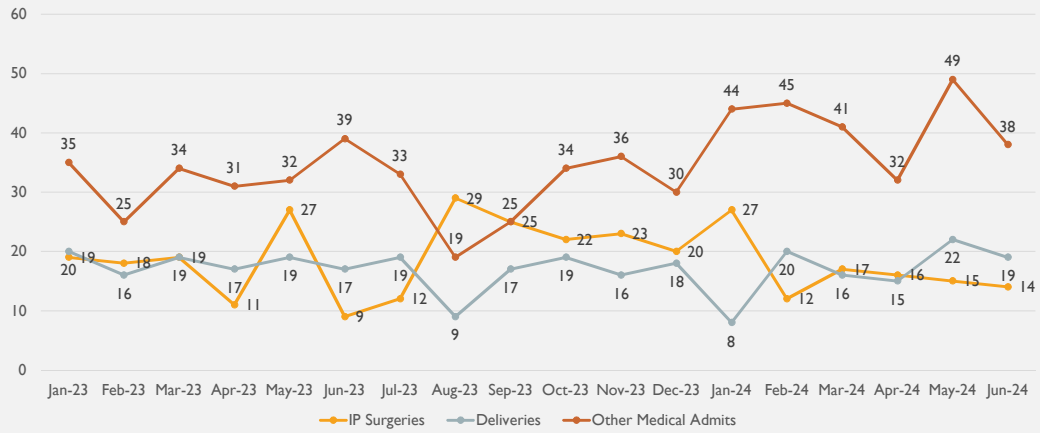


EBIDA MARGIN

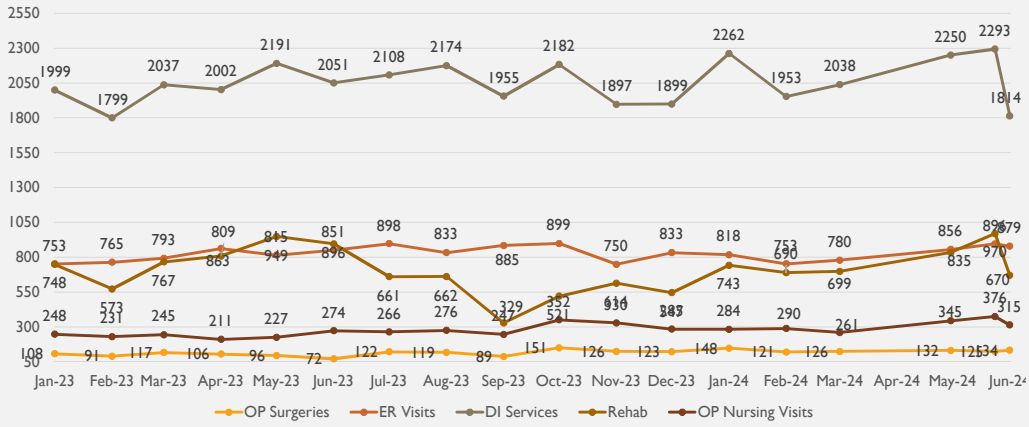


VOLUMES

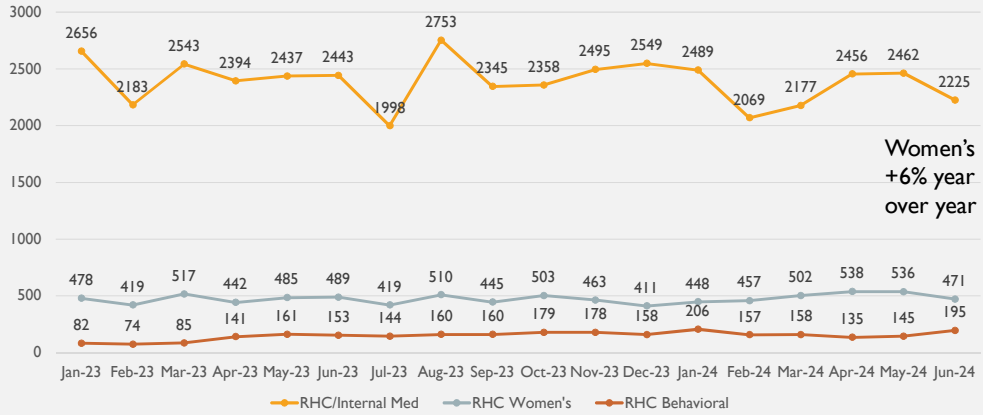
INPATIENT VOLUME PERFORMANCE



OUTPATIENT VOLUME PERFORMANCE

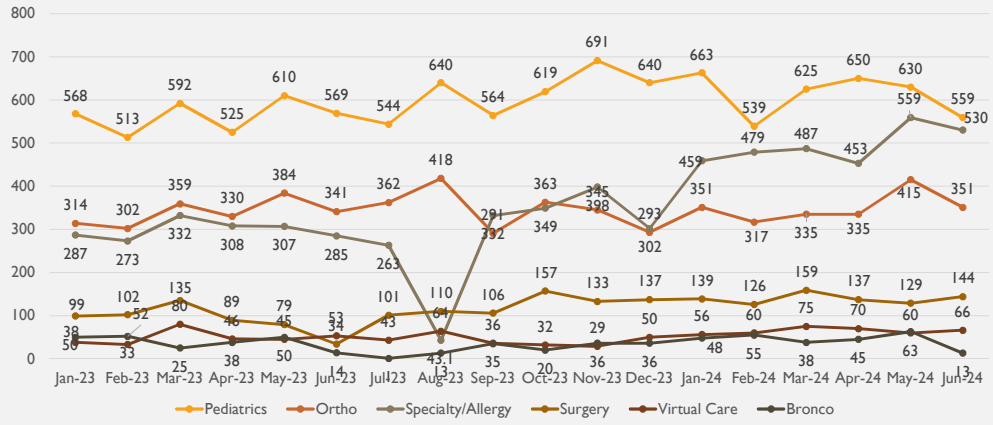


RHC VOLUME PERFORMANCE



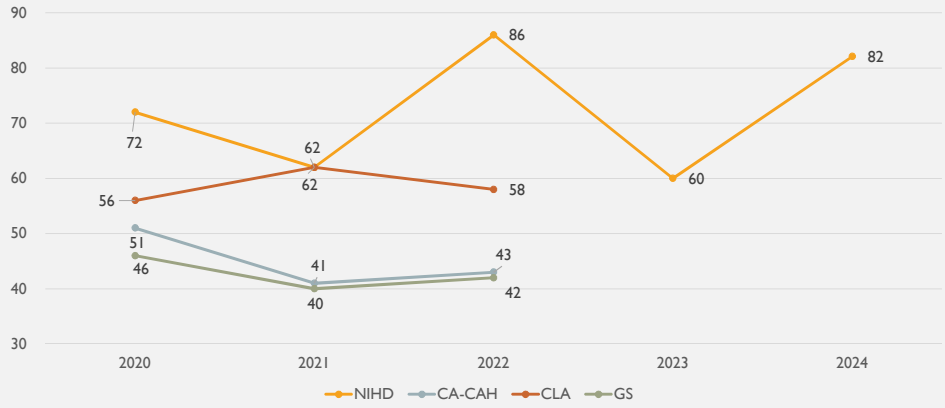
Women's +6% year over year

CLINIC VOLUME PERFORMANCE

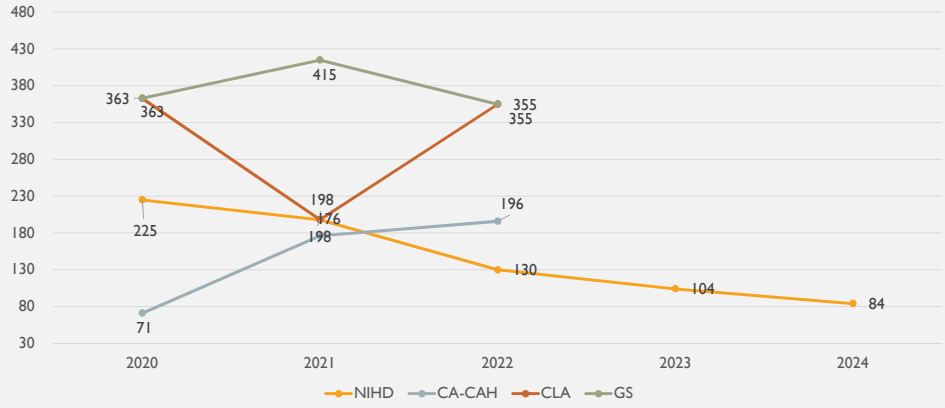


KEY PERFORMANCE INDICATORS

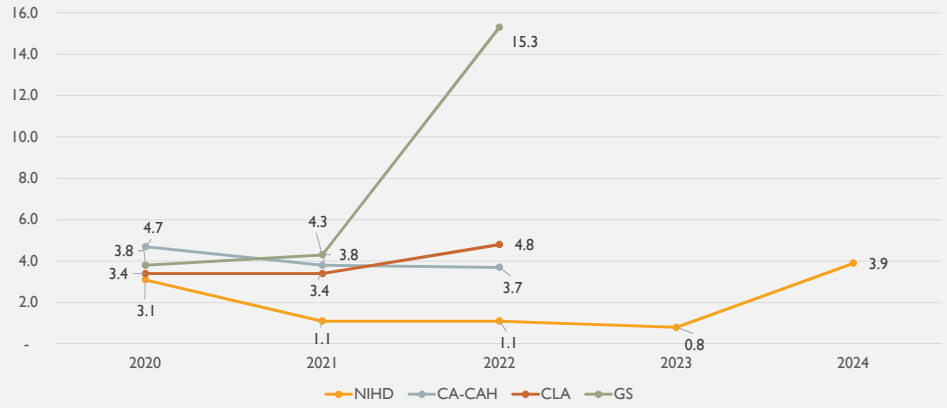
AR DAYS



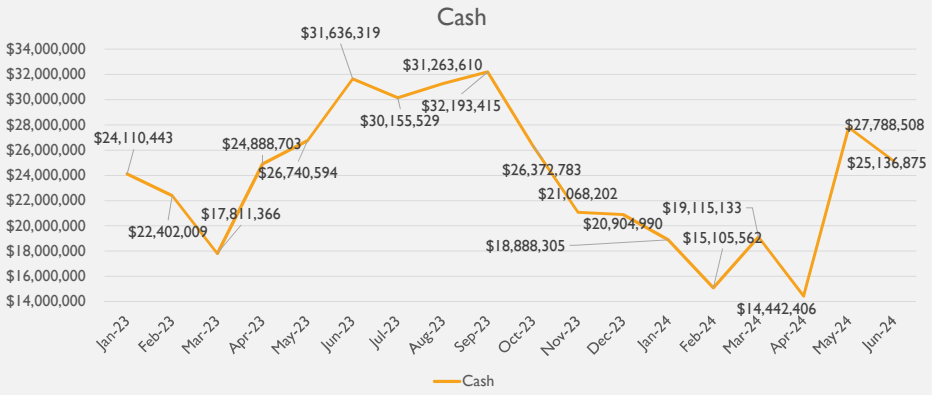
DAYS CASH ON HAND



DEBT SERVICE COVERAGE RATIO



UNRESTRICTED FUNDS



WAGE COSTS

	YTD 2023	YTD 2024	% Change
Total Paid FTEs	445	380	-15%
Salaries, Wages, Benefits (SWB) Expense	$60.2M	$57.6M	-4%
SWB % of total expenses	50%	51%	-1%
Employed Average Hourly Rate	$52.28	$43.29	22%
Benefits % of Wages	49%	70%	-21%

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2024

	3/31/2024	3/31/2023	4/30/2024	4/31/2023	5/31/2024	5/31/2023	6/30/2024	6/30/2023	2024 YTD	2023 YTD	PYM Change	PYTD Change
Gross Patient Service Revenue												
Inpatient Patient Revenue	3,740,981	3,633,689	3,215,615	2,295,049	3,646,287	3,261,629	2,799,611	2,123,257	41,353,814	36,784,193	384,658	4,569,621
Outpatient Revenue	11,921,652	12,610,463	15,650,478	12,236,228	14,890,447	13,355,732	13,848,705	12,723,066	166,032,671	145,867,603	1,534,715	20,165,067
Clinic Revenue	1,601,821	1,550,929	1,763,094	1,390,394	1,822,994	1,526,050	1,665,622	1,443,993	19,388,997	16,953,471	296,944	2,435,526
Gross Patient Service Revenue	17,264,454	17,795,080	20,629,186	15,921,672	20,359,728	18,143,411	18,313,938	16,290,316	226,775,482	199,605,268	2,216,317	27,170,214
Deductions from Revenue												
Contractual Adjustments	(15,144,877)	(9,900,790)	(10,525,952)	(8,452,990)	(9,761,982)	(8,271,575)	(9,150,988)	(7,565,721)	(112,228,375)	(94,029,030)	(1,490,407)	(18,199,344)
Bad Debt	4,239,262	525,913	131,776	(240,320)	(538,525)	(1,264,180)	(271,822)	(2,498,013)	(1,935,492)	(11,383,794)	725,655	9,448,302
A/R Writeoffs	(706,178)	(721,088)	(285,526)	(450,123)	(410,472)	(245,437)	(362,039)	(265,508)	(5,503,223)	(5,140,023)	(165,035)	(363,200)
Other Deductions from Revenue	-	38	53	(637,163)	-	-	-	-	53	(187,687)	-	187,741
Deductions from Revenue	(11,611,793)	(10,095,928)	(10,679,648)	(9,780,597)	(10,710,978)	(9,781,192)	(9,784,849)	(10,329,242)	(119,667,037)	(110,740,535)	(929,786)	(8,926,502)
Other Patient Revenue												
Incentive Income	-	-	-	-	-	-	-	-	-	-	-	-
Other Oper Rev - Rehab Thera Serv	-	5,396	-	929	3,163	696	-	-	6,979	45,044	2,467	(38,065)
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	-	5,396	-	929	3,163	696	-	-	6,979	45,044	2,467	(38,065)
Net Patient Service Revenue	**5,652,661**	**7,704,549**	**9,949,538**	**6,142,004**	**9,651,912**	**8,362,915**	**8,529,089**	**5,961,074**	**107,115,424**	**88,909,777**	**1,288,997**	**18,205,647**
CNR%	**33%**	**43%**	**48%**	**39%**	**47%**	**46%**			**47%**	**45%**	**1%**	**3%**
Cost of Services - Direct												
Salaries and Wages	2,677,613	2,511,015	2,792,227	2,962,848	2,867,100	2,543,864	2,586,924	4,693,942	33,072,822	30,249,481	323,236	2,823,341
Benefits	1,490,439	1,831,123	2,146,672	1,865,932	1,340,313	1,780,302	1,246,538	1,776,252	17,447,082	20,859,423	(439,988)	(3,412,341)
Professional Fees	1,976,553	1,716,884	1,780,229	1,923,375	1,979,333	1,615,480	1,925,702	1,814,698	21,672,034	20,550,740	363,853	1,121,294
Contract Labor	364,547	788,024	205,329	500,915	952,538	401,571	629,292	729,261	5,357,160	8,868,145	550,967	(3,510,986)
Pharmacy	442,678	333,474	656,870	224,919	400,601	(96,169)	869,201	781,308	5,832,893	3,870,316	496,770	1,962,576
Medical Supplies	642,449	485,465	352,626	466,240	345,474	324,135	(1,689,273)	(1,766,340)	3,485,151	2,663,746	21,339	821,404
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	(768,589)	160,195	16,399	147,652	17,826	330,555	135,492	435,979	393,606	2,282,482	(312,729)	(1,888,876)
Other Direct Expenses	834,238	651,545	571,418	530,520	562,883	495,250	681,482	520,929	7,981,583	7,188,017	67,633	793,566
Total Cost of Services - Direct	7,659,929	8,477,724	8,521,770	8,622,401	8,466,067	7,394,987	6,385,358	8,986,029	95,242,330	96,532,351	1,071,080	(1,290,021)
General and Administrative Overhead												
Salaries and Wages	494,737	458,763	547,877	520,721	444,697	426,210	446,557	797,424	5,601,993	5,197,574	18,487	404,419
Benefits	284,918	2,870,040	346,888	367,789	231,676	223,735	209,744	297,368	2,942,916	5,953,921	7,941	(3,011,005)
Professional Fees	451,329	260,367	153,271	403,951	222,585	525,104	348,376	634,797	3,061,845	4,169,234	(302,519)	(1,107,389)
Contract Labor	63,611	27,375	114,784	21,225	16,409	62,613	144,973	74,020	667,446	473,705	(46,204)	193,741
Depreciation and Amortization	1,264,318	341,803	438,198	326,475	447,841	337,294	439,581	339,325	5,498,024	4,065,591	110,547	1,432,433
Other Administative Expenses	258,954	163,103	336,216	182,837	175,162	202,135	197,765	140,594	2,338,203	2,082,264	(26,974)	255,938
Total General and Administrative Overhead	2,817,866	4,121,641	1,937,234	1,822,998	1,538,370	1,777,092	1,786,996	2,283,528	20,110,427	21,942,481	(238,722)	(1,832,054)
Total Expenses	**10,477,795**	**12,599,365**	**10,459,004**	**10,445,400**	**10,004,437**	**9,172,079**	**8,172,354**	**11,269,558**	**115,352,756**	**118,474,831**	**832,358**	**(3,122,075)**
Financing Expense	345,952	180,509	197,249	178,979	209,254	183,480	766,491	182,548	2,962,306	2,169,434	25,774	792,872
Financing Income	228,125	247,716	228,125	247,716	228,125	247,716	646,162	247,716	3,155,532	2,972,589	(19,591)	182,942
Investment Income	39,189	40,992	164,066	158,772	46,777	56,107	49,701	58,185	724,763	726,149	(9,330)	(1,385)
Miscellaneous Income	342,474	5,590,718	121,862	236,130	250,735	137,633	498,962	153,540	11,924,005	11,029,889	113,102	894,116
Net Income (Change in Financial Position)	**(4,561,299)**	**803,710**	**(192,661)**	**(3,839,657)**	**(36,142)**	**(551,189)**	**785,068**	**(5,031,592)**	**4,604,662**	**(17,006,153)**	**515,047**	**21,610,814**
Operating Income	(4,825,134)	(4,894,817)	(509,466)	(4,303,296)	(352,524)	(809,164)	356,735	(5,308,483)	(8,237,332)	(29,564,955)	456,639	21,327,622
EBIDA	(3,296,981)	1,145,512	245,536	(3,513,182)	411,699	(888,483)	1,224,650	(5,370,917)	10,102,686	(12,940,561)	1,300,181	23,043,248
Net Profit Margin	-80.7%	10.4%	-1.9%	-62.5%	-0.4%	-6.6%	9.2%	-84.4%	4.3%	-19.1%	6.2%	23.4%
Operating Margin	-85.4%	-63.5%	-5.1%	-70.1%	-3.7%	-9.7%	4.2%	-89.1%	-7.7%	-33.3%	6.0%	25.6%
EBIDA Margin	-58.3%	14.9%	2.5%	-57.2%	4.3%	-10.6%	14.4%	-90.1%	9.4%	-14.6%	14.9%	126.6%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2024

	PY Balances	2/29/2024	2/28/2023	3/31/2024	3/31/2023	4/30/2024	4/31/2023	5/31/2024	5/31/2023	6/30/2024	6/30/2023	MOM Change	Prior Year Change
Assets													
Current Assets													
Cash and Liquid Capital	17,558,072	8,770,199	7,914,764	12,778,438	10,502,555	8,030,005	13,568,674	21,374,165	16,815,088	18,718,424	17,558,072	(2,655,741)	1,160,352
Short Term Investments	10,497,077	6,335,363	10,418,390	6,336,695	10,410,937	6,412,401	10,506,281	6,414,343	10,501,488	6,418,451	10,497,077	4,107	(4,078,626)
PMA Partnership	-	-	-	-	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	14,932,580	19,458,681	19,699,808	12,458,272	20,562,360	17,119,074	14,264,930	13,540,975	9,681,108	17,964,704	14,932,580	4,423,729	3,032,125
Other Receivables	3,244,845	19,050,631	9,308,827	18,203,532	9,317,329	17,139,611	9,679,612	7,531,522	10,166,066	4,358,089	2,912,818	(3,173,433)	1,445,270
Inventory	5,159,474	5,158,222	3,063,026	5,162,663	3,089,267	5,200,224	3,081,283	5,203,267	3,062,773	5,193,281	5,159,474	(9,987)	33,807
Prepaid Expenses	1,793,630	1,276,680	1,401,834	1,744,260	1,333,985	1,583,016	1,241,525	1,192,179	1,185,652	1,110,589	1,793,630	(81,591)	(683,041)
Total Current Assets	**53,185,677**	**60,049,776**	**51,806,650**	**56,683,861**	**55,216,432**	**55,484,330**	**52,342,303**	**55,256,452**	**51,412,175**	**53,763,537**	**52,853,650**	**(1,492,915)**	**909,887**
Assets Limited as to Use													
Internally Designated for Capital Acquisitions	-	-	-	-	-	-	-	-	-	-		-	-
Short Term - Restricted	1,466,355	1,467,283	1,446,108	1,467,411	1,466,171	1,467,535	1,466,232	1,467,662	1,466,295	1,467,786	1,466,355	124	1,431
Limited Use Assets												-	-
LAIF - DC Pension Board Restricted	798,218	-	778,293	-	785,746	-	789,013	-	793,806	-	798,218	-	(798,218)
LAIF - DB Pension Board Restricted	15,684,846	15,684,846	19,296,858	15,684,846	19,296,858	15,684,846	19,296,858	15,684,846	19,296,858	15,684,846	15,684,846	-	-
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-	-	-		-	-
PEPRA Pension	-	-	-	-	-	-	-	-	-	-		-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	-	573,097	-	573,097		573,097	-	573,097		-	573,097
Total Limited Use Assets	17,056,161	16,257,943	20,075,151	16,257,943	20,082,604	16,257,943	20,085,871	16,257,943	20,090,664	16,257,943	16,483,064	-	(225,121)
Revenue Bonds Held by a Trustee	1,078,187	1,051,852	1,081,516	1,046,147	1,075,802	962,817	1,070,092	957,113	1,083,896	376,411	1,078,187	(580,702)	(701,777)
Total Assets Limited as to Use	**19,600,703**	**18,777,078**	**22,602,775**	**18,771,501**	**22,624,577**	**18,688,294**	**22,622,196**	**18,682,718**	**22,640,855**	**18,102,140**	**19,027,606**	**(580,579)**	**(925,466)**
Long Term Assets													
Long Term Investment	2,767,655	1,831,779	2,744,893	1,832,199	2,752,606	1,834,470	2,771,350	1,840,643	2,761,001	1,846,138	2,767,655	5,495	(921,517)
Fixed Assets, Net of Depreciation	85,078,613	85,151,277	76,485,894	84,393,675	76,673,974	84,323,364	76,823,477	84,562,800	77,195,012	84,273,088	77,264,968	(289,712)	7,008,120
Total Long Term Assets	**87,846,268**	**86,983,056**	**79,230,787**	**86,225,875**	**79,426,580**	**86,157,833**	**79,594,827**	**86,403,444**	**79,956,013**	**86,119,226**	**80,032,623**	**(284,218)**	**6,086,603**
Total Assets	**160,632,647**	**165,809,910**	**153,640,212**	**161,681,236**	**157,267,589**	**160,330,458**	**154,559,326**	**160,342,614**	**154,009,043**	**157,984,903**	**151,913,878**	**(2,357,711)**	**6,071,024**
Liabilities													
Current Liabilities													
Current Maturities of Long-Term Debt	4,932,910	3,849,316	957,628	3,907,233	901,673	3,883,529	875,213	4,167,637	848,672	4,147,934	3,784,696	(19,703)	363,239
Accounts Payable	5,088,334	4,346,694	5,482,703	5,131,234	5,186,458	4,047,103	6,096,323	4,728,733	5,933,534	4,994,937	5,088,334	266,204	(93,397)
Accrued Payroll and Related	8,318,121	7,226,154	5,321,872	7,439,170	5,913,994	7,585,529	5,850,013	7,216,488	6,742,378	5,933,109	8,318,121	(1,283,378)	(2,385,012)
Accrued Interest and Sales Tax	92,441	238,080	238,573	314,125	310,734	140,964	119,257	39,126	194,008	109,159	92,441	70,033	16,718
Notes Payable	1,532,689	1,035,689	2,133,708	931,738	2,133,708	931,738	2,133,708	446,860	1,633,671	446,860	1,532,689	-	(1,085,828)
Unearned Revenue	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(1,812)	(4,542)	662	(4,542)	(4,542)	(4,542)	(5,204)	-
Due to 3rd Party Payors	693,247	693,247	478,242	693,247	262,335	693,247	693,247	693,247	693,247	693,247	693,247	-	-
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	1,942,292	1,925,736	2,146,080	1,923,666	2,146,080	1,921,596	2,146,080	1,919,527	2,146,080	1,917,457	1,873,995	(2,070)	43,462
Total Current Liabilities	**22,595,491**	**19,310,372**	**16,754,263**	**20,335,871**	**16,850,439**	**19,201,894**	**17,909,298**	**19,212,280**	**18,187,048**	**18,238,162**	**21,378,980**	**(974,119)**	**(3,140,819)**
Long Term Liabilities													
Long Term Debt	37,511,965	36,545,985	33,455,530	35,863,988	33,455,530	36,434,249	33,455,530	36,382,902	33,455,530	36,299,514	30,305,060	(83,388)	5,994,454
Bond Premium	203,263	178,166	215,811	175,029	212,674	171,892	209,537	168,755	206,400	165,618	203,263	(3,137)	(37,645)
Accreted Interest	16,540,170	17,302,780	16,743,218	17,396,138	16,838,349	16,804,350	16,933,481	16,897,707	17,028,613	16,991,065	16,540,170	93,358	450,895
Other Non-Current Liability - Pension	47,257,663	47,257,663	47,821,876	47,257,663	50,366,473	47,257,663	50,366,473	47,257,663	50,366,473	47,257,663	47,257,663	-	-
Total Long Term Liabilities	**101,513,061**	**101,284,595**	**98,236,435**	**100,692,818**	**100,873,027**	**100,668,154**	**100,965,022**	**100,707,028**	**101,057,016**	**100,713,860**	**94,306,156**	**6,832**	**6,407,704**
Suspense Liabilities	-	-	-	-	-	-	-	-	-	-		-	
Uncategorized Liabilities (grants)	44,693	124,918	615,594	123,693	686,039	124,093	681,315	122,993	676,582	33,006	44,693	(89,987)	(11,687)
Total Liabilities	**124,153,245**	**120,719,885**	**115,606,292**	**121,152,382**	**118,409,505**	**119,994,141**	**119,555,635**	**120,042,301**	**119,920,646**	**118,985,028**	**115,729,830**	**(1,057,273)**	**3,255,198**
Fund Balance													
Fund Balance	45,515,489	35,013,047	43,831,306	35,013,047	43,831,306	35,013,047	43,831,306	35,013,057	43,831,306	32,927,427	52,469,687	(2,085,630)	(19,542,260)
Temporarily Restricted	1,466,354	1,467,283	2,590,039	1,467,411	2,610,102	1,467,535	2,610,163	1,467,662	2,610,225	1,467,786	1,466,354	124	1,432
Net Income	(10,502,442)	8,609,695	(8,387,425)	4,048,396	(7,583,324)	3,855,735	(11,437,779)	3,819,593	(12,353,135)	4,604,662	(17,751,993)	785,068	22,356,654
Total Fund Balance	**36,479,402**	**45,090,025**	**38,033,921**	**40,528,854**	**38,858,084**	**40,336,317**	**35,003,690**	**40,300,313**	**34,088,397**	**38,999,875**	**36,184,049**	**(1,300,438)**	**2,815,826**
Liabilities + Fund Balance	**160,632,647**	**165,809,910**	**153,640,212**	**161,681,236**	**157,267,589**	**160,330,458**	**154,559,326**	**160,342,614**	**154,009,043**	**157,984,903**	**151,913,878**	**(2,357,711)**	**6,071,024**
(Decline)/Gain		7,268,230	(1,263,649)	(4,128,674)	3,627,377	(1,350,778)	(2,708,264)	12,156	(550,282)	(2,357,711)	(2,095,165)	(2,369,867)	(262,546)
	0	0	0	0	0	0	0	0	0	0	0	0	0

Northern Inyo Healthcare District
Long-Term Debt Service Coverage Ratio
FYE 2024

Calculation method agrees to SECOND and THIRD SUPPLEMENTAL INDENTURE OF TRUST 2021 Bonds Indenture

Long-Term Debt Service Coverage Ratio Calculation

Numerator:	HOSPITAL FUND ONLY	
Excess of revenues over expense	$ 4,604,662	11 months of earnings
+ Depreciation Expense	5,498,024	
+ Interest Expense	2,962,306	
Less GO Property Tax revenue	1,901,493	
Less GO Interest Expense	511,253	
"Income available for debt service" *(definition per 2010 and 2013 and 2021 Indenture)*	**$ 10,652,246**	
Denominator:		
Supplemental Indenture of Trust)		
2021A Revenue Bonds	$ 112,700	
2021B Revenue Bonds	905,057	
2009 GO Bonds (Fully Accreted Value)		
2016 GO Bonds		
Financed purchases and other loans	1,704,252	
Total **Maximum Annual Debt Service**	**$ 2,722,009**	Full year of debt
		YTD debt
Ratio: (numerator / denominator)	**3.91**	YTD debt service coverage
Required Debt Service Coverage Ratio:	1.10	
In Compliance? (Y/N)	**Yes**	

Unrestricted Funds and Days Cash on Hand

	HOSPITAL FUND ONLY
Cash and Investments-current	$ 25,136,874
Cash and Investments-non current	1,846,138
Sub-total	26,983,012
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	(376,411)
Building and Nursing Fund	(1,467,786)
Total Unrestricted Funds	**$ 25,138,815**
Total Operating Expenses	$ 115,352,756
Less Depreciation	5,498,024
Net Expenses	109,854,732
Average Daily Operating Expense	$ 300,150
Days Cash on Hand	**84**

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2024

CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts from and on Behalf of Patients	$	107,832,697
Payments to Suppliers and Contractors		(44,635,538)
Payments to and on Behalf of Employees		(65,089,418)
Other Receipts and Payments, Net		(882,622)
Net Cash Provided (Used) by Operating Activities		(2,774,881)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Noncapital Contributions and Grants		10,468,424
Property Taxes Received		1,254,039
Payments on CHFFA Loans		(981,877)
Other		-
Net Cash Provided (Used) by Noncapital Financing Activities		10,122,869
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES		
Principal Payments on Long-Term Debt		(3,496,378)
Proceeds from the Issuance of Refunding Revenue Bonds		-
Payment to Defease Revenue Bonds		-
Interest Paid		(2,962,306)
Purchase and Construction of Capital Assets		(5,498,024)
Payments on Lease Liability		(80,186)
Payments on Subscription Liability		(864,632)
Property Taxes Received		1,901,493
Net Cash Provided (Used) by Capital and Capital Related Financing Activities		(11,000,034)
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment Income		724,763
Rental Income		9,009
Net Cash Provided (Used) by Investing Activities		733,772
NET CHANGE IN CASH AND CASH EQUIVALENTS		(2,918,273)
Cash and Cash Equivalents - Beginning of Year		28,055,148
CASH AND CASH EQUIVALENTS - END OF YEAR	$	25,136,875

Northern Inyo Healthcare District
June 2024 – Financial Summary

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Net Income (Loss)	785,068	(5,031,592)	(1,074,243)	5,816,660	1,859,312	4,604,662	(17,006,153)	(17,162,242)	21,610,814	21,766,904	116%	127%	127%
Operating Income (Loss)	356,735	(5,308,483)	(935,262)	5,665,218	1,291,997	(8,237,332)	(29,564,955)	(13,808,992)	21,327,622	5,571,660	107%	72%	40%
EBIDA (Loss)	1,224,650	(5,370,917)	(993,535)	6,595,567	2,218,185	10,102,686	(12,940,561)	(16,391,918)	23,043,248	26,494,604	123%	178%	162%

Income is favorable this year for the month due to a large inventory adjustment. This is not final and may be adjusted along with potential audit adjustments. Income for the year is favorable due to $18M in higher revenue.

IP Gross Revenue	2,799,611	2,123,257	2,670,778	676,355	128,833	41,353,814	36,784,193	35,065,725	4,569,621	6,288,089	32%	12%	18%
OP Gross Revenue	13,848,705	12,723,066	12,273,289	1,125,638	1,575,416	166,032,671	145,867,603	147,548,159	20,165,067	18,484,512	9%	14%	13%
Clinic Gross Revenue	1,665,622	1,443,993	1,434,073	221,629	231,549	19,388,997	16,953,471	15,769,553	2,435,526	3,619,444	15%	14%	23%
Net Patient Revenue	8,529,089	5,961,074	6,890,026	2,568,014	1,639,063	107,115,424	88,909,777	83,451,309	18,205,647	23,664,115	43%	20%	28%
Cash Net Revenue % of Gross	47%	37%	42%	10%	5%	47%	45%	42%	3%	5%	27%	6%	12%

Gross Revenue increased $2.2M due to volumes increasing. For the year, gross revenue increased $27M. Net revenue is slightly higher as a % of gross revenue due to less aging (>270 days) AR.

Admits (excl. Nursery)	71	65		6		856	820		36		9%	4%	
IP Days	223	165		58		2,562	2,458		104		35%	4%	
IP Days (excl. Nursery)	192	144		48		2,265	2,161		104		33%	5%	
Average Daily Census	6.40	4.80		1.60		6.19	5.90		0.28		33%	5%	
ALOS	2.70	2.22		0.49		2.65	2.64		0.01		22%	0%	
Deliveries	19	17		2		197	202		(5)		12%	-2%	
OP Visits	3,930	3,689		241		44,190	43,678		512		7%	1%	
RHC Visits	2,891	2,722		169		35,879	31,923		3,956		6%	12%	
Rural Health Clinic Visits	2,225	2,080		145		28,175	25,442		2,733		7%	11%	
Rural Health Women Visits	471	489		(18)		5,703	5,384		319		-4%	6%	
Rural Health Behavioral Visits	195	489		(294)		1,962	1,097		865		-60%	79%	
NIA Clinic Visits	1,663	1,659		4		19,405	20,355		(950)		0%	-5%	
Bronco Clinic Visits	13	14		(1)		403	370		33		-7%	9%	
Internal Medicine Clinic Visits	-	363		(363)		201	4,338		(4,137)		-100%	-95%	
Orthopedic Clinic Visits	351	341		10		4,176	3,935		241		3%	6%	
Pediatric Clinic Visits	559	569		(10)		7,364	6,798		566		-2%	8%	
Specialty Clinic Visits	530	285		245		5,042	3,299		1,743		86%	53%	
Surgery Clinic Visits	144	34		110		1,578	1,077		501		324%	47%	
Virtual Care Clinic Visits	66	53		13		641	538		103		25%	19%	
Surgeries IP	14	9		5		232	219		13		56%	6%	
Surgeries OP	134	72		62		1,516	1,185		331		86%	28%	
Total Surgeries	148	81		67		1,748	1,404		344		83%	25%	
Cardiology	2	-		-		4	-		4		0%	0%	
General	65	10		55		848	585		263		550%	45%	
Gynecology & Obstetrics	12	9		3		184	143		41		33%	29%	
Ophthalmology	25	29		(4)		271	292		(21)		-14%	-7%	
Orthopedic	29	27		2		304	349		(45)		7%	-13%	
Pediatric	-	-		-		-	1		(1)		0%	-100%	
Podiatry	1	1		-		2	4		(2)		0%	-50%	
Urology	14	5		9		135	30		105		180%	350%	
Diagnostic Imaging	1,814	2,051		(237)		24,825	24,240		585		-12%	2%	
Emergency Visits	879	825		54		10,080	9,716		364		7%	4%	
ED Admits	39	80		(41)		428	502		(74)		-51%	-15%	
ED Admits % of ED Visits	4.4%	9.7%		-5.3%		4.2%	5.2%		-0.9%		-54%	-18%	
Rehab	670	896		(226)		7,941	9,148		(1,207)		-25%	-13%	
Nursing Visits	715	274		441		4,431	2,970		1,461		161%	49%	
Observation Hours	1,064	1,540		(476)		21,806	21,300		507		-31%	2%	

Not Available

For the year, admissions are up 4% due to higher IP surgeries. RHC increased due to women's clinic. All clinics are higher than prior year. Emergency and diagnostic imaging have also increased. Nursing visits have increased due to higher infusion volumes.

Payor mix													
Blue Cross	27.5%	27.8%		-0.4%		27.3%	27.2%		0.1%		-1%	0%	
Commercial	7.5%	6.7%		0.7%		5.5%	6.4%		-1.0%		11%	-15%	

Northern Inyo Healthcare District
June 2024 – Financial Summary

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Medicaid	19.8%	19.3%		0.5%		19.5%	21.9%		-2.3%		2%	-11%	
Medicare	40.6%	40.5%	N/A	0.1%	N/A	42.5%	40.0%	N/A	2.6%	N/A	0%	6%	N/A
Self-pay	2.7%	2.9%		-0.2%		2.9%	2.6%		0.2%		-7%	9%	
Workers' Comp	0.9%	2.3%		-1.4%		1.3%	1.4%		-0.1%		-61%	-6%	
Other	1.1%	0.4%		0.7%		1.0%	0.5%		0.5%		168%	107%	
DEDUCTIONS													
Contract Adjust	9,150,988	7,565,721	8,840,054	1,585,268	310,934	112,228,375	94,029,030	107,083,190	18,199,344	5,145,185	21%	19%	5%
Bad Debt	271,822	2,498,013	324,030	(2,226,191)	(52,208)	1,935,492	11,383,794	3,924,469	(9,448,302)	(1,988,977)	-89%	-83%	-51%
Write-off	362,039	265,508	324,030	96,531	38,009	5,503,223	5,327,710	3,924,469	175,513	1,578,754	36%	3%	40%

Payor mix is relatively consistent with prior year. Net Revenue % of Gross Revenue is up 2% due to less aged AR

DENIALS

Denials increased $800M from the 6-month average

CHARITY	-	209	-	(209)	-	37,364	393,677	-	(356,313)		-100%	-91%	

Charity discounts have decreased compared to prior year due to policy update

BAD DEBT

Bad debt write offs were $248k which is $55k lower than trend

CASH

Cash for June was unfavorable by $1.2 due to receiving low cash collections month. Patient collections were $600k lower than 6-month average. 28% of bad debt AR has been collected by our 3rd party vendor vs $10% in 2023.

CENSUS													
Patient Days	223	165		58		2,562	2,458		104		35%	4%	
Adjusted Days	1,259	1,266		(7)		13,710	12,389		1,321		-1%	11%	
Employed Paid FTE	353.75	364.62		(10.87)		353.70	391.51		(37.81)		-3%	-10%	
Contract Paid FTE	25.95	39.55	N/A	(13.59)	N/A	26.67	53.50	N/A	(26.83)	N/A	-34%	-50%	N/A
Total Paid FTE	379.71	404.17		(24.46)		380.37	445.01		(64.64)		-6%	-15%	
EPOB (Employee per Occupied Bed)	1.76	2.54		(0.79)		1.77	2.04		(0.27)		-31%	-13%	
Adjusted EPOB	0.27	0.33		(0.06)		0.32	0.38		(0.05)		-19%	-14%	

SALARIES													
Per Adjust Bed Day	$ 2,409	$ 4,338		$ (1,929)		$ 2,821	$ 2,861		$ (40)		-44%	-1%	
Total Salaries	$ 3,033,481	$ 5,491,366	$ 4,923,604	(2,457,885)	(1,890,123)	$ 38,674,815	$ 35,447,055	$ 31,689,834	3,227,760	6,984,981	-45%	9%	22%
Average Hourly Rate	$ 50.02	$ 87.85		$ (37.83)		$ 52.28	$ 43.29		$ 8.99		-43%	21%	
Employed Paid FTEs	353.75	364.62		(10.87)		353.70	391.51		$ (37.81)				

Salaries decreased compared to last year due to SB 1334 accrual made in June 2023 of nearly $2M. FTEs for the year declined compared to last year due to RIFFs. Average hourly rate increased due to raises.

BENEFITS													
Per Adjust Bed Day	$ 1,156	$ 1,638		$ (482)		$ 1,381	$ 1,997		$ (616)		-29%	-31%	
Total Benefits	$ 1,456,281	$ 2,073,621	$ 1,973,962	$ (617,340)	(517,681)	$ 18,933,716	$ 24,739,723	$ 23,761,320	$ (4,827,604)	(4,827,604)	-30%	-20%	-20%
Benefits % of Wages	48%	38%	40%	10%		49%	70%	75%	-21%		27%	-30%	
Pension Expense	$ 760,350	$ 846,569	$ 807,273	$ (86,219)	(46,923)	$ 5,777,673	$ 11,903,427	$ 9,510,543	$ (3,732,870)	(3,732,870)	-10%	-31%	-39%
MDV Expense	$ 360,144	$ 567,787	$ 539,348	$ (207,643)	(179,204)	$ 10,773,145	$ 6,015,639	$ 6,539,824	$ 4,233,321	4,233,321	-37%	70%	65%
Taxes, PTO accrued, Other	$ 335,787	$ 659,265	$ 627,341	$ (323,478)	(291,554)	$ 2,382,898	$ 6,820,657	$ 7,710,953	$ (5,328,055)	(5,328,055)	-49%	-78%	-69%

For the month, benefits as a % of wages is higher than prior year due to lower wages. For the year, benefits % of wages is lower due to savings on pension plan

Salaries, Wages & Benefits	$ 4,489,762	$ 7,564,987	$ 6,897,566	$ (3,075,225)	(2,407,804)	$ 57,608,531	$ 60,186,778	$ 55,451,154	$ (2,578,247)	$ 2,157,377	-41%	-4%	4%
SWB/APD	$ 3,565	$ 5,976		$ (2,410)		$ 4,202	$ 4,858		$ (656)		-40%	-14%	
SWB % of Total Expenses	54.9%	67.1%	88.1%	-12.2%	-33%	49.9%	50.8%	57.0%	-0.9%	-7%			

Total SWB for the month are lower than prior year due to nearly $2M SB 1334 accrual made in June 2023. For the year, SWB decreased due to one-time penalty (SB 1334) accrued in 2023 along with reduced benefits and

Northern Inyo Healthcare District
June 2024 – Financial Summary

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
FTEs.													
PROFESSIONAL FEES													
Per Adjust Bed Day	$ 2,144	$ 2,068	$ 1,539	$ 76	606	$ 2,244	$ 2,749	$ -	$ (506)	$ 2,244	4%	-18%	
Total Physician Fee	$ 1,621,499	$ 1,428,974	$ 1,088,701	$ 192,525	532,798	$ 16,807,609	$ 15,378,635	$ 13,060,527	$ 1,428,974	$ 3,747,082	13%	9%	29%
Total Contract Labor	$ 774,264	$ 803,281	$ 344,589	$ (29,017)	429,675	$ 6,024,606	$ 9,341,850	$ 5,056,010	$ (3,317,244)	$ 968,596	-4%	-36%	19%
Total Other Pro-Fees	$ 304,206	$ 385,724	$ 514,516	$ (81,518)	$ (210,310)	$ 7,926,270	$ 9,341,339	$ 6,293,969	$ (1,415,069)	$ 1,632,301	-21%	-15%	26%
Total Professional Fees	$ 2,699,969	$ 2,617,979	$ 1,947,806	$ 81,990	752,163	$ 30,758,485	$ 34,061,824	$ 24,410,506	$ (3,303,339)	$ 6,347,979	3%	-10%	26%
Contract Paid FTEs	25.95	39.55		(13.59)		26.67	53.50		(26.83)		-34%	-50%	
Physician Fee per Adjust Bed Day	$ 1,288	$ 1,129		$ 159		$ 1,226	1,241		(15)				
Physician expense increased due to adding a general surgeon and urology. However, this is contributing to higher volumes and revenue and is lower on a per patient basis. Contract labor has been reduced $3.3M compared to last year and nearly 27 FTEs													
PHARMACY													
Per Adjust Bed Day	$ 690	$ 617		$ 73		$ 425	$ 312		$ 113		12%	36%	
Total Rx Expense	$ 869,201	$ 781,308	$ 276,837	$ 87,893	592,365	$ 5,832,893	$ 3,870,316	$ 3,575,244	$ 1,962,576	$ 2,257,649	11%	51%	63%
Pharmacy increased due to patient volume increases along with rising costs.													
MEDICAL SUPPLIES													
Per Adjust Bed Day	$ (1,342)	$ (1,395)		$ 54		$ 254	$ 215		$ 39		-4%	18%	
Total Medical Supplies	$ (1,689,273)	$ (1,766,340)	$ 291,660	$ 77,067	(1,980,933)	$ 3,485,151	$ 2,663,746	$ 3,684,207	$ 821,404	$ (199,057)	-4%	31%	-5%
Credit in supplies this month due to $2M hold for inventory adjustment. It is still being reviewed and pending audit. For the year, supplies are higher due to volumes increasing along with inflation.													
EHR SYSTEM													
Per Adjust Bed Day	$ 108	$ 344		$ (237)		$ 29	$ 184		$ (156)		-69%	-84%	
Total EHR Expense	$ 135,492	$ 435,979	$ 118,447	$ (300,487)	17,045	$ 393,606	$ 2,282,482	$ 1,502,750	$ (1,888,876)	$ (1,109,144)	-69%	-83%	-74%
Expense is lower than prior year and budget due to an accounting rule change that requires Cerner software to be listed as a right of use asset instead of expense.													
OTHER EXPENSE													
Per Adjust Bed Day	$ 975	$ 1,024		$ (49)		$ 859	$ 916		$ (57)		-5%	-6%	
Total Other	$ 1,227,621	$ 1,296,319	$ (1,787,737)	$ (68,698)	3,015,357	$ 11,776,066	$ 11,344,093	$ 7,946,825	$ 431,973	$ 3,829,242	-5%	4%	48%
Other expenses are up due to higher utlities, insurance, and sales taxes on supplies which has increased.													
DEPRECIATION AND AMORTIZATION													
Per Adjust Bed Day	$ 349	$ 268		$ 81		$ 401	$ 328		$ 73		30%	22%	
Total Depreciation and Amortization	$ 439,581	$ 339,325	$ 80,708	$ 100,256	358,873	$ 5,498,024	$ 4,065,591	$ 689,615	$ 1,432,433	$ 4,808,409	30%	35%	697%
Amortization is higher due to a change in lease (GASB 87) and software accounting (GASB 96) requiring assets to be added for contracts and those assets are amortized over the life of the contract.													
Total Expenses	$ 8,172,354	$ 11,269,558	$ 7,825,288	$ (3,097,204)	$ 347,066	$ 115,352,756	$ 118,474,831	$ 97,260,301	$ (3,122,075)	$ 18,092,455	27%	10%	-8%
Per Adjust Bed Day	$ 6,490	$ 8,902		$ (2,412)		$ 8,414	$ 9,563		$ (1,149)				
Per Calendar Day	$ 272,411.79	$ 375,651.92	$ 260,842.93	$ (103,240)	11,569	$ 315,171.47	$ 323,701.73	$ 265,738.53	$ (8,530)	49,433	-27%	-3%	19%
For the month, expenses were lower due to accrual made in prior year for SB 1334. Expenses are $3M lower than prior year which even with an increase in volumes.													

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

Medical Staff Office
(760) 873-2174 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Sierra Bourne, MD, Chief of Medical Staff
DATE: August 6, 2024
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 Initial Appointments 2024-2025 (*action item*)
    1. Amr Elmaghraby, MD (*neurology*) – Telemedicine Staff
    2. David Lichtenfeld, MD (*internal medicine*) – Active Staff

B. Medical Staff Reappointments 2024-2025 (*action item*)
    1. Wanda Lam, MD (*general surgery*) – Courtesy Staff

C. Proposed Medical Staff Bylaws Amendments 07/16/2024 (*action item*)

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

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

Northern Inyo Healthcare District
Medical Staff Office

150 Pioneer Lane
Bishop, CA 93514
(760) 873-2136

TO: Northern Inyo Healthcare District Board of Directors
FROM: Northern Inyo Healthcare District Active Medical Staff Members
RE: Proposed Bylaws Amendments
DATE: July 16, 2024

The Medical Staff on July 16, 2024 voted to approve several amendments to the Medical Staff Bylaws and is hereby requesting adoption of these changes by the Board of Directors. Below is a summary of the proposals, followed by the actual Bylaws text. You may select the blue hyperlink which will take you directly to the section referenced.

1. **Courtesy staff members will be required to pay annual dues of $100** **(Section 3.4-2)**

   The 2021 bylaws revision saw the removal of annual dues payments for Courtesy Staff members and Telemedicine Staff. With recent activity of the Physician Wellness Committee in planning events and other wellness initiatives, additional medical staff funds would better cover these expenditures. The Wellness committee would like to propose reinstatement of dues payments for Courtesy Staff, as these members do have the opportunity to participate in medical staff events (current # courtesy staff = 28).

2. **Remove the core committee member structure for departmental meetings** **(Section 11.12-1, Section 12.3-2)**

   The concept of three core committee members who are designated to attend their assigned departmental meetings was introduced 3 years ago when achieving a quorum was challenging for departmental meetings. In practice, it has not improved attendance in departments where it continues to be a challenge and the medical staff has not been implementing the rules of the core committee membership consistently. Departmental meetings overall are now better attended since remote (Zoom) attendance is an option and as new members have been on-boarded with the expectation to attend 50% of their department meetings.

3. **Corrective action proceeding updates**

   a. Consulting medical staff legal counsel (Section 6.2) – a reminder sentence has been added to recommend working with medical staff legal counsel early in corrective action proceedings.

   b. Subsequent action (Section 6.2-5) – updated language to add clarity in the corrective action proceedings following an MEC recommendation. Update to more closely match CHA and CMA model medical staff bylaws.

   c. Pre-hearing procedure (Section 7.4-1) – updated this entire section as per medical staff legal counsel recommendations to allow more time and flexibility in the notice and evidence period.

Northern Inyo Healthcare District
Medical Staff Office

150 Pioneer Lane
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d. Hearing officer (Section 7.4-3) – removal of requirement for board of directors to approve the selection of a hearing officer at the recommendation of medical staff legal counsel. Also in alignment with CHA and CMA model bylaws.

4. **Clarification of "election year" (Section 9.1-3)**

   Proposal to update the language such that it specifies the Chief of Staff election is every two years and the member-at-large election is every year.

5. **Leave of absence defined as a duration exceeding ninety (90) days (Section 5.7)**

   The 2021 bylaws revision updated the duration of a leave of absence requiring notification from 60 days to 180 days. Recommend decreasing this to 90 days.

6. **Language clean-up regarding "medical directors" (Section 2.7, Section 10.5-2)**

   Medical staff leadership in 2021 included administratively-appointed Medical Directors. For example, we had a Medical Director of Pediatrics and a Chief of Pediatrics (often held by the same individual, but not necessarily). The leadership structure changed in 2022 and most Medical Director positions no longer exist. The bylaws language which was originally introduced in 2021 to mitigate possible conflicts of interest with these two positions is no longer relevant and has been removed.

7. **Consolidation of Quality Improvement Committee and the Medical Executive Committee (Section 11.4)**

   Proposal to eliminate the separate medical staff Quality Improvement Committee that convenes immediately prior to the Medical Executive Committee with the same members. The duties of the Quality Improvement Committee are moved into the Medical Executive Committee.

Northern Inyo Healthcare District
Medical Staff Bylaws

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ARTICLE I: PURPOSE AND TERMS

1.1 PURPOSE OF THE BYLAWS

(a) These bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the Northern Inyo Healthcare District Board of Directors in protecting the quality of medical care provided at Northern Inyo Healthcare District and assuring the competency of the District's Medical Staff. These bylaws provide a framework for the self-governance of the Medical Staff, which is a collegial and democratic body with extensive knowledge in medical care. These bylaws assure an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of medical staff functions supportive of those purposes, and to account to the Board of Directors for the effective performance of Medical Staff responsibilities. These bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors, and relations with applicants to and members of the Medical Staff.

(b) These bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards. They establish clinical criteria and standards for quality assurance, utilization review, and other medical staff activities including, but not limited to, periodic meetings of the Medical Staff, its committees and departments, and review and analysis of patient medical records. They describe the standards and procedures for selecting and removing Medical Staff officers, and they address the respective rights and responsibilities of the Medical Staff.

(c) The Medical Staff acknowledges that the Board of Directors, in exercising its responsibility to protect the quality of medical care provided by and the competency of the Medical Staff and to ensure the responsible governance of the hospital, possesses administrative oversight authority of the Medical Staff. In exercising its administrative authority, the Board of Directors acknowledges and commits to respecting the rights and functions of a self-governing Medical Staff, as established by statute and through the Medical Staff bylaws. The Medical Staff commits to exercising its rights and responsibilities with diligence and good faith, and acknowledges that if it does not do so, the Board of Directors may act, as delineated in these bylaws, to fulfill the specific responsibility that the Medical Staff has failed to perform.

1.2 NAME

The name of this organization is the Medical Staff of Northern Inyo Hospital, a 501(c)(6) recognized organization.

1.3 PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

The medical staff's purposes are:

(a) To assure that all patients admitted or treated in any of the Northern Inyo Healthcare District services receive a uniform standard of quality patient care, treatment and efficiency consistent with generally accepted standards attainable within the district's means and circumstances.

(b) To support professional education and community health education.

(c) To initiate and maintain rules for the medical staff to carry out its responsibilities for the professional work performed in Northern Inyo Healthcare District.

(d) To provide an avenue for the medical staff, board of directors, and administration to discuss issues of mutual concern.

(e) To exercise its rights and responsibilities in a manner that does not jeopardize the district's license, Medicare and Medi-Cal provider status, accreditation, and other credentialed statuses.

The medical staff's responsibilities are:

(a) To provide quality patient care.

(b) To assure for the benefit of the public, and also to account to the board of directors for, the quality of patient care provided by all members authorized to practice in Northern Inyo Healthcare District through the following measures:

(1) Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;

(2) A credentials program, including mechanisms of appointment, reappointment and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the applicant;

(3) Participating in a utilization review program to provide for the appropriate use of all medical services.

(c) To establish and enforce professional standards related to the delivery of healthcare within Northern Inyo Healthcare District.

(d) To initiate and pursue corrective action with respect to members where warranted.

(e) To cooperate with other community health facilities and/or educational institutions or efforts that strive to improve the quality ~~of scope~~ of patient care within Northern Inyo Healthcare District.

(f) To establish and amend as needed medical staff bylaws and policies.

(g) To select and remove medical staff officers.

(h) To assess and utilize medical staff dues as appropriate for the purposes of the medical staff.

1.4 DEFINITIONS

ACTIVE STAFF means the category of medical staff members who regularly provide care at Northern Inyo Healthcare District and meet the qualifications and prerogatives as listed in these bylaws.

AD HOC COMMITTEE means a committee created for a particular purpose for a finite amount of time, as necessary.

ADVERSE ACTION means an action which is reportable under Business and Professions Code 805.

ADMINISTRATOR or CHIEF EXECUTIVE OFFICER means the person appointed by the board of directors to serve in an administrative capacity in the overall management of the district.

ADVANCED PRACTICE PROVIDER or APP means an individual, other than a licensed physician, dentist, or podiatrist, who exercises independent judgement within the areas of his or her professional competence and the limits established by the board of directors, the medical staff, and the applicable State Practice Act, who is qualified to render direct or indirect medical care under the supervision or direction of a medical staff member (with the exception of certified registered nurse anesthetists, who are APPs that practice under an independent license as per current California regulations).

AUTHORIZED REPRESENTATIVE means the individual(s) designated by the district and approved by the medical executive committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws.

BOARD OF DIRECTORS means the governing body of Northern Inyo Healthcare District.

CHAIR means the individual practitioner elected to preside over a committee or meeting.

CHIEF EXECUTIVE OFFICER see ADMINISTRATOR.

CHIEF MEDICAL OFFICER means an active member of the medical staff appointed by the administrator to provide administrative support for the medical staff, communicate the views of the hospital administration to the medical staff, and serve as a liaison between the medical staff and the administration. The chief medical officer shall serve on medical staff committees without vote unless otherwise specified at the time of appointment.

CHIEF OF STAFF means the chief officer of the medical staff elected by members of the medical staff.

CONTRACT PRACTITIONER means a practitioner who is party to a clinical services agreement with the district.

CONSULTING STAFF means the category of medical staff members who treat and otherwise care for patients at Northern Inyo Healthcare District and meet the qualifications and prerogatives as listed in these bylaws.

~~**CORE COMMITTEE MEMBER** means a practitioner designated to regularly attend the departmental committee meetings to which they are assigned in order to represent their specialty.~~

COURTESY STAFF means the category of medical staff members who do not utilize Northern Inyo Healthcare District as the principle location of their practice but are given privileges and meet the qualifications and prerogatives as listed in these bylaws.

CURRENT COMPETENCE means a combination of observable and measurable knowledge, skills, abilities and personal attributes that constitute a practitioner's performance within the last twenty-four (24) months.

DATE OF RECEIPT means the date any notice, special notice, or other communication was delivered personally; or if such notice was sent by mail, it shall mean seventy-two (72) hours after the notice, special notice, or communication was deposited postage prepaid, in the United States mail.

DAYS means calendar days, unless otherwise specified.

DEPARTMENT or CLINICAL DEPARTMENT is a group of practitioners holding privileges in a designated clinical practice area.

DEPARTMENT CHIEF is the individual practitioner who is the elected leader of the designated clinical department.

DISTRICT means Northern Inyo Healthcare District (NIHD) and includes all inpatient and outpatient services operated by Northern Inyo Healthcare District.

EX-OFFICIO means service by virtue of office or position held. An ex-officio appointment is without vote unless otherwise specified.

HONORARY STAFF means those former medical staff members or other physicians, dentists or podiatrists who do not actively practice at Northern Inyo Healthcare District but are deemed deserving of membership as described in these bylaws.

IN GOOD STANDING means a member has unrestricted clinical privileges, is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws or policy of the medical staff.

INVESTIGATION means a process specifically instigated to determine the validity, if any, to a concern or complaint raised against a practitioner, and does not include activity of the physician wellness committee.

LEAD APP means the elected representative of the Advanced Practice Providers (APPs).

LIMITED LICENSE PRACTITIONER means a practitioner who is not a physician or an APP, but who practices under a license such as a dentist or podiatrist.

MEDICAL EXECUTIVE COMMITTEE means the executive committee of the medical staff.

MEDICAL DIRECTOR means the administratively-appointed physician leader of the medical or district department(s) or group(s).

MEDICAL STAFF means those Northern Inyo Healthcare District physicians (MD or DO), dentists, and podiatrists who have been granted recognition as members pursuant to the terms of these bylaws.

MEDICAL STAFF YEAR means the twelve-month period beginning July 1 through the subsequent June 30.

MEMBER means any physician, dentist, or podiatrist who has been appointed to the medical staff.

NOTICE means a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the medical staff or the district.

PHYSICIAN means an individual with an MD or DO degree who is currently licensed to practice medicine.

PRACTITIONER means, unless otherwise expressly limited, any currently licensed physician (MD or DO), limited license practitioner, or Advanced Practice Provider.

PREROGATIVES means the specific governance rights to which a member or APP may be entitled, depending upon the practitioner's category, including without limitation, rights to vote on medical staff and medical staff committee matters, hold medical staff office, or serve on medical staff committees.

PRIVILEGES or CLINICAL PRIVILEGES means the permission granted to a medical staff member or APP to render specific patient services.

PROCEDURAL RIGHTS means rights to a hearing and appeal in accordance with Article VII to which a practitioner becomes entitled to as the result of adverse actions taken or recommended which constitute grounds for a hearing.

TELEMEDICINE or TELEHEALTH means the remote diagnosis and treatment of patients by means of telecommunications technology.

UNFAVORABLE ACTION means an action which adversely affects the practitioner but, unlike an adverse action, is not reportable as defined under Business and Professions Code 805.

ARTICLE II: MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

No practitioner, including those in a medical-administrative position by virtue of a contract with the district, shall admit or provide medical or health-related services to patients of Northern Inyo Healthcare District unless the practitioner is a member of the medical staff or advanced practice provider with corresponding privileges or has been granted temporary, telemedicine or disaster privileges in accordance with the procedures set forth in these bylaws. Appointment to the medical staff shall confer only such clinical privileges and rights as have been granted by the board of directors in accordance with these bylaws. Privileges shall be granted and maintained only if the requested privileges are within Northern Inyo Healthcare District's patient care needs.

2.2 QUALIFICATIONS FOR MEMBERSHIP

2.2-1 GENERAL QUALIFICATIONS

Membership and privileges shall be extended only to practitioners who are professionally competent and continuously meet the qualifications, standards, and requirements as described in this article.

2.2-2 BASIC QUALIFICATIONS

A practitioner must demonstrate compliance with all basic standards set forth in this Section in order to have an application for medical staff membership or privileges accepted for review, except in the instance of appointment to honorary staff. The practitioner must:

(a) Qualify to practice in California as follows:

(1) Physicians must hold an MD or DO degree or their equivalent and a valid and unrestricted license to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Examiners. For purposes of this Section, "or their equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the California Board of Osteopathic Examiner;

(2) Podiatrists must hold a DPM degree and a valid and unrestricted certificate to practice podiatry issued by the Medical Board of California;

(3) Dentists must hold a DDS or equivalent degree and a valid and unrestricted license to practice dentistry issued by the California Board of Dental Examiners;

(b) Where applicable to their practice, have a valid and unrestricted federal Drug Enforcement Administration (DEA) certificate.

(c) Have professional liability insurance in not less than the minimum amounts as from time to time may be jointly determined by the board of directors and medical executive committee.

(d) Be board certified or board eligible as determined by the individual service and in the criteria for privileging.

(e) Be eligible to receive payments from the federal Medicare and state Medicaid (Medi-Cal) programs.

(f) If requesting privileges only in departments operated under an exclusive contract, be a member, employee, or subcontractor of the group or person that has the contract.

(g) Not have been convicted of, or plead guilty or no contest to, a felony related directly to his/her professional practice, or patient relationships, or involving moral turpitude, within the past seven (7) years.

A practitioner who does not meet these basic standards is ineligible to apply for medical staff membership or privileges, and the application shall not be accepted for review, except that the honorary medical staff do not need to comply with any of the basic standards. If it is determined during processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these bylaws.

2.2-3 ADDITIONAL QUALIFICATIONS FOR MEMBERSHIP

In addition to meeting the basic standards, the practitioner must, through the credentialing and privileging processes:

(a) Demonstrate his or her:

(1) Adequate education, training and experience in the requested privileges;

(2) Current professional competence;

(3) Good judgment; and

(4) Adequate physical and mental health status to demonstrate to the satisfaction of the medical staff that he or she is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality of care.

(b) Be determined to:

(1) Adhere to the lawful ethics of his or her profession;

(2) Work cooperatively with others in the district setting so as to not adversely affect patient care or district operations, as well as abide by the policy on professional conduct and prohibition of disruptive or discriminatory behavior;

(3) Keep as confidential, as required by law, all information or records received in the physician-patient relationship; and

(4) Participate in and properly discharge medical staff responsibilities.

2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership or privileges in the medical staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization,

is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this district.

2.4 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, physical or mental impairment, or sexual orientation if it does not pose a threat to the quality and safety of patient care.

2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for honorary staff, the ongoing responsibilities of each practitioner shall include:

(a) providing patients with the quality of care meeting the professional standards of the medical staff of this district;

(b) abiding by the medical staff bylaws, applicable Joint Commission (or other applicable accrediting body) standards, and applicable medical staff and district policies and procedures, including those related to the security of electronic health records;

(c) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of medical staff membership or privileges, including committee assignments, serving as a proctor, or performing peer review;

(d) preparing and completing in timely fashion medical records for all the patients to whom the practitioner provides care in the district;

(e) abiding by the ethical principles of the appropriate state medical or other professional association(s);

(f) working cooperatively with members, nurses, district administration and others so as not to adversely affect patient care, as well as complying with medical staff policy on professional conduct;

(g) making appropriate arrangements for coverage of that member's patients;

(h) refusing to engage in improper inducements for patient referral;

(i) participating in and documenting continuing education programs as determined by the medical staff for maintenance of privileges;

(j) discharging such other reasonable staff obligations as may be lawfully established from time to time by the medical staff or medical executive committee;

(k) performing and documenting, if granted the requisite privileges, or arranging for the performance of, a history and physical on every patient he/she admits. As further detailed in medical staff policy, a medical history and physical examination shall be completed no more than thirty (30) days before, or twenty-four (24) hours after, admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination is completed

within thirty (30) days before admission or registration, the physician must complete and document an updated examination of the patient within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The history and physical must be completed and documented by a practitioner in accordance with state law and medical staff policy.

(l) paying applicable dues and/or fees, if required; and

(m) promptly notifying the medical staff office in writing as soon as reasonably possible, but within 30 days:

(1) the initiation of formal proceedings by a medical licensing authority or the DEA to suspend, revoke, restrict or place on probation a license or DEA certificate;

(2) an action by the medical staff executive committee or the governing body of another hospital or health care entity to suspend, revoke, restrict, or deny clinical privileges for reasons related to professional competence or conduct;

(3) the practitioner's exclusion from participation in Medicare, Medi-Cal or any federal health care program or conviction of a criminal offense related to the provision of health care items or services;

(4) any formal allegations of fraud or abuse or illegal activity relating to the practitioner's professional practice or conduct made by any State or Federal government agency;

(5) any report filed with the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank,

(6) any injury, disability, or illness that would significantly interfere with his/her medical practice;

(7) the filing of any malpractice claim or action in which the Practitioner is a named defendant; or

(8) any other action that could affect his/her medical staff standing and/or clinical privileges at the healthcare district.

Failure to abide by the above-listed duties may result in adverse action.

2.6 CONTRACT PRACTITIONERS

2.6-1 MEMBERSHIP AND PRIVILEGES REQUIRED

A contract practitioner may provide services authorized pursuant to the applicable specified clinical services contract only if the specified clinical services are within the scope of privileges which the contract practitioner has been granted in accordance with these bylaws. Also, a practitioner who is an employee or subcontractor of a contract practitioner or a medical group or other professional entity which is a party to a contract at the district may be granted temporary privileges to serve as locum tenens for a contract practitioner, provided the practitioner otherwise meets applicable bylaws requirements for the granting and exercise of such temporary privileges.

2.6-2 EFFECT OF SPECIFIED CLINICAL SERVICES CONTRACT TERMINATION

The termination or expiration of the applicable specified clinical services contract shall automatically terminate only the practitioner's rights to provide services on such basis as specified in the contract, and

(a) Expressly shall not, of itself, affect the medical staff membership or privileges granted to the practitioner, and

(b) Accordingly, shall not entitle the contract practitioner to procedural rights unless otherwise required by law or expressly provided in the applicable specified clinical services contract.

The affected individual who wishes to maintain medical staff membership or privileges after termination of a contract must continue to comply with and adhere to the requirements set forth in these bylaws. Failure to comply will be deemed a voluntary resignation from medical staff membership and privileges. Such deemed resignation shall not entitle the practitioner to procedural rights.

2.6-3 MEDICAL STAFF ROLE IN SPECIFIED CLINICAL SERVICES CONTRACTING

Prior to approving, renewing, or modifying and, to the extent reasonably practical, prior to terminating, a specified clinical services contract, the board of directors, administrator, or chief medical officer shall give notice of the planned action to the medical staff by transmitting the notice to the medical executive committee. The medical staff and/or the medical executive committee may review and make recommendations to the board of directors regarding quality of care issues related to specified clinical services contractual arrangements for physician and/or professional services, prior to the district board taking final action in the matter.

2.7 ADMINISTRATIVE PRACTITIONERS

Members may be assigned duties by the district board which are solely administrative in nature, provided that such duties are reasonably related to the member's official medical staff responsibilities. The district board, in its sole discretion, may terminate such assignment at any time. Unless otherwise required by law, such purely administrative service assignment and termination is independent of, and shall have no effect on, the member's membership or privileges, shall not entitle the member to procedural rights, and records of such assignment or termination shall not be deemed part of the member's credentials files or any other medical staff records.

~~The medical executive committee may make recommendations to administration in the selection of and assignment of responsibilities to department medical directors or other practitioners contracted by the district to provide administrative services.~~

ARTICLE III: CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES

The categories of the medical staff shall include the following: active, courtesy, consulting, and honorary. At appointment and each time of reappointment, the member's staff category shall be determined.

There are several groups of practitioners who, due to the nature of their practice, do not require assignment to a medical staff category. The scope and extent of these practitioners' relationships with the healthcare district can be found in Article IV of these bylaws.

3.2 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the credentials committee, or pursuant to a request by a member under Section 5.6-1(b), or upon direction of the board of directors as set forth in Section 6.2-6, the medical executive committee may recommend a change in the medical staff category of a member consistent with the requirements of these bylaws.

3.3 ACTIVE STAFF

3.3-1 QUALIFICATIONS

The active staff shall consist of members who:

(a) meet the qualifications for membership set forth in Section 2.2;

(b) when on duty, are located close enough to the healthcare district to provide appropriate quality care, as per the policies of the specific department; and

(c) are regularly involved in patient care in this healthcare district and regularly involved in medical staff functions, as determined by the medical staff.

3.3-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

Except as otherwise provided, the rights and responsibilities of an active member shall be to:

(a) exercise such clinical privileges as are granted pursuant to these bylaws;

(b) attend and vote on matters presented at general and special meetings of the medical staff and of the department and committees to which the member is duly appointed;

(c) hold staff or department office and serve as a voting member of committees to which the member is duly appointed or elected by the medical staff or duly authorized representative thereof, so long as the activities required by the position fall within the member's scope of practice;

(d) pay medical staff membership dues and application fees in the amount as determined by the medical executive committee; and

(e) exercise other such rights and responsibilities at outlined in Table 3.8.

3.3-3 TRANSFER OF ACTIVE STAFF MEMBER

After two consecutive ongoing professional practice evaluation (OPPE) cycles as per policy in which a member of the active staff fails to regularly care for patients in this healthcare district or be regularly involved in medical staff functions as determined by the medical staff, that member shall be referred to the credentials committee to determine the appropriate category, if any, for which the member is qualified.

3.4 COURTESY STAFF

3.4-1 QUALIFICATIONS

The courtesy staff shall consist of members who:

(a) meet the general qualifications set forth in Section 2.2;

(b) when on duty, are located close enough to the healthcare district to provide appropriate quality care, as per the policies of the specific department;

(c) do not utilize this healthcare district as the principle location in their practice and are not regularly involved in medical staff functions; and

(d) are members in good standing of the active medical staff of another licensed hospital, and at the time of appointment and reappointment, are able to provide proof of continued membership and privileges at the primary hospital. Exceptions to this requirement may be made by the medical executive committee for good cause.

3.4-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

Except as otherwise provided, the rights and responsibilities of the courtesy staff shall be to:

(a) care for patients of the healthcare district and exercise such clinical privileges as are granted pursuant to these bylaws;

(b) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs, when available. Courtesy staff have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment;

(c) provide patient activity and quality review information from his or her primary facility as may be requested at the time of appointment and reappointment;

(d) pay medical staff membership dues and application fees, as determined by the medical executive committee; and

(e) exercise other such rights and responsibilities at outlined in Table 3.8.

Courtesy staff members shall not be eligible to hold office in the medical staff.

3.4-3 LIMITATIONS

Courtesy staff members who regularly admit patients or regularly care for patients at the district shall, upon review of the credentials committee and medical executive committee, be obligated to seek appointment to the appropriate staff category.

Courtesy staff members who do not maintain active staff membership at another licensed hospital shall be referred to the credentials committee to determine the appropriate category, if any, for which the member is qualified.

3.5 CONSULTING STAFF

3.5-1 QUALIFICATIONS

Any member of the medical staff in good standing may consult in that member's area of expertise; however, the consulting medical staff shall consist of such practitioners who:

(a) meet the qualifications set forth in Section 2.2 and are not otherwise members of the medical staff;

(b) possess adequate clinical and professional expertise;

(c) are called upon periodically by a practitioner at Northern Inyo Healthcare District to render care to patients treated at or admitted to this facility.

3.5-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

The rights and responsibilities of the consulting staff shall be to:

(a) treat and otherwise care for patients at this facility on request of the patient's practitioner;

(b) exercise such additional clinical privileges as are granted pursuant to these bylaws;

(c) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs, when available. Consulting staff have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment;

(d) pay application fees, as determined by the medical executive committee; and

(e) exercise other such rights and responsibilities at outlined in Table 3.8.

Consulting staff members shall not be eligible to hold office in the medical staff.

3.6 HONORARY STAFF

3.6-1 QUALIFICATIONS

The honorary staff shall consist of physicians, dentists, or podiatrists who do not actively practice at the district but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the district,

and who continue to exemplify high standards of professional and ethical conduct. Members who have retired from active practice and, at the time of their retirement, were members in good standing of the medical staff, and who continue to adhere to appropriate professional and ethical standards, shall also be eligible for appointment to honorary staff upon recommendation of the medical executive committee.

3.6-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

Honorary members are not eligible to admit patients to the hospital or to exercise clinical privileges in the district, or to vote or hold office in this medical staff organization, but they may serve upon committees without vote at the discretion of the medical executive committee. They may attend staff and department meetings, including open committee meetings and educational programs. Appointment to honorary staff shall be indefinite, unless otherwise requested by the member.

3.7 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the medical staff, limited license members (i.e., podiatrists and dentists):

(a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the medical executive committee; and

(b) shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 4.7.

3.8 TABLE OF PREROGATIVES BY MEDICAL STAFF CATEGORY

	Active	Courtesy	Consulting	Honorary
Exercise privileges	Yes	Yes	Yes	No
General voting rights	Yes	No	No	No
Attendance at general medical staff meeting required	Yes	No	No	No
May be committee member	Yes	Yes	Yes	Yes
Vote in committee	Yes	No, unless specified at time of appointment to committee	No, unless specified at time of appointment to committee	No
May hold medical staff office	Yes	No	No	No
May be committee chair	Yes	No	No	No
May be department chief	Yes	No	No	No
Pay dues	Yes	~~No~~Yes	No	No
Pay reappointment application fee	No	Yes	Yes	No
Must have malpractice insurance	Yes	Yes	Yes	No
Must file for reappointment	Yes	Yes	Yes	No

ARTICLE IV: CLINICAL PRIVILEGES

4.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws, a practitioner providing clinical services at this healthcare district shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to applicable policies and the authority of the department chief. Medical staff privileges may be granted or continued by the board of directors only upon recommendation of the medical staff and following the procedures outlined in these bylaws. Medical staff privileges may be modified or terminated by the mechanisms as outlined in these medical staff bylaws.

4.2 PRIVILEGE REQUESTS

Each application for privileges must contain a request for the specific clinical privileges desired by the applicant. A request for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

4.3 LAPSE OF APPLICATION

If a practitioner requesting initial or additional clinical privileges fails to furnish the information necessary to evaluate the request within thirty (30) days (or as otherwise agreed upon), the application shall be regarded as incomplete and lapse as detailed in Section 5.5-4, and the applicant shall not be entitled to a hearing.

4.4 BASIS FOR PRIVILEGE DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, current demonstrated professional competence and judgment, clinical performance, physical and mental health affecting the ability to perform duties, and the documented results of patient care and other quality review and monitoring as per ongoing and focused professional practice evaluations (OPPE and FPPE). If current competency cannot be demonstrated, an applicant may be eligible for re-entry per the current policy. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges. The decision to grant or deny a privilege and/or to renew an existing privilege shall include peer recommendations which address the applicant's:

1. Patient care
2. Medical/clinical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems-based practice

Privileges shall be granted and maintained only if the requested privileges are within the district's patient care needs. Furthermore, no specific privilege may be granted to a practitioner if the task, procedure or activity constituting the privilege is not available within the district despite the practitioner's qualifications or ability to perform the requested privilege, except as provided for under emergency privileges Section 4.11.

4.5 CRITERIA FOR "CROSS-SPECIALTY" OR NEW PRIVILEGES WITHIN THE DISTRICT

Any request for clinical privileges that are new to the district shall initially be reviewed by the appropriate departments and administration in order to establish the need for, and appropriateness of, the new procedure or services. Any request for new clinical privileges that overlap more than one department shall initially be reviewed by the appropriate departments in order to address criteria for the procedure. The medical executive committee shall facilitate the establishment of district-wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the medical executive committee may establish an ad hoc committee with representation from all appropriate departments.

Further details regarding the development and approval process for new privileges or new services can be found in applicable policy.

4.6 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

4.6-1 FPPE FOR INITIAL PRIVILEGES

(a) General Provisions:

(1) All initial appointees to the medical staff and all practitioners granted new clinical privileges shall be subject to a period of initial review and evaluation as further described in the medical staff's Focused and Ongoing Professional Practice Evaluation (FPPE and OPPE) policy.

(2) Until an initial appointee has been evaluated for core privileges and released from FPPE for these core privileges, he or she cannot be considered for a medical staff leadership position and cannot vote on any medical staff issues.

(b) Failure to Complete FPPE:

(1) If FPPE for core privileges is not completed due to an insufficient amount of clinical activity as per the FPPE and OPPE policy, the practitioner's membership and privileges will automatically expire, unless otherwise recommended by the credentials committee and medical executive committee. Such expiration shall not entitle the practitioner to procedural rights.

(2) If FPPE for special privileges is not completed due to an insufficient amount of clinical activity, FPPE can be extended as recommended by the proctor(s), the credentials committee, and the medical executive committee. In this instance, the practitioner's core privileges and eligibility for reappointment shall not be affected. Additionally, such extension of FPPE shall not be considered a limitation or restriction of privileges entitling the practitioner to procedural rights.

(3) If FPPE for any privilege (core or special) is not completed satisfactorily due to competency or quality of care concerns, the relevant privilege, and the membership if the privileges under question are core privileges, may be terminated and/or revoked. In this instance, the practitioner shall be entitled to the procedural rights outlined in these bylaws.

4.6-2 FPPE ARISING FROM CONCERNS

FPPE may also be initiated when the performance or outcomes of a practitioner are questionable, which may become evident with the occurrence of a single or sentinel event and/or patterns or trends indicating potentially unsafe patient care. The initiation of FPPE arising from concerns differs from FPPE for new privileges described under Section 4.6-1. Practitioners subject to FPPE arising from concerns may be entitled to procedural rights if such action is a reportable action.

4.7 CONDITIONS FOR PRIVILEGES OF PRACTITIONERS

4.7-1 ADMISSIONS

(a) The following categories of practitioners are eligible to independently admit patients to the hospital:

(1) Physicians (MDs or DOs)

(b) The following categories of practitioners are eligible to co-admit patients to the hospital:

(1) Dentists (non-MD)

(2) Podiatrists

(3) Certified Nurse Midwives

(c) Additionally, the following categories of APPs with admitting privileges (as per relevant standardized procedures/protocols) may admit patients upon order of a member of the medical staff who has admitting privileges and who maintains responsibility for the overall care of the patient:

(1) Physician Assistants

(2) Nurse Practitioners

4.7-2 RESPONSIBILITY FOR CARE OF PATIENTS

(a) The admitting practitioner shall establish at the time of admission, the patient's condition and provisional diagnosis.

(b) For patients admitted by or upon order of a limited license practitioner, a physician with appropriate privileges must assume responsibility for the care of the patient's medical or psychiatric problems that are present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

(c) Where a dispute exists regarding proposed treatment between a physician member and a practitioner with co-admitting privileges, the physician member's treatment plan shall be the recognized treatment plan.

4.7-3 SURGERY

Surgical procedures performed by limited license practitioners shall be under the overall supervision of the chief of the department of surgery or his or her designee.

4.8 TEMPORARY CLINICAL PRIVILEGES

Temporary privileges shall not exceed one hundred twenty (120) consecutive days, unless the medical executive committee recommends and the board of directors approves a longer period for good cause, and are allowed under two circumstances only: (1) to address a patient care need and (2) to permit patient care to be provided while an application is pending.

4.8-1 PATIENT CARE NEEDS

(a) Care of Specific Patient

Temporary clinical privileges may be granted to a practitioner where good cause exists to provide care to a specific patient or group of patients.

(b) Locum Tenens

Temporary clinical privileges may be granted to a practitioner serving as a locum tenens for a current member of the medical staff to meet the care needs of that member's patients or duties in his/her absence.

(c) Other Important Patient Care Needs

Temporary clinical privileges may be granted to allow a practitioner to fulfill an important patient care, treatment, or service need.

4.8-2 PENDING APPLICATION FOR MEDICAL STAFF MEMBERSHIP OR PRIVILEGES

Temporary clinical privileges may be granted to an applicant while his or her application for medical staff membership and/or privileges is completed and awaiting review and approval of the credentials committee, the medical executive committee or the board of directors.

4.8-3 PROCESS FOR GRANTING TEMPORARY CLINICAL PRIVILEGES

Applicants who have qualifications, ability, and judgment consistent with Section 2.2 can qualify to be granted temporary clinical privileges for patient care needs or to permit patient care while an application is pending, provided that:

(a) The medical executive committee has not made a final recommendation that is adverse or with limitation.

(b) The applicant has no current or previously successful challenge to professional licensure or registration.

(c) The application has no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges.

(d) The applicant has no unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment adverse to the applicant.

(e) The following has been completed:

(1) Verification of current California licensure;

(2) Verification of the National Practitioner Data Bank report;

(3) Verification of relevant training and experience;

(4) Verification of current competence and ability to perform the privileges requested.

A decision to grant temporary privileges to an applicant under this Section shall not be binding or conclusive with respect to an applicant's pending request for appointment to the medical staff. No practitioner has any right to be granted temporary privileges.

The administrator is given authority to grant temporary privileges to an applicant. Such action, however, shall be on the recommendation of the following medical staff members:

(1) The applicable clinical department chief;

(2) The credentials committee chairperson; and

(3) The chief of staff.

4.8-4 GENERAL CONDITIONS OF TEMPORARY PRIVILEGES

(a) If granted temporary privileges, the applicant shall act under the supervision of the department chief (or designee) to which the applicant has been assigned.

(b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VI and/or VII of these bylaws or unless affirmatively renewed. A medical staff applicant's temporary privileges shall automatically terminate if the applicant's initial application is withdrawn.

(c) Notwithstanding any other provision of these bylaws to the contrary, an applicant shall not be entitled to procedural rights if the applicant's request for temporary privileges is refused, or if all or any portion of the applicant's temporary privileges are suspended, unless such action is a reportable action.

(d) All persons receiving temporary privileges shall be bound by the medical staff bylaws and policies, and all applicable district policies.

4.9 TELEMEDICINE PRIVILEGES

Practitioners who wish to provide approved types of telehealth services will be credentialed and privileged according with this Section but, unless they separately qualify, apply, and are approved for

membership in a staff category described in Article III of these bylaws, will not be appointed to the medical staff in any membership category.

4.9-1 TELEMEDICINE CREDENTIALING

(a) In processing a request for telemedicine privileges, the medical staff may follow the normal credentialing process described in Article V of these bylaws, including but not limited to the collection of information from primary sources. Alternatively, the medical staff may elect to rely upon the credentialing and privileging decisions made by distant-site hospitals and telemedicine entities when making recommendations on privileges for individual distant-site practitioners, subject to meeting the conditions required by law and those specified in these bylaws.

(b) Telemedicine privileges shall be for a period not to exceed two (2) years, and shall be subject to re-evaluation and renewal pursuant to the same principles and process described in these bylaws for the renewal of clinical privileges held by medical staff members.

(c) The direct care or interpretive services provided by the distant-site practitioner must meet the professional standards of the district and its medical staff at all times. Distant-site practitioners holding telemedicine privileges shall be obligated to meet all of the basic responsibilities that must be met by members of the medical staff, as described in these bylaws, modified only to take into account their distance from the hospital and the need to pay dues.

(d) Telemedicine privileges may be denied, restricted, suspended or revoked at the discretion of the medical executive committee or the chief of staff acting on its behalf, without hearing rights as described in Article VII of these bylaws, except as required by law.

(e) Recognizing that telemedicine physicians may be privileged at many healthcare facilities and entities, the district shall conduct the primary verification procedures for an adequate number of hospitals, health care organizations and/or practice settings with whom the telemedicine physician is or has previously been affiliated in order to ensure current competency. In order to assist in this credentialing and privileging process, the district may request information from the telemedicine physician's primary practice site to assist in evaluation of current competency. The district may also accept primary source verification of credentialing information from the physician's primary practice site or the telemedicine entity to supplement its own primary source verification.

4.9-2 RELIANCE ON DISTANT-SITE ENTITIES

The medical staff may rely upon the credentialing and privileging decisions made by a distant-site hospital or distant-site telemedicine entity if the district board ensures through a written agreement with the distant-site hospital or entity that all of the following provisions are met:

(a) The distant-site entity acknowledges that it is a contractor of services to this district and, in accordance with 42 CFR §485.635(c)(4)(ii), furnishes services in a manner that permits Northern Inyo Healthcare District to be in compliance with the Medicare Conditions of Participation and appropriate accreditation agencies.

(b) The distant-site entity is either a Medicare-participating hospital or a lawful provider of the telemedicine services in question, and it confirms that its credentialing and privileging processes and standards for practitioners meet the standards described in the Medicare Conditions of Participation 42 CFR §485.616(c).

(c) The distant-site entity acknowledges, or the district confirms, that the distant-site entity has a process that is consistent with the credentialing and privileging requirements of the ~~Healthcare Facilities Accreditation Program standards for critical access hospitals (05.00.14 and 05.00.15).~~Joint Commission standards for critical access hospitals.

(d) The individual distant-site practitioner holds privileges at the distant-site entity to provide the services involved, and the distant-site entity provides the district with a current list of the distant-site practitioner's privileges at the distant-site entity.

(e) The individual distant-site practitioner is licensed in California, or is otherwise authorized by California law, to provide the services at issue, and is covered by professional liability insurance meeting the standards that apply to medical staff members at this district as described in these bylaws.

(f) The medical staff of Northern Inyo Healthcare District performs, and maintains evidence of, peer review of the distant-site practitioners' performance as it relates to district patients and sends the distant-site telemedicine entity such performance information for use in the periodic appraisal of the individual distant-site practitioners. At a minimum, the information this district will provide must include all adverse events that result from the telemedicine services provided by the distant-site practitioners to this district's patients and all complaints this district has received about the distant-site practitioners.

When the district is not a party to a written agreement with a distant-site Medicare participating hospital or distant-site entity containing all of the requirements of the CMS Hospital Conditions of related to distant-site telemedicine credentialing, the telemedicine physician must be credentialed and privileged pursuant to the general credentialing and privileging procedures described in Article V of these bylaws.

4.10 ADVANCED PRACTICE PROVIDERS

Advanced Practice Providers (APPs) are not eligible for medical staff membership, as per California law. They may be granted practice privileges if they hold a license, certificate, or other legal credential in a category of APPs that the board of directors (after securing medical executive committee recommendations) has identified as eligible to apply for practice privileges as set forth in Article VIII.

4.11 EMERGENCY PRIVILEGES

In the case of an emergency involving a particular patient, any practitioner with clinical privileges, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save the patient from serious harm provided that the care provided is within the scope of the individual's license or training. Once the emergency has passed or assistance has been made available, further care of the patient shall be assumed by a practitioner of the appropriate department.

4.12 DISASTER PRIVILEGES

In the case of a disaster in which the disaster plan has been activated and the district is unable to handle the immediate patient needs, the following may grant disaster privileges to volunteer practitioners in accordance with the process outlined in the applicable medical staff policy:

(a) the chief of staff;

(b) any physician member of the medical executive committee;

(c) any department chief;

(d) any active medical staff member; or

(e) designee of any of the above.

The volunteer practitioner shall be required to submit identification and other such required documentation for verification as further detailed in policy. The medical staff shall oversee the performance of all volunteer practitioners. Once the care of disaster victims can be adequately assumed by the members of the regular medical staff, then disaster privileges of the volunteer will be terminated as further detailed in policy.

ARTICLE V: APPLICATION PROCEDURES FOR PRIVILEGES

5.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by Northern Inyo Healthcare District in administratively responsible positions) shall exercise clinical privileges in the district or via telemedicine link unless and until that person applies for and receives approval to exercise clinical privileges as set forth in these bylaws, or, with respect to advanced practice providers, has been granted a service authorization or privileges under applicable medical staff policies.

A request for an initial application will be reviewed by the chief of staff for appropriateness. By applying to the medical staff for privileges (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these bylaws and policies, and agrees to comply with the responsibilities of medical staff membership and with the bylaws and policies of the medical staff as they exist and as they may be modified from time to time.

5.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, privileges, or transfer of staff category, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's current competence, character, ethics, and other qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for the medical staff's refusal to take action on the application, which shall not be subject to appeal or review under Article VII of these bylaws. To the extent consistent with law, this burden may include submission to a medical or psychological examination as per relevant credentialing policy, at the applicant's expense, if deemed appropriate by the medical executive committee, which may select the examining physician. If current competency cannot be demonstrated, an applicant may be eligible for re-entry per the current policy.

5.3 APPOINTMENT AND AUTHORITY

The medical staff shall make recommendations to the board of directors for appointments, denials and revocations of appointments to the medical staff as set forth in these bylaws.

5.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Initial appointments and reappointments to the medical staff shall be for a period of up to two (2) years. Any recommendation for appointment or reappointment of less than two (2) years is at the sole discretion of the medical executive committee and is not subject to rights of appeal as set forth in Article VII.

5.5 APPLICATION FOR INITIAL APPOINTMENT, REAPPOINTMENT, AND PRIVILEGES

5.5-1 APPLICATION FORM

An application form shall be developed by the district and the medical staff. The form shall require detailed information which shall include, but not be limited to, information concerning:

(a) the applicant's qualification, including, but not limited to, professional education, training and experience, current licensure, current DEA registration (if applicable), and continuing

medical education information related to the clinical privileges to be exercised by the applicant;

(b) peer references familiar with the applicant's current professional competence and ethical character;

(c) requests for membership categories, departments, and clinical privileges;

(d) past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of medical staff membership or privileges or any licensure or registration, and related matters;

(e) any past or pending arrests, indictments, criminal charges, or convictions brought against the applicant;

(f) current physical and mental health status, to the extent necessary to determine the applicant's ability to perform obligations or requested privileges, or as otherwise permitted by law;

(g) final judgments, settlements, or arbitration awards made against the applicant in professional liability cases, and any filed and served cases pending;

(h) professional liability insurance coverage, in not less than the minimum amounts as from time to time may be jointly determined by the medical executive committee and board of directors; and

(i) any past, pending or current exclusion of suspension from a state or federal health care program, or any investigation or disciplinary action by any governmental agency relating to the applicant's professional license or practice.

Each application shall be in writing, or electronically submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, that person shall be given a copy of these bylaws and, as deemed appropriate by the medical executive committee, copies or summaries of any other applicable medical staff and district policies relating to clinical practice in the district. Failure to disclose the information requested in the application, or knowingly providing false or misleading information may result in disciplinary action, including suspension or termination of membership and/or privileges, or in a decision that the application does not qualify for credentialing consideration.

5.5-2 EFFECT OF APPLICATION

In addition to the matters set forth in Section 5.1, by submitting an application for privileges, each applicant:

(a) signifies willingness to appear for interviews in regard to the application;

(b) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

(c) consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

(d) releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

(e) releases from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

(f) consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the district or medical staff may have, and releases the medical staff and district from liability for so doing to the fullest extent permitted by law;

(g) if a requirement then exists for medical staff dues, acknowledges responsibility for timely payment;

(h) agrees to provide quality care for patients;

(i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the care of the applicant's patients, seeking consultation whenever indicated, refraining from providing illusory or unnecessary surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;

(j) pledges to be bound by the medical staff bylaws and policies, as well as applicable district policies; and

(k) agrees that if membership and/or privileges are granted, and for the duration of medical staff membership and/or privileges, the applicant has an ongoing and continuous duty to report to the medical staff office as soon as reasonably possible, but within thirty (30) days, any and all information that would otherwise correct, change, modify or add to any information provided in the application or most recent reapplication.

5.5-3 VERIFICATION OF INFORMATION

The applicant shall deliver a completely filled-in, signed, and dated application and supporting documents to the medical staff office and an advance payment of non-refundable medical staff dues or fees, if any is required. The administrator or chief medical officer and chief of staff shall be notified of the application. The medical staff office shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The district's authorized representative shall query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the credentials committee for inclusion in the applicant's or member's credentials file. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain any reasonably requested information. Failure to provide any requested information within thirty (30) days of a request, or an otherwise agreed

to timeframe, shall be deemed a voluntary withdrawal of the application and no further action will be taken with respect to the application. When collection and verification of information is accomplished, all such information shall be transmitted to the credentials committee and the appropriate department(s). No final action on an application may be taken until receipt of the Data Bank report.

5.5-4 DETERMINE IF APPLICATION IS COMPLETE

The application will be deemed complete when all required information has been submitted by the applicant and all necessary verifications have been obtained. An application will become incomplete if the need arises for new, additional, or clarifying information at any time prior to final determination by the board. Notwithstanding any other provision of these bylaws, an application that is determined to be incomplete shall not qualify for privileging recommendations, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after thirty (30) days of a request, or an otherwise agreed-to timeframe, the credentialing and privileging process will be terminated. An incomplete application will not be processed. Termination of the credentialing and privileging process under this provision shall not entitle the applicant to any hearing or appeal under Article VII.

5.5-5 DEPARTMENT ACTION

After receipt of the application, the chief of each department to which the application is submitted shall review the application and supporting documentation, may seek additional information, and may conduct a personal interview with the applicant at the chief's discretion. The chief shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges requested, his/her clinical and technical skills, any relevant data available from district performance improvement activities, and the applicant's participation in relevant continuing education. The chief shall transmit to the credentials committee his or her recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The chief may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

5.5-6 CREDENTIALS COMMITTEE ACTION

The credentials committee shall review the application, evaluate and verify the supporting documentation, the department chief's recommendations, and other relevant information. The credentials committee may elect to interview the applicant and seek additional information. As soon as practicable, the credentials committee shall transmit to the medical executive committee a written report with its recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The credentials committee may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

5.5-7 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the credentials committee report and recommendation, or as soon thereafter as is practicable, the medical executive committee shall consider the report and any other relevant information. The medical executive committee may request additional information, return the matter to the credentials committee for further investigation, and/or elect to interview the applicant. The medical executive committee shall immediately forward to the administrator, for prompt transmittal to the board of directors, a written report with its recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The medical executive committee may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

5.5-8 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) Favorable recommendation: When the recommendation of the medical executive committee is favorable to the applicant, it shall be immediately forwarded to the board of directors and the supporting documentation shall be made available upon request.

(b) Unfavorable recommendation: When the recommendation of the medical executive committee is an unfavorable action, in whole or in part, the board of directors and the applicant shall be promptly informed by written notice. The applicant shall not be entitled to procedural rights as provided in Article VII.

(c) Adverse recommendation: When a final recommendation of the medical executive committee is an adverse action, in whole or in part, the board of directors and the applicant shall be promptly informed by written notice. The applicant shall be entitled to procedural rights as provided in Article VII. The board of directors shall not take action on the pending adverse recommendation until the applicant has exhausted or waived his/her procedural rights.

5.5-9 BOARD OF DIRECTORS ACTION

On favorable recommendation of the medical executive committee:

(a) A decision of the board to adopt a favorable recommendation of the medical executive committee shall be deemed as final action.

(b) If the board is inclined to reject or modify a favorable recommendation, the board shall refer the matter to the joint conference committee.

(c) If the board's resolution constitutes grounds for a hearing under Article VII of the bylaws, the administrator shall promptly inform the applicant and the chief of staff, and the applicant shall be entitled to the procedural rights as provided in that Article. Once the applicant has exhausted or waived his/her procedural rights, the board may then take final action.

On adverse recommendation of the medical executive committee:

(a) Once the applicant has exhausted or waived his or her procedural rights, the board may take final action in the matter or refer the matter to the joint conference committee.

5.5-10 NOTICE OF FINAL DECISION

(a) Notice of the final decision shall be given to the applicant, the chief of staff, the chief of each department concerned, and the administrator if not previously informed.

(b) A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the department to which that person is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

5.5-11 REAPPLICATION AFTER ADVERSE OR UNFAVORABLE ACTION

An applicant who has received a final adverse action, as defined in these bylaws, regarding an application for appointment, reappointment, or privileges shall not be eligible to reapply to the medical staff for a period of three (3) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

An applicant who has received an unfavorable action, as defined in these bylaws, is eligible to reapply once the deficiency has been corrected. The waiting period shall not apply.

5.5-12 TIMELY PROCESSING OF APPLICATIONS

Once an application is deemed complete, it is expected to be processed within one hundred twenty (120) days, unless it becomes incomplete at any point during processing as described in these bylaws. This time period is provided to assist in the processing of the application and not to create rights for applicants to have their applications processed within this specific time period.

5.6 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

Applicants for reappointment, renewal of privileges, and requests for modifications of staff status or privileges shall be subject to all of the general application provisions of these bylaws, subject only the following additional provisions:

5.6-1 REAPPLICATION DEADLINE AND CONTENT

(a) At least one hundred fifty (150) days prior to the expiration date of the current staff appointment or expiration of privileges for privileges-only practitioners (for example, telemedicine), a reapplication form shall be submitted to the member or privileged practitioner. At least one hundred twenty (120) days prior to the expiration date, each applicant shall submit to the medical staff office the completed application form for renewal of appointment to the staff and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant. However, an applicant for reappointment shall not be required to repeat information which has been provided and verified in a prior application and in which there has been no change during the period since the application submitted

the prior application. For such information, in response to each relevant portion of the application form, the applicant shall indicate that the information is unchanged.

(b) A medical staff member or privileged practitioner who seeks a change in medical staff status or modification of clinical privileges may submit such a request at any time.

(c) The timely processing of reapplications from receipt of the application to final action shall be one hundred twenty (120) days.

5.6-2 FAILURE TO FILE REAPPOINTMENT APPLICATION

If an application for reappointment is not received at least one hundred twenty (120) days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. The applicant may submit a request for extension to the medical executive committee for consideration.

If an applicant fails, without good cause, to submit the required application by the deadline, but submits it prior to the expiration date of the applicant's privileges, and no final decision has been rendered by the expiration date due to the delays caused by the applicant's failure to timely submit the complete application, the applicant's privileges and prerogatives shall be deemed to be automatically suspended upon the expiration date unless otherwise extended by the medical executive committee with the approval of the board of directors. The automatic suspension shall remain in effect until the district board makes a final decision on the application.

If an applicant fails, without good cause, to submit the required reappointment application by the expiration date of the applicant's privileges, or to provide information requested to complete the application after receiving a notice of incomplete application, the applicant shall be deemed to have voluntarily resigned from membership and relinquished all privileges, effective as of the expiration date of the applicant's term of appointment and/or privileges.

In the event membership terminates and/or privileges lapse for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

5.7 LEAVE OF ABSENCE

A practitioner taking any of the following leaves of absence for a duration exceeding ~~one hundred eighty (180)~~ninety (90) days must notify the medical staff office prior to the start of leave, stating the approximate period of leave desired, which may not exceed one (1) year. Absence for longer than one (1) year shall result in automatic expiration of medical staff appointment and clinical privileges, unless an extension is requested in writing at least forty-five (45) days prior to the one-year date and granted by the medical executive committee. Reinstatement from any leave shall be subject to the provisions listed in Section 5.7-5.

5.7-1 ROUTINE LEAVE OF ABSENCE

A practitioner may take a routine leave of absence, giving consideration to his/her contractual obligations. The medical executive committee shall be notified of the leave.

5.7-2 MEDICAL LEAVE OF ABSENCE

A practitioner may take a medical leave of absence to accommodate treatment for, or recovery from, a behavioral health or physical health condition affecting his or her fitness to practice safely. The approximate period of leave needed shall be specified, and as reasonable during the leave, the medical executive committee shall be kept informed of changes to the projected date of return. The practitioner may be required to submit a letter of release from the treating physician as part of the reinstatement process confirming that his or her health is free from any impairment prior to exercising any patient care. The medical executive committee may, at its discretion, require a fit for duty evaluation be performed by a provider of its choosing and at the practitioner's cost.

5.7-3 MILITARY LEAVE OF ABSENCE

A practitioner may request a leave of absence to fulfill military service obligations. Such request shall be granted upon notice and review by the medical executive committee.

5.7-4 OBLIGATION UNDER LEAVE OF ABSENCE

During the period of the leave, the practitioner shall not exercise clinical privileges at Northern Inyo Healthcare District, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical executive committee.

Before any routine leave of absence may begin, all medical records must be completed and dues must be current, unless such dues are excused by the medical executive committee. Meeting attendance requirements will be waived during the period of leave.

5.7-5 REQUEST FOR REINSTATEMENT

At least forty-five (45) days prior to the termination of the leave of absence or as soon as reasonably known, the practitioner may request reinstatement of privileges by submitting a written notice to the medical executive committee (and in the case of an advanced practice provider, written notice to the interdisciplinary practice committee in addition to the medical executive committee). The medical executive committee shall make a recommendation concerning the reinstatement of the practitioner's privileges and prerogatives, which may take into consideration a summary of the practitioner's activities during the leave. Reinstatement may be granted subject to focused professional practice monitoring and/or evaluation as determined by the medical executive committee. A recommendation that a practitioner be denied reinstatement shall be considered a denial of privileges and may be appealed as such pursuant to these bylaws.

5.7-6 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff or advanced practice provider staff and shall result in automatic expiration of membership, privileges, and prerogatives. A practitioner whose membership and/or privileges automatically expires under this provision may contest this action to the medical executive committee by submitting a written statement or request a meeting before the committee. The medical executive committee's decision on the matter shall be final. A request for membership and/or privileges subsequently received from a member terminated under this provision shall be submitted and processed in the manner specified in these bylaws for initial appointments.

5.7-7 EXPIRATION OF APPOINTMENT WHILE ON LEAVE

If a practitioner's term of appointment is scheduled to expire during the period for which a leave is requested, the practitioner may:

(a) Seek and obtain reappointment prior to going on leave, which would result in an adjustment of the practitioner's subsequent term of appointment to reflect the new date of reappointment. The medical staff may require that supplemental information be produced to confirm current competence upon reinstatement; or

(b) Apply for reappointment at the scheduled time while on leave. The medical staff may require that supplemental information be produced to confirm current competence upon reinstatement; or

(c) Permit the current term of appointment to expire and reapply for membership and/or privileges as an initial applicant once the leave of absence has ended.

ARTICLE VI: PEER REVIEW AND CORRECTIVE ACTION

6.1 MONITORING AND PEER REVIEW

Medical staff departments and committees are responsible for carrying out delegated peer review and quality assessment functions as per applicable peer review and quality policies. They may counsel, educate, issue letters of warning or censure, or initiate focused review or retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admission and procedures) without initiating an investigation or formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. Informal actions, focused review, monitoring or counseling shall be documented in the practitioner's file and reviewed as part of their ongoing professional practice evaluation. Medical executive committee approval is not required for such actions, but the medical executive committee shall be notified if trends or concerns are noted. Such routine peer review and quality assessment functions shall not constitute an investigation and shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights as described in Article VII of these bylaws.

6.2 CORRECTIVE ACTION

Corrective action is separate from routine monitoring and peer review and can be initiated at any time as outlined in this Section. A practitioner is not required to have exhausted all monitoring and peer review activities prior to initiation of a corrective action. It is recommended that medical staff legal counsel be consulted in corrective action proceedings.

6.2-1 CRITERIA FOR INITIATION

Any person may provide information to the medical staff office or officer of the medical staff about the conduct, performance, or competence of its members and practitioners, who will then take this information to the department chief, the chief of staff or medical executive committee. When reliable information indicates a practitioner may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the district; (2) unethical; (3) contrary to the medical staff bylaws; or (4) below applicable professional standards, an investigation or request for action may be initiated.

6.2-2 INITIATION

A request for an investigation or action against such practitioner may be initiated by the chief of staff or the medical executive committee. The request must be submitted to the medical executive committee, and supported by reference to specific activities or conduct alleged. If the medical executive committee initiates the request, it shall make an appropriate recording of the reasons in the minutes.

6.2-3 INVESTIGATION

If the medical executive committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The medical executive committee may conduct the investigation itself, or may assign the task to an ad hoc committee of the medical staff. If an ad hoc committee is formed, the chief of staff shall appoint the members of the ad hoc committee with the recommendation of the medical executive committee. If the investigation is delegated to an officer or committee other than the

medical executive committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the medical executive committee as soon as practicable. The report may include recommendations for appropriate corrective action. The affected practitioner shall be promptly notified by the chief of staff that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The body investigating the matter may, but is not obligated to:

(a) conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply; and

(b) review the practitioner's file.

Despite the status of any investigation, at all times the medical executive committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

6.2-4 EXECUTIVE COMMITTEE ACTION

As soon as practicable after the conclusion of the investigation, the medical executive committee shall take action which may include, without limitation:

(a) determining no corrective action be taken and, if the medical executive committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the practitioner's file;

(b) referring the practitioner to the Physician Wellness Committee for evaluation and follow-up as appropriate;

(c) deferring action for a reasonable time where circumstances warrant;

(d) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude committees or departments or their chiefs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected practitioner may make a written response which shall be placed in his or her file;

(e) recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;

(f) recommending reduction, modification, suspension or revocation of clinical privileges;

(g) recommending reductions of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care;

(h) recommending suspension, revocation or probation of medical staff membership; and

(i) taking other actions deemed appropriate under the circumstances.

6.2-5 SUBSEQUENT ACTION

~~The medical executive committee's action or recommendation following an investigation as described herein shall be presented to the board of directors at its next regularly scheduled meeting.~~

If the medical executive committee has imposed or recommended corrective action as to which the affected practitioner may request a hearing, the board of directors ~~may~~ shall be advised of the action and hearing request~~. at their next regularly scheduled meeting~~.

~~(a) If the medical executive committee decides not to take or recommend corrective action, or to take or recommend corrective action as to which the practitioner either has no rights of hearing or appeal or has waived such rights, and the board of directors questions or disagrees with the action of the medical executive committee, the matter may be remanded back to the medical executive committee for further consideration. If the decision of the board of directors is to take corrective action more severe than the action of the medical executive committee, and a hearing is required pursuant to Article VII, the procedure shall be as described in that Article for hearings that are prompted by action of the board of directors.~~

6.2-6 INITIATION BY BOARD OF DIRECTORS

If the medical executive committee fails to investigate or take disciplinary action in response to information about a practitioner's competence, performance, or conduct that is provided in accordance with the provisions of this Article, and if the board of directors determines that the medical executive committee's failure to proceed is contrary to the weight of the evidence, the board of directors may direct the medical executive committee to initiate investigation or disciplinary action. The board's request for medical staff action shall be in writing and shall set forth the basis for the request.

If the medical executive committee fails to take action in response to such direction from the board of directors, then the board may initiate the dispute resolution process as described in the Joint Conference Committee of these bylaws (unless immediate action is required to protect the health or safety or any individual, in which event the procedures for summary suspension shall apply). If the dispute resolution process does not result in action by the medical executive committee, and the board of directors still believes action is necessary, then the board of directors may initiate an investigation or corrective action after written notice to the medical executive committee, and shall fully comply with Articles VI and VII of these medical staff bylaws.

6.3 SUMMARY RESTRICTION OR SUSPENSION

6.3-1 CRITERIA FOR INITIATION

Whenever a practitioner's conduct is such that failure to take action may result in an imminent danger to the health of any individual, including but not limited to current or future patients, the chief of staff, the medical executive committee, or the chief of the department in which the practitioner holds privileges may summarily restrict or suspend the medical staff membership or clinical privileges of such practitioner. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to

the board of directors, the medical executive committee, the medical staff office, the chief medical officer and the administrator. In addition, the affected practitioner shall be provided with a written notice of the action that fully complies with the requirements of Section 6.3-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the practitioner's patients shall be promptly assigned to another practitioner by the department chief or by the chief of staff, considering where feasible, the wishes of the patient in the choice of a substitute practitioner. Summary suspension or restriction shall automatically constitute a request for investigation pursuant to this Article.

6.3-2 NOTICE OF SUMMARY SUSPENSION

The affected practitioner shall be promptly provided with written notice of such suspension within two (2) business days. This initial written notice shall generally describe the reasons for the action, the extent of the action, and the effective date and time of the action. Oral notice of summary suspension may be provided immediately to the affected practitioner and prior to the written notice if needed in order to assure patient safety.

This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3-1 (which applies in all cases where the medical executive committee does not immediately terminate the summary suspension). The notice under Section 7.3-1 may supplement the initial notice provided under this Section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

6.3-3 MEDICAL EXECUTIVE COMMITTEE ACTION

As soon as reasonably possible under all circumstances after such summary restriction or suspension has been imposed, a meeting of the medical executive committee shall be convened to review and consider the action. Upon request, the affected practitioner may attend and make a statement concerning the issues under investigation, on such terms and conditions as the medical executive committee may impose, although in no event shall any meeting of the medical executive committee, with or without the practitioner, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The medical executive committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the practitioner with notice of its decision within two (2) working days of the meeting. A copy of the notice shall be given to the administrator and the chief medical officer, the district board, and the relevant department chief.

6.3-4 PROCEDURAL RIGHTS

Unless the medical executive committee promptly terminates the summary restriction or suspension, it shall remain in effect during the pendency of the corrective action, hearing and appeal process, and the practitioner shall be entitled to the procedural rights afforded by Article VII.

6.3-5 INITIATION BY BOARD OF DIRECTORS

If the chief of staff, members of the medical executive committee and the chief of the department in which the practitioner holds privileges are not available to summarily restrict or suspend the practitioner's membership or clinical privileges, the board of directors (or the administrator on-call, as

designee) may immediately suspend a practitioner's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any person, provided that the board of directors (or administrator on-call) made reasonable attempts to contact the chief of staff, members of the medical executive committee and the chief of the department before the suspension.

A suspension under this Section is subject to ratification by the medical executive committee. If the medical executive committee does not ratify such a summary suspension within two (2) business days, the summary suspension shall terminate automatically. If the medical executive committee does ratify the summary suspension, all other provisions under Section 6.3 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the medical executive committee for purposes of compliance with notice and hearing requirements.

6.4 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the practitioner's privileges or membership may be suspended or limited as described, with no right to hearing unless reportable by law to the Medical Board of California. However, the practitioner may appear before the medical executive committee or submit a written statement addressing the question of whether grounds exist for the special action as set forth below. A practitioner may be eligible to reapply for reinstatement of privileges if the cause for such automatic action has been resolved.

6.4-1 LICENSURE

(a) Revocation and Suspension: Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked or suspended, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

(b) Restriction: Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any clinical privileges which the practitioner has been granted which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(c) Probation: Whenever a practitioner is placed on probation by the applicable licensing or certifying authority, membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

(d) Expiration: Whenever a practitioner's license is expired or evidence of renewal has not been received, the practitioner shall be automatically suspended until such time as evidence of current licensure has been received. Failure to reinstate such license or other legal credential within thirty (30) days of such lapse or expiration shall result in automatic termination of medical staff membership and/or clinical privileges.

6.4-2 DRUG ENFORCEMENT ADMINISTRATION (DEA) CERTIFICATE

(a) Whenever a practitioner's DEA certificate is revoked, limited, expired, or suspended, the practitioner shall automatically and correspondingly be divested of the right to prescribe

medications covered by the certificate, as of the date such action becomes effective and throughout its term.

(b) Probation: Whenever a practitioner's DEA certificate is subject to probation, the practitioner's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

6.4-3 MEDICAL RECORDS

Members of the medical staff and other clinically privileged practitioners are required to complete medical records within such reasonable time as may be prescribed by the district and the medical staff. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed may be imposed by the chief of staff after notice of delinquency for failure to complete medical records within such period has been given to the practitioner. For the purpose of this Section, "related privileges" means voluntary on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within Northern Inyo Healthcare District. Bona fide leave may constitute an excuse subject to approval by the medical executive committee. Practitioners whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the chief of staff or his or her designee. If within ninety (90) days after implementation of suspension the practitioner has not completed the delinquent records, the practitioner's membership and privileges shall be automatically terminated without right to a hearing unless reportable by law.

6.4-4 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance in the amounts indicated shall result in an automatic suspension of a practitioner's clinical privileges, and if within ninety (90) days after written warning of the delinquency the practitioner does not provide evidence of required professional liability insurance and evidence of coverage for the interim, the practitioner's membership and privileges shall be automatically terminated without right to a hearing unless reportable by law.

6.4-5 FAILURE TO PROVIDE INFORMATION OR SATISFY SPECIAL ATTENDANCE REQUIREMENT

Failure without good cause to provide information or appear when requested by a medical staff committee or department as described in these bylaws shall result in the referral to the medical executive committee for action, which may include automatic suspension of all privileges. The automatic suspension shall remain in effect until the practitioner has provided the requested information and/or satisfied the special attendance requirement.

6.4-6 FELONY CONVICTION OR PLEA

A practitioner who has been convicted of, or who has pleaded guilty or no contest to, a felony within the past seven (7) years shall not be eligible for privileges or initial appointment to the medical staff unless the medical executive committee determines, in its sole discretion, the felony was not directly related to the practitioner's professional practice or patient relationships,.

If a practitioner of the medical staff is convicted of, or pleads guilty or no contest to a felony, the practitioner's medical staff membership and privileges shall be automatically suspended pending review

by the medical executive committee. If the medical executive committee, in its sole discretion, confirms that the felony was directly related to the practitioner's professional practice or patient relationships or involving moral turpitude, the practitioner's staff membership and privileges shall terminate without right to a hearing. If the medical executive committee determines, in its sole discretion, the felony was not directly related to the practitioner's professional practice or patient relationships, the practitioner shall be permitted to request reinstatement as an initial applicant.

6.4-7 EXCLUSION FROM GOVERNMENTAL PROGRAM

A practitioner who is excluded as a provider from any governmental health care program (including but not limited to Medicare and Medi-Cal) may not apply for initial appointment to the medical staff. If a privileged practitioner is excluded as a provider from such governmental program during their appointment, the practitioner's medical staff membership and privileges shall be automatically terminated without right to a hearing.

6.4-8 NOTICE OF AUTOMATIC ACTION

No notice shall be required for an automatic action to become effective. However, as soon as reasonably practical after the automatic action becomes effective, written notice shall be provided to the affected practitioner, the administrator, the chief medical officer, the department chief, and the chief of staff.

6.4-9 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after automatic action is taken or warranted, the medical executive committee shall convene to review and consider the facts, and may recommend any further corrective action as it may deem appropriate in accordance with these bylaws.

ARTICLE VII: HEARINGS AND APPELLATE REVIEWS

7.1 GENERAL PROVISIONS

7.1-1 PROCESS TO CHALLENGE ADVERSE ACTIONS REPORTABLE UNDER BUSINESS AND PROFESSIONS CODE SECTION 805

The notice, hearing and appeal provisions available to a practitioner to contest an action or final recommended action which must be reported to the Medical Board of California under Business and Professions Code Section 805 shall be governed by the provisions of this Article commencing with Section 7.2 below.

7.1-2 PROCESS TO CHALLENGE UNFAVORABLE ACTIONS NOT REPORTABLE UNDER BUSINESS AND PROFESSIONS CODE SECTION 805

A practitioner who is adversely and significantly affected by an unfavorable action or recommended action for which a review process is not otherwise provided in these bylaws or in or policies, and which is not reportable under Business and Professions Code Section 805, may contest such actions or recommended actions by delivering a written request for review to the medical executive committee. In no event shall any meeting of the medical executive committee, with or without the practitioner, constitute a hearing within the meaning of Article VII, nor shall any procedural hearing rights apply. If the action or recommended action was made by the board of directors, the practitioner may contest the matter by providing written request for review to the board of directors. Any such request for review must be delivered within thirty (30) days from the practitioner's receipt of notice of the action or recommendation.

Examples of matters reviewable under this Section include, without limitation, restriction of clinical privileges for less than thirty (30) days in a twelve (12) month period; summary suspension of clinical privileges for fourteen (14) days or less; and termination, denial or restriction of privileges or membership rights for reasons other than medical disciplinary cause as defined in Business and Professions Code Section 805.

7.1-3 DUTY TO EXHAUST INTERNAL REMEDIES

All practitioners and applicants are obligated to exhaust all remedies provided in this Article or elsewhere in medical staff bylaws before initiating legal action. Any practitioner who fails to exhaust the remedies (including all hearing and appeal remedies) provided in these bylaws before initiating legal action, shall be liable to pay the full costs, including legal fees, required to respond to such legal action.

7.1-4 TIMELY COMPLETION OF PROCESS

The hearing and appeal process shall be completed within a reasonable time.

7.1-5 FINAL ACTION

Recommended adverse actions described in Section 7.2 shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived, and only upon being adopted as final actions by the board of directors.

7.2 GROUNDS FOR HEARING

Except as otherwise specified in these bylaws, any one or more of the following adverse actions shall constitute grounds to request a hearing:

(a) denial of initial medical staff appointment or requested reappointment to the medical staff, based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;

(b) denial of requested clinical privileges based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;

(c) summary suspension of staff membership or staff privileges for greater than fourteen (14) days;

(d) termination or revocation of medical staff membership or clinical privileges based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;

(e) involuntary reduction or restriction of clinical privileges or membership for thirty (30) days or more in any twelve (12) month period; or

(f) any other disciplinary action or recommendation that must be reported, by law, to the practitioner's California licensing authority under Business and Professions Code Section 805.

7.3 REQUESTS FOR HEARING

7.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the practitioner shall be given prompt written notice of:

(a) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Medical Board of California and/or to the National Practitioner Data Bank, if required;

(b) a brief description of the reasons for the proposed action;

(c) the right to request a hearing pursuant to Section 7.3-3, and that such hearing must be requested in writing within thirty (30) days; and

(d) a summary of the rights granted in the hearing pursuant to the medical staff bylaws.

7.3-2 HEARINGS PROMPTED BY BOARD OF DIRECTORS ACTION

If the hearing is based upon an adverse decision or recommendation of the board of directors, the board of directors or its designee shall fulfill the duties assigned to the medical executive committee or the chief of staff when the medical executive committee is the body whose decision prompted the hearing. This shall include, but not be limited to, preparing the notice of adverse action or recommended action and right to a hearing, scheduling the hearing, providing the notice of hearing and statement of charges, and designating the judicial review committee, presenter and witnesses.

7.3-3 REQUEST FOR HEARING

The practitioner shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the medical executive committee with a copy to the board of directors. Any such request shall include the practitioner's intent with regard to representation. In the event the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

7.3-4 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the medical executive committee has thirty (30) days to schedule a hearing. The medical executive committee will give notice to the practitioner of the time, place and date of the hearing. The date of the commencement of the hearing shall be not be more than sixty (60) days from the date of receipt of the request by the medical executive committee for a hearing, so long as the practitioner has at least thirty (30) days from the date of notice to prepare for the hearing, or both parties mutually agree to an earlier date. When the request is received from a practitioner who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made.

7.3-5 NOTICE OF HEARING AND NOTICE OF REASONS OR CHARGES

Together with the notice stating the place, time and date of the hearing, the chief of staff or designee on behalf of the medical executive committee shall provide the reasons for the recommended action, including the acts or omissions with which the practitioner is charged and a list of the charts in question, where applicable.

7.3-6 JUDICIAL REVIEW COMMITTEE

When a hearing is granted, the medical executive committee shall recommend a judicial review committee. The judicial review committee shall be composed of not less than three (3) members of the active medical staff. The judicial review committee members shall be unbiased, shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, initial decision-makers or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the medical staff from serving as a member of the judicial review committee. In the event that it is not feasible to appoint a judicial review committee from the active medical staff, the medical executive committee may appoint members from other staff categories or practitioners who are not members of the medical staff. Such appointment shall include designation of the chair. The judicial review committee shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the practitioner. All other judicial review committee members shall have MD or DO degrees or equivalent license.

7.3-7 FAILURE TO APPEAR OR PROCEED

Failure without good cause of the practitioner to personally attend and proceed at such a hearing in an efficient and orderly manner shall be grounds for termination of the hearing and shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

7.3-8 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws may be permitted by the officer presiding over the hearing on a showing of good cause, or upon agreement of the parties.

7.4 HEARING PROCEDURE

7.4-1 PREHEARING PROCEDURE

(a) Not less than fifteen (15) days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. Failure to provide the name of any witness at least ten (10) days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.~~If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, and in no event less than ten (10) days before commencement of the hearing, each party shall furnish to the other a written list of the names of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. Failure to disclose the identity of a witness at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance.~~

(b) The practitioner may inspect and copy, at their expense, any documentary information relevant to the charges that the medical executive committee has in its possession or under its control. The medical executive committee may inspect and copy, at its expense, any documentary information relevant to the charges that the practitioner has in their possession or under their control. Requests for discovery shall be met as soon as practicable. Failure to comply with reasonable discovery requests at least thirty (30) days prior to the hearing shall be good cause for a continuance of the hearing. ~~At least thirty (30) days prior to the hearing, the practitioner may receive copies of documents or other evidence relevant to the charges which the medical executive committee possess or controls. The medical executive committee may inspect and copy at least thirty (30) days prior to the hearing, any documents or other evidence relevant to the charges which the practitioner possesses or controls as soon as practicable after receiving the request. The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance.~~ The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable practitioners, other than the practitioner under review.

(c) The practitioner and the medical executive committee shall ~~have the right to receive~~exchange all evidence which will be made available to the judicial review committee and introduced at the hearing. Failure to produce copies of all documents expected to be

produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance.

(d) The hearing officer (see Section 7.4-3) shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:

(1) whether the information sought may be introduced to support or defend the charges;

(2) the exculpatory or inculpatory nature of the information sought, if any;

(3) the burden imposed on the party in possession of the information sought, if access is granted; and

(4) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(e) The practitioner shall be entitled to a reasonable opportunity to question and challenge the impartiality of judicial review committee members and the hearing officer. Challenges to the impartiality of any judicial review committee member shall be ruled on by the hearing officer. Challenges to the impartiality of the hearing officer shall be ruled on by the hearing officer.

(f) It shall be the duty of the practitioner and the medical executive committee or its designee to exercise reasonable diligence in notifying the chair of the judicial review committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

7.4-2 REPRESENTATION

The hearings provided for in these bylaws are for the purpose of intraprofessional resolution of matters bearing on professional conduct, professional competency, or character. The parties may be represented by legal counsel.

In all instances, the chief of staff or another physician designated by the medical executive committee shall have the authority to:

(a) be present during all phases of the hearing process;

(b) to make decisions regarding the detailed contents of the notice of reasons or charges;

(c) to make decisions regarding the presentation of testimony and exhibits;

(d) to direct the activities of the medical executive committee's attorney, if any;

(e) to consult with prospective and designated witnesses for the medical executive committee; and

(f) to amend the notice of reasons or charges as he or she seems warranted during the course of the proceedings, subject to the practitioner's procedural rights.

However, the medical executive committee's representative shall not have the authority to modify the nature of the medical executive committee's action or recommendation without the medical executive committee's approval.

7.4-3 THE HEARING OFFICER

The medical executive committee shall recommend a hearing officer ~~to the board of directors~~ to preside at the hearing. ~~The board of directors shall be deemed to approve the selection unless it provides prompt written notice to the medical executive committee stating the reasons for its objections.~~ The hearing officer shall be an attorney-at-law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the district, the medical staff or the involved practitioner or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances, in accordance with California law. If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

7.4-4 RECORD OF THE HEARING

A court reporter shall be present to make a thorough and accurate record of the hearing proceedings, and the prehearing proceedings, if deemed appropriate by the hearing officer. The cost of attendance of the recorder shall be borne by the district, but the cost of the transcript, if any, shall be borne by the party requesting it. The judicial review committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by a person lawfully authorized to administer such oath.

7.4-5 RIGHTS OF THE PARTIES

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The practitioner may be called by the medical executive committee (or its designee) and examined as if under cross-examination.

7.4-6 MISCELLANEOUS RULES

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The judicial review committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the judicial review committee may request both sides to file written arguments. The hearing process shall be completed within a reasonable time after the notice of the action is received, unless the hearing officer issues a written decision that the practitioner or the medical executive committee failed to provide information in a reasonable time or consented to the delay.

7.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

(a) At the hearing the medical executive committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The practitioner may present evidence in response.

(b) An applicant shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the medical staff but not produced during the application process or corrective action proceedings, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided above for applicants, throughout the hearing, the medical executive committee shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

7.4-8 ADJOURNMENT AND CONCLUSION

After consultation with the chair of the judicial review committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the medical executive committee and the practitioner may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

7.4-9 BASIS FOR DECISION

The decision of the judicial review committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the judicial review committee shall be subject to such rights of appeal as described in these bylaws.

7.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the judicial review committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the medical executive committee. If the practitioner is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the administrator, the chief medical officer, the board of directors, and to the practitioner. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. Both the practitioner and the medical executive committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the judicial review committee shall be subject to such rights of appeal or review as described in these bylaws.

7.5 APPEAL

7.5-1 TIME FOR APPEAL

Within ten (10) days after receipt of the decision of the judicial review committee, either the practitioner or the medical executive committee may request an appellate review. A written request for such review shall be delivered to the chief of staff, the administrator, the chief medical officer, the other party in the hearing, and a copy provided to the board of directors. If a request for appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the medical staff.

7.5-2 GROUNDS FOR APPEAL

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be:

(a) substantial non-compliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice;

(b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5-5; or

(c) the judicial review committee failed to sustain an action or recommendation from the medical executive committee that, based on the evidence in the hearing record was reasonable and warranted.

7.5-3 APPEAL BOARD

The board of directors may sit as the appeal board, or it may delegate that function to an appeal board which shall be composed of not less than three (3) individuals designated by the board of directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the board of directors shall be neither the attorney firm that represented either party at the hearing before the judicial review committee nor the attorney who assisted the hearing panel or served as hearing officer.

7.5-4 TIME, PLACE AND NOTICE

The appeal board shall, within thirty (30) days after receipt of request for appellate review, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The appellate review shall commence within sixty (60) days from the date of such request for appellate review, provided however, that when a request for appellate review concerns a practitioner who is under suspension which is then in effect, the appellate review should commence within forty-five (45) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the appeal board for good cause.

7.5-5 APPEAL PROCEDURE

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the judicial review committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the judicial review committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal board may remand the matter to the judicial review committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the board of directors its written recommendations as to whether the board of directors should affirm, modify, or reverse the judicial review committee decision consistent with the standard set forth in Section 7.5-6, or remand the matter to the judicial review committee for further review and decision.

7.5-6 DECISION

(a) Except as provided in Section 7.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the board of directors shall render a final decision. The board of directors may affirm, modify, reverse the decision or remand the matter for further review by the judicial review committee or any other body designated by the board of directors for reconsideration stating the purpose for the referral. The board of directors shall give great weight to the judicial review committee findings and shall not act arbitrarily or capriciously. The board of directors may, however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision was reasonable and warranted, and whether any bylaw or policy relied upon by the judicial review committee is unreasonable and unwarranted. The decision shall be in writing, shall specify the reasons for the action taken, and shall provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from those of the judicial review committee. If the board of directors determines that the practitioner was not afforded a fair hearing in compliance with the bylaws, the board of directors shall remand the matter.

(b) If the matter is remanded to the judicial review committee or other body designated by the board of directors for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the board of directors. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the board of directors and the judicial review committee.

(c) The appeal board's decision shall constitute the final decision of the district. Any recommendation affirmed by the appeal board shall become effective immediately. The decision reached shall be forwarded to the chief of staff, the medical executive and credentials committees, the subject of the hearing, the chief medical officer and the administrator.

7.5-7 RIGHT TO ONE HEARING

Except in circumstances where a new hearing is ordered by the board of directors or a court because of procedural irregularities or otherwise for reasons not the fault of the practitioner, no practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

7.6 EXCEPTION TO HEARING RIGHTS

7.6-1 AUTOMATIC ACTION BASED UPON ACTIONS TAKEN BY ANOTHER PEER REVIEW BODY

(a) The medical executive committee shall be empowered to:

(1) use as a basis for disqualification from membership and/or privileges, or

(2) automatically impose

any adverse action that has been taken within the preceding thirty-six (36) months by another peer review body (as that term is used in the federal or California laws) after that action is considered final and the action was taken in conformance with California Business & Professions Code section 809 et seq. For purposes of this Section, an action shall be considered final when the practitioner has completed the hearing, appeal and judicial proceedings related to the action.

(b) The practitioner shall not be entitled to any hearing or appeal unless the medical executive committee takes an action that is more restrictive than the final action taken by the original peer review body. Any hearing and appeal that is requested by the practitioner shall not address the merits of the action taken by the original peer review body, which were already reviewed at the original peer review body's hearing, and shall be limited to only the question of whether the automatic action is more restrictive than the original peer review body's action.

(c) Nothing in this Section shall preclude the medical staff or board of directors from taking a more restrictive action than another peer review body based upon the same facts or circumstances.

ARTICLE VIII: ADVANCED PRACTICE PROVIDERS

8.1 QUALIFICATIONS OF ADVANCED PRACTICE PROVIDERS

Advanced Practice Providers (APPs) are non-physician practitioners who are eligible to apply for privileges at Northern Inyo Healthcare District. APPs are not eligible for medical staff membership as described in California state law. They may be granted practice privileges if they hold a license, certificate or other credentials in a category of APPs that the board of directors (after securing medical executive committee recommendation) has identified as eligible to apply for practice privileges, and only if the APPs are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the medical staff bylaws as demonstrated by the medical staff ongoing and focused professional practice evaluation process.

8.2 CATEGORIES

The board of directors may determine, based upon recommendation of the medical executive committee and such other information as it has before it, those categories of APPs that shall be eligible to exercise privileges at Northern Inyo Healthcare District. Such APPs shall be subject to the supervision requirements developed and approved by the interdisciplinary practice committee, the medical executive committee, and the board of directors.

8.3 PRIVILEGES

(a) APPs may exercise only those setting-specific privileges granted to them by the board of directors. The range of privileges for which each APP may apply, and any special limitations or conditions to the exercise of such privileges, shall be based on recommendations of the interdisciplinary practice committee, subject to approval by the credentials committee, the medical executive committee and the board of directors.

(b) An APP must apply and qualify for practice privileges. Applications for initial granting of practice privileges and biennial renewal thereof shall be submitted and processed in a similar manner to that provided for medical staff members, unless otherwise specified in medical staff policies.

(c) Each APP shall be subject to terms and conditions similar to those specified for medical staff members as they may logically be applied to APPs and appropriately tailored to the particular APP.

8.4 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

The prerogatives which may be extended to an APP shall be defined in medical staff and/or district policies. Such prerogatives may include:

(a) Provision of specified patient care services; which services may be provided independently or under the supervision or direction of a medical staff member and consistent with the practice privileges granted to the APP and within the scope of the APP’s licensure or certification.

(b) Participation in the open session of general meetings of the medical staff in a non-voting role.

(c) Being a voting participant at departmental committees appropriate to their specialty, which vote shall be limited to the following:

(1) Departmental policies, procedures, or other matters specific to the APP's line of practice; and

(2) Election of department chief.

(d) Attendance at district and medical staff education programs.

Additionally, each APP shall:

(a) Meet those responsibilities required by applicable policies and as specified in the bylaws, Section 2.5, and as they may be logically applied to reflect the scope of practice of the APP.

(b) Retain appropriate responsibility within the APPs area of professional competence for the care and supervision of each patient in the district for whom the APP is providing services.

(c) Participate in peer review of other APPs as appropriate, participate in quality improvement and discharge such other functions as may be required from time to time.

8.5 PROCEDURAL RIGHTS OF ADVANCED PRACTICE PROVIDERS

8.5-1 GRIEVANCE RIGHTS AFTER ADVERSE ACTIONS

Except as otherwise provided in this Section with respect to automatic termination or other matters, an APP shall have the right to utilize the grievance hearing process set forth in this Section in order to challenge any action that, if taken against a medical staff member, would be an adverse action constituting grounds for a procedural rights hearing pursuant to these bylaws. However, nothing contained in these bylaws shall be interpreted to entitle an APP to procedural rights, including, but not limited to, a procedural rights hearing or appellate review to which a medical staff member may be entitled.

An APP may challenge such adverse action by filing a written grievance with the medical executive committee no later than fifteen (15) days after such action. Upon receipt of such a grievance, the medical executive committee or its designee shall conduct an investigation that shall afford the APP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a "hearing" pursuant to the bylaws and shall not be conducted according to the procedural rules applicable to such hearings as set forth in Article VII. Before the interview, the APP shall be informed of the general nature and circumstances giving rise to the action, and the APP may present information relevant thereto at the interview. A record of the interview shall be made. The medical executive committee or its designee shall make a decision and recommendation for final action based on the interview and all other information available to it, and shall submit a written report of its recommendation, decision, and statement of basis for it to the board of directors. After receipt of the medical executive committee report, the board of directors shall take final action on the matter.

8.5-2 EMPLOYMENT BY THE DISTRICT

If the APP is an employee of Northern Inyo Healthcare District, disciplinary actions related to the terms and conditions of employment of the APP shall be governed by applicable human resources policies.

8.5-3 AUTOMATIC TERMINATION

(a) Notwithstanding the provisions of Section 8.5-1, an APP's privileges shall automatically terminate without review if the APP's certification or license expires, is revoked, or is suspended.

(b) Notwithstanding the provisions of Section 8.5-1, an APP's privileges may be subject to termination following review by the interdisciplinary practice committee and medical executive committee if no appropriate supervising practitioner is available because:

(1) The medical staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary and no other member is able or willing to function as the supervising practitioner; or

(2) The supervising practitioner no longer agrees to act as the supervising practitioner for any reason, or the relationship between the APP and the supervising practitioner is otherwise terminated, regardless of the reason thereof and no other member is able or willing to function as the supervising practitioner.

(c) Additionally, APPs are subject to the automatic action provisions of Section 6.4 of these bylaws.

8.5-4 REVIEW OF CATEGORY DECISIONS

The grievance rights afforded by this Section shall not apply to any decision regarding whether a category of APP shall or shall not be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the board of directors, which has the discretion to decline to review the request or to review it using any procedure the board of directors deems appropriate.

ARTICLE IX: OFFICERS

9.1 OFFICERS OF THE MEDICAL STAFF

9.1-1 IDENTIFICATION

The officers of the medical staff shall be the chief of staff, vice chief of staff, immediate past chief of staff, and member(s)-at-large. In addition, the medical staff's department chiefs shall be deemed medical staff officers within the meaning of California law.

9.1-2 QUALIFICATIONS

Officers must be members of the active medical staff at the time of their nomination and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

The chief medical officer will not be eligible to hold medical staff office during employment by the District. Should a medical staff officer accept a position as chief medical officer they will resign from their medical staff position and a replacement shall be determined per the process outlined in these bylaws. The chief medical officer will retain voting privileges to which they are eligible to participate based on their rights as an active medical staff member.

Additionally, if possible, the chief of staff must have previously served on the medical executive committee in some capacity for at least one term.

9.1-3 NOMINATIONS

(a) ~~The medical staff election year shall be every two years.~~Elections for chief of staff shall be every two years. Elections for member(s)-at-large shall be every year.

(b) The medical executive committee shall nominate one or more nominees for the office of chief of staff and may nominate one or more nominees for member-at-large to be filled at the time of elections. The medical executive committee shall give notice of the nominations to members eligible to vote on the officers no later than thirty (30) days prior to the election.

(c) Nominations may also be made by any member entitled to vote by submitting a written nomination to the medical staff office. A member may also nominate him- or herself, provided that he or she qualifies for such office.

(d) All nominees for election shall disclose in writing to the medical staff those current or impending personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the district, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.

9.1-4 ELECTIONS

The chief of staff and member(s)-at-large shall be elected by written ballot sent to eligible members prior to the end of the medical staff year during which an election is held. Whenever feasible, the election shall be held three (3) to six (6) months prior to the end of the medical staff year so as to give the newly elected officer the opportunity to begin transitioning into the role. Voting shall be by written ballot submitted to the medical staff office or via electronic vote.

A nominee for chief of staff shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the medical executive committee shall decide the election by written ballot at its next meeting or a special meeting called for that purpose.

In the election for member-at-large where there are two or more nominees, the two nominees receiving the highest numbers of votes shall be elected to each serve in the role of member-at-large. If there are not two or more nominees on the ballot, only one position of member-at-large need be filled.

9.1-5 TERM OF ELECTED OFFICE

The chief of staff shall serve a two (2) year term, commencing on the first day of the medical staff year following the election. The chief of staff shall be eligible to serve consecutive terms.

The vice chief of staff, immediate past chief of staff, and member(s)-at-large shall serve a one (1) year term. The vice chief of staff and member(s)-at-large shall be eligible to serve consecutive terms.

Each officer shall serve until the end of that officer's term, unless that officer resigns or is removed from office.

9.1-6 RECALL OF OFFICERS

Any medical staff officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a medical staff officer may be initiated by the medical executive committee or by a petition signed by at least one-third of the members of the active medical staff presented to the medical executive committee or chief of staff. Recall shall require a majority vote of the medical executive committee. A special meeting may be called for this purpose.

At least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the medical executive committee prior to a vote on removal. This provision does not include actions such as summary suspension where such timeline may not be feasible.

9.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies shall be filled by appointment by the chief of staff with consultation with the medical executive committee until the next regular election, except for the member-at-large, which may remain vacant.

9.2 DUTIES OF OFFICERS

9.2-1 CHIEF OF STAFF

The chief of staff shall serve as the chief officer of the medical staff. With the assistance of the medical executive committee where appropriate, the duties required of the chief of staff (or designee, as allowed by the bylaws) shall include, but not be limited to:

(a) enforcing the medical staff bylaws and policies, implementing sanctions where indicated in consultation with the medical executive committee, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

(b) calling, presiding at, and being responsible for the agenda of all general meetings of the medical staff;

(c) serving as chair of the medical executive committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

(d) in the interim between medical executive committee meetings, performing those responsibilities of the committee that, in the chief of staff's opinion, must be performed prior to the next regular or special meeting of the committee;

(e) serving as an ex-officio member of all other staff committees without vote, unless chief of staff membership in a particular committee is required by these bylaws;

(f) interacting with the administrator, chief medical officer and board of directors in all matters of mutual concern within the district;

(g) representing the views and policies of the medical staff to the board of directors, the administrator or designee, and chairing the joint conference committee as indicated in these bylaws;

(h) regularly reporting to the board of directors on the performance of medical staff functions and communicating to the medical staff any concerns expressed by the district board;

(i) being a spokesperson for the medical staff in external professional and public relations;

(j) serving on liaison committees with the board of directors and administration, as well as outside licensing or accreditation agencies;

(k) performing such other functions as may be assigned to the chief of staff by the bylaws, the medical staff, or the medical executive committee.

9.2-2 VICE CHIEF OF STAFF

The vice chief of staff shall serve a one (1) year term and is selected from among the current ~~department chiefs~~members serving on the medical executive committee. The vice chief of staff shall assume all duties and authority of the chief of staff in the absence of the chief of staff and shall perform such other duties as may be assigned.

9.2-3 IMMEDIATE PAST CHIEF OF STAFF

The immediate past chief of staff will remain a member of the medical executive committee for one (1) year, and shall attend at least the first three (3) consecutive months of their term to assure a smooth transition with the change in leadership and longer as deemed necessary. The immediate past chief of staff shall perform such other duties as may be assigned.

9.2-4 MEMBER-AT-LARGE

There may be one or two officers with the title member-at-large. The member(s)-at-large shall be members of the medical executive committee and shall perform duties as may be assigned.

ARTICLE X: CLINICAL DEPARTMENTS

10.1 ORGANIZATION OF CLINICAL DEPARTMENTS

The active medical staff shall be organized into clinical departments. Each department shall be organized as a separate component of the medical staff and shall have a chief selected and entrusted with the authority, duties, and responsibilities specified in this Article. When appropriate, or at the recommendation of the departmental committee, the medical executive committee may approve the creation, elimination, modification, or combination of departments.

Department committees, as described in Article XI, may represent a single clinical department or a combination of clinical departments as appropriate.

Additional medical or surgical specialties not currently listed as a department will be assigned to an existing department through the credentialing and privileging process.

10.2 DEPARTMENTS

The clinical departments under these bylaws are:

(a) Anesthesia

(b) Emergency Medicine

(c) Surgery (including Pathology)

(d) Inpatient Medicine

(e) Obstetrics & Gynecology

(f) Orthopedic Surgery (including Podiatry)

(g) Outpatient Medicine

(h) Pediatrics

(i) Radiology

10.3 ASSIGNMENT TO DEPARTMENTS

Each privileged practitioner shall be assigned membership based on specialty or board certification in at least one department, but may also be granted membership and/or clinical privileges in other departments consistent with practice privileges granted.

10.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

(a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department, as per the medical staff's policy on ongoing and focused professional practice evaluation.

(b) Recommending to the medical executive committee guidelines for the granting of clinical privileges and the performance of specified services within the department.

(c) Evaluating and making appropriate recommendations to the credentials committee and the medical executive committee regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department.

(d) Reviewing and evaluating departmental adherence to: (1) medical staff and district policies and procedures, (2) sound principles of clinical practice, and (3) quality improvement.

(e) Coordinating with nursing and ancillary staff in regards to patient care provided by the department's members with nursing and ancillary patient care services.

(f) Reporting to the departmental committee concerning: (1) the activities of the department, and (2) recommendations for maintaining and improving the quality of care provided in the department and the district.

(g) Meeting regularly for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions.

(h) Taking appropriate action when problems in patient care and clinical performance or opportunities to improve care are identified.

(i) Formulating departmental policies/procedures as reasonably necessary for the proper discharge of its responsibilities subject to the approval by the medical executive committee.

10.5 DEPARTMENT CHIEFS

10.5-1 QUALIFICATIONS

Each department shall have a chief who shall be a member of the active staff and shall be qualified by licensure, training, experience and demonstrated ability in at least one of the clinical areas covered by the department. If required by applicable California regulations or other law, the department chief must be certified by an appropriate specialty board or eligible for certification by an appropriate specialty board. Otherwise, the department chief shall possess comparable competence as affirmatively established through the peer review process.

10.5-2 SELECTION

The department chief shall be elected by the voting members of their department. In the event of a tie vote, the chief will be appointed by vote of the medical executive committee. Departments with a single member will automatically have the single member designated as chief. Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt.

~~The medical director of the department may be eligible to serve as the department chief, if so elected. If after election, the department chief becomes the administratively-appointed medical director of his or her department, a re-election will be held at the next departmental meeting.~~

10.5-3 TERM OF OFFICE

Each department chief shall serve a one (1) year term which coincides with the medical staff year or until his or her successor is chosen, unless he or she shall sooner resign, be removed from office, or lose his or her medical staff membership or clinical privileges in that department. Department chiefs shall be eligible to serve consecutive terms.

10.5-4 REMOVAL

Removal of department chiefs from office may occur for cause by a two-thirds vote of the department members. The medical executive committee may remove department chiefs in the course of a corrective action proceeding as indicated.

10.5-5 DUTIES

Each chief shall have the following authority, duties and responsibilities, and shall otherwise perform such duties as may be assigned:

(a) oversee the quality of patient care, professional performance and behaviors rendered by practitioners with clinical privileges in the department and designate proctors as necessary;

(b) assign a member of the medical staff to assume responsibility for duties and/or the care of another member's patients in the event the member is unable to fulfill their obligations due to termination of privileges, illness, or similar extenuating circumstances;

(c) enforce the medical staff bylaws and medical staff and district policies within the department;

(d) implement within the department appropriate actions taken by the medical executive committee;

(e) coordinate with district administration, department medical director (if any), and nursing services in matters relevant to the department;

(f) perform such other duties commensurate with the office as may from time to time be reasonably requested by the chief of staff or the medical executive committee.

ARTICLE XI: COMMITTEES

11.1 DESIGNATION

The medical executive committee and the other committees described in these bylaws shall be the standing committees of the medical staff. Special or ad hoc committees may be created by the medical executive committee or the chief of staff to perform specified tasks. Any committee that is carrying out all or any portion of a function or activity required by these bylaws is deemed a duly-appointed and authorized committee of the medical staff.

11.2 GENERAL PROVISIONS

11.2-1 APPOINTMENT OF COMMITTEE MEMBERS AND CHAIRS

The chair and members of committees shall be designated as per the bylaws. If not specified in the bylaws, the chair and members of committees shall be appointed by and may be removed by the chief of staff, subject to consultation with the medical executive committee. Medical staff committees shall be responsible to the medical executive committee. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

The administrator, or his or her designee, shall appoint any non-medical staff committee members who are not otherwise designated by title in the provision or resolution creating the committee.

The removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

11.2-2 COMMITTEE COMPOSITION

Except as otherwise provided in the bylaws, committees established to perform medical staff functions required by these bylaws may include any category of: medical staff members; advanced practice providers; representatives from district services such as administration, nursing services, or medical records; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each active medical staff member and advanced practice provider who serves on a committee participates with vote unless the statement of committee composition provides for designation of the position as non-voting.

11.2-3 REPRESENTATION ON DISTRICT COMMITTEES AND PARTICIPATION IN DELIBERATIONS

The medical staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing medical staff representation on district committees established to perform such functions. The medical executive committee will be responsible for providing a medical staff or APP representative on district committees when requested by the board or administration.

11.2-4 EX-OFFICIO MEMBERS

The chief of staff and the administrator or designee are ex-officio members of all standing and special committees of the medical staff. They and all other persons designated to serve as ex-officio committee members shall serve without vote unless provided otherwise in the provision or resolution creating the committee.

11.2-5 ACTION THROUGH SUBCOMMITTEES

Any medical staff standing committee may establish subcommittees to assist in carrying out its duties, in addition to any such subcommittees established by the medical executive committee or expressly designated in the bylaws. A subcommittee shall be composed of one or more voting members of the standing committee. The medical executive committee shall be informed when a subcommittee is established. The committee chair may also appoint individuals to serve as non-voting subcommittee members, after consulting with, and subject to the approval of, the chief of staff regarding medical staff members, and the administrator or designee regarding district personnel. An ad hoc committee is not considered a subcommittee.

11.2-6 TERM OF COMMITTEE MEMBERS

The term of committee members shall be as designated in the bylaws. If not specified, a committee member shall be appointed for a term of one year, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee.

11.2-7 COMMITTEE VACANCIES

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

11.2-8 LIMITATION OF ATTENDANCE AT COMMITTEE MEETINGS

Unless otherwise specified in the bylaws, any privileged practitioner who is in good standing may be permitted to attend any portion of a medical staff committee's meeting dealing with a matter of importance to that practitioner even though the practitioner is not a member of the committee. However, the committee chair or the chief of staff shall have the discretion to deny entry to the meeting to such practitioner, or to request any nonmember to leave the meeting. Any such nonmember who attends shall abide by all bylaws applicable to that committee.

In addition, during any portion of a committee meeting when the committee is in closed session or conducting peer review and chart review functions with respect to specific medical staff members, applicants, or other practitioners or advanced practice providers, attendance at the committee's meeting shall be restricted to (a) privileged practitioners who are members of the committee through assignment or election by the medical staff, and (b) any medical staff member or other person whom the committee has invited or requested to attend to assist in the functions (but only for the portion of the meeting designated by the committee or the committee chair).

The committee chair, after consulting with the chief of staff and administrator, may call on outside consultants or other special advisors to assist the committee in fulfilling its duties and allow such special

advisors to attend committee meetings related to the assistance they are providing, but such advisors shall not be deemed members of the committee.

Any nonmember who attends a committee meeting shall be deemed to have agreed, by his or her presence at the meeting, to maintain the confidentiality of and to refrain from any unauthorized disclosure to other persons of the committee's records, deliberations, and proceedings.

11.2-9 ACCOUNTABILITY

All medical staff committees shall be accountable to the medical executive committee.

11.3 MEDICAL EXECUTIVE COMMITTEE

11.3-1 COMPOSITION

The medical executive committee shall be composed of the chief of staff, vice chief of staff, immediate past chief of staff, department committee chairs, and up to two members-at-large, if elected. The chief of staff shall chair and preside over the medical executive committee. The administrator or designee and the chief nursing officer shall be a non-voting ex-officio members.

11.3-2 DUTIES

With the assistance of the chief of staff and/or the use of ad hoc committees as appropriate, the medical executive committee shall:

(a) represent and act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws;

(b) ensure the medical staff fulfills its responsibilities to the district board as per the district bylaws;

(c) monitor, evaluate, and supervise the performance of all medical staff functions, including conducting an annual review of medical staff policies;

(d) review, evaluate, or take other appropriate action for matters related to the competence and other qualifications of privileged practitioners or practitioners applying for privileges;

(e) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all privileged practitioners and when indicated, initiate and/or pursue disciplinary or corrective actions affecting privileged practitioners, as provided in the bylaws;

(f) ensure medical staff's knowledge of and compliance with the medical staff bylaws and policies; the district's bylaws, rules, and policies; state and federal laws and regulations; and other accreditation requirements;

(g) oversee the development of medical staff policies, approve (or disapprove) all such policies, and oversee the dissemination and implementation of all such policies following their approval by the medical staff;

(h) implement, as they relate to the medical staff, the approved policies, procedures, standards, and rules of the district, including, without limitation, the Compliance program (which

program relates to Medicare and Medi-Cal fraud and abuse matters); the district confidentiality policies and procedures related to compliance with applicable law, including but not limited to the federal Health Insurance Portability and Accountability Act ("HIPAA") and the California Medical Information Act; and the district medical error reporting program, including without limitation, applicable disclosure and reporting protocols.

(i) provide liaison between the medical staff, the administrator and the district board by regularly reporting to the district board and to the medical staff;

(j) make recommendations to the district board regarding medical staff structure, membership and privileges requirements, application, disciplinary, and hearing procedures, peer review and quality assessment and improvement activities, and other aspects of medical staff affairs addressed in the medical staff bylaws;

(k) make recommendations to administration in the selection of and assignment of responsibilities to department medical directors, the chief medical officer, or other practitioners contracted by the district to provide administrative services;

(l) review and make recommendations to the chief medical officer regarding quality of care issues related to specified clinical services contract arrangements for professional medical services;

(m) participate and provide information when requested in district proceedings involved with making specified clinical services contracting decisions;

(n) in collaboration with the district, oversee the development and implementation of a district-wide quality improvement plan and recommend revisions as needed;

~~(m)~~(o) review quality improvement reports from department chiefs, committees, and other medical staff patient care review activities;

~~(n)~~(p) establish, as needed, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the medical executive committee;

~~(o)~~(q) appoint committee members for all standing committees, all special medical staff, liaison, or multi-disciplinary committees, and designating the chairs of these committees, except where otherwise provided by these bylaws; and

~~(p)~~(r) recommend the amount of annual dues for each medical staff membership category, subject to medical staff approval, and recommend the manner of expenditure of dues funds, subject to the committee's acknowledgment that such expenditures must be consistent with applicable law regarding such expenditures.

11.3-3 MEETINGS

The medical executive committee should be scheduled to meet on a monthly basis and shall meet at least ten (10) times during the medical staff year.

~~11.4 QUALITY IMPROVEMENT COMMITTEE~~

~~11.4-1 COMPOSITION~~

~~The quality improvement committee shall consist of the members of the medical executive committee. The administrator or designee and the chief nursing officer shall be ex officio non-voting members. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity. The chair shall be the chief of staff.~~

~~**11.4-2 DUTIES**~~

~~The quality improvement committee shall be responsible for overall supervision of patient care services quality monitoring, assessment, and improvement activities and accordingly shall:~~

~~(a) in collaboration with the district, oversee the development and implementation of a district-wide quality improvement plan and perform an annual review and recommend revisions as needed;~~

~~(b) carry out the duties as described in the district quality improvement plan;~~

~~(c) review quality improvement reports from department chiefs, committees, and other medical staff patient care review activities; and~~

~~(d) refer problems for assessment and corrective action to appropriate departments or committees.~~

~~**11.4-3 MEETINGS AND REPORTS**~~

~~The medical staff quality improvement committee should be scheduled to meet on a monthly basis and shall meet at least ten (10) times during the medical staff year.~~

11.4 BYLAWS COMMITTEE

11.4-1 COMPOSITION

The bylaws committee shall be composed of at least three (3) active staff members.

11.4-2 DUTIES

The bylaws committee shall make reasonable efforts to assure that the medical staff bylaws and policies adequately and accurately reflect the current structure and practices of the medical staff and comply with applicable legal requirements by:

(a) conducting an annual review of the bylaws;

(b) developing and submitting proposals for bylaws changes to the medical executive committee and to the medical staff in accordance with bylaws procedures;

(c) receiving, evaluating, and making recommendations with respect to bylaws or policies proposals made by the executive committee, department chiefs, member petition or other sources; and

(d) engaging in such other activities as reasonably appropriate for fulfilling these and other functions as specified in the bylaws or policies.

11.4-3 MEETINGS AND REPORTS

The bylaws committee will meet at least annually and otherwise as requested by the bylaws committee chair or chief of staff. The committee shall report its activities and recommendations at least annually to the medical executive committee.

11.5 CREDENTIALS COMMITTEE

11.5-1 COMPOSITION

The credentials committee shall be composed of at least five (5) active staff members, selected on a basis that will ensure insofar as feasible, representation of the clinical departments and the major clinical specialties which are routinely practiced by privileged practitioners at Northern Inyo Healthcare District.

11.5-2 DUTIES

The credentials committee shall evaluate and make recommendations with respect to the qualifications of all applicants for medical staff appointment, reappointment, privileges, and changes in staff categories, and fulfill other functions as specified in the bylaws or policies.

11.5-3 MEETINGS AND REPORTS

The credentials committee shall meet at least quarterly, or as often as necessary as determined and called by the committee chair, the chief of staff, or the medical staff office. The committee shall report its activities and recommendations with respect to applicants as specified in the bylaws and shall otherwise report the status of pending applications and its activities to the medical executive committee.

11.6 INFECTION CONTROL COMMITTEE

11.6-1 COMPOSITION

The infection control committee shall be composed of at least two (2) privileged practitioners, at least one (1) of which shall be an active staff member, and the infection prevention nurse (with vote). A quorum shall consist of one (1) privileged practitioner and the infection prevention nurse.

Ex-officio members serving without vote shall include the administrator (or the administrator's designee), and a representative from the clinical laboratory (bacteriology). In addition, representatives from areas such as, but not limited to, the employee health, dietary, respiratory therapy, and environmental service departments may be invited to attend and participate in discussion without vote. The chair of the infection control committee shall be required to complete the necessary infection control training as mandated per state regulations.

11.6-2 DUTIES

The duties of the infection control committee shall include assisting the district in:

(a) developing a hospital-wide infection control program and maintaining surveillance over the program;

(b) developing a system for reporting, identifying and analyzing the incidence and cause of healthcare-associated infections, including assignment of responsibility for the ongoing collection and analytic review of such data;

(c) monitoring implementation of corrective actions for healthcare-associated infections, and making recommendations to eliminate future such infections;

(d) developing and implementing a preventative and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

(e) developing written policies defining special indications for isolation requirements;

(f) coordinating actions on findings from the medical staff's review of the clinical use of antibiotics;

(g) taking such actions as reasonably necessary to assure infection control compliance with regulatory agencies and with established guidelines such as those of the Center for Disease Control and APIC (Association for Professionals in Infection Control and Epidemiology); and

(h) reviewing sensitivities of organisms specific to the facility.

11.6-3 MEETINGS

The infection control committee shall meet at least quarterly. The committee, or a representative of the committee, shall provide to the medical executive committee ~~and the quality improvement~~ regular reports of the committee's activities.

11.7 INTERDISCIPLINARY PRACTICE COMMITTEE

11.7-1 COMPOSITION

The interdisciplinary practice committee (IDPC) shall be composed of:

(a) an equal number of medical staff members who are physicians and nursing staff who are registered nurses;

(b) the lead advanced practice provider;

(c) the chief nursing officer; and

(d) the administrator (or the administrator's designee, who may not be a registered nurse or a physician medical staff member).

The medical executive committee shall appoint the physician members and designate one of them as the chairperson. The chief nursing officer shall appoint the nursing staff members. In addition, representatives in the categories of advanced practice providers granted privileges in the district may serve as consultants on an as-needed basis, and shall participate, when requested and feasible, in the committee proceedings when a member of the same APP category is applying for privileges.

11.7-2 DUTIES

The IDPC functions to establish, implement, monitor, and evaluate policies and procedures for interdisciplinary medical practice pursuant to Title 22, California Code of Regulations, Sections 70706 and 70706.2, other applicable law, and the bylaws. IDPC duties shall include, but not necessarily be limited to, the standardized procedures and credentialing duties as set forth below in this Section.

(a) **STANDARDIZED PROCEDURE DUTIES:**

(1) The IDPC shall develop and review standardized procedures that apply to nurses or APPs, identify functions that are appropriate for standardized procedures, initiate such procedures, and review and approve standardized procedures in accordance with applicable licensure regulations, such as Title 22, California Code of Regulations, Sections 70706 and 70706.2, other applicable law, and the bylaws.

(2) Request for development of standardized procedures may be initiated by the administrator, the chief medical officer, the chief nursing officer, the medical executive committee, the chief of staff, the appropriate department chiefs, the affected registered nurses or APPs, or supervising practitioners.

(3) Prior to approval of new or amended standardized procedures, the IDPC shall obtain consultation and recommendations from the department chief(s), other appropriate medical staff members, and nonmedical staff members who practice in the clinical field or medical or nursing specialties under review as subject of the proposed standardized procedures.

(4) Standardized procedures shall be reviewed and approved by the IDPC, the medical executive committee, the administrator, and the board of directors in order to become effective.

(5) The IDPC may approve standardized procedures only by affirmative vote of the following IDPC members: the administrator (or the administrator's designee), a majority of the physician members, and a majority of the registered nurse members (including the chief nursing officer).

(6) The IDPC is responsible for assuring that standardized procedures are a collaborative effort among administrators and health professionals, including physicians and nurses. Each standardized procedure shall:

i. Be in writing and show the date or dates of each required approval, including approval by the IDPC;

ii. Specify which standardized procedure functions which registered nurses are authorize to perform and under what circumstances;

iii. State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure;

iv. Specify any experience, training, and/or special education requirements for performance of the standardized procedure functions;

v. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform the standardized procedure functions;

vi. Provide for a method of maintaining a written record of those persons authorized to perform the standardized procedure functions;

vii. Specify the nature and scope of review and/or supervision required for performance of the standardized procedure functions. For example, if the function is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated;

viii. Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition;

ix. State the limitations on settings or departments within the facility where the standardized procedure functions may be performed;

x. Specify any special requirements for procedures relating to patient recordkeeping; and

xi. Provide for a method of periodic review of the standardized procedure.

(b) **CREDENTIALING ADVANCED PRACTICE PROVIDERS DUTIES:**

(1) Upon request by the medical executive committee or the board of directors, or at its own initiative, the IDPC shall make recommendations regarding APP category eligibility, delineation of APP practice privileges, supervision requirements, and other such matters related to APP practice at the district.

(2) The IDPC shall review and evaluate APP applications and requests for privileges and forward its written report and recommendations to the appropriate department chief or credentials committee.

(3) The IDPC shall serve as liaison between APPs and the medical staff.

11.7-3 MEETINGS

The IDPC shall meet as often as needed, but at least annually. The committee shall report its activities and recommendations with respect to applicants as specified in the bylaws to the credentials committee.

11.8 JOINT CONFERENCE COMMITTEE

11.8-1 COMPOSITION

The joint conference committee is an ad hoc committee composed of two (2) members of the board of directors and two (2) members of the medical executive committee, one (1) of which shall be the chief of staff, and the other which shall be appointed by the medical executive committee. The administrator, or designee, shall be a non-voting, ex-officio member. The chair of the committee should alternate yearly between the board of directors and the medical staff; odd-numbered years will be the board of directors, and even-numbered years will be the medical staff.

11.8-2 DUTIES

The function of the joint conference committee is to serve as a liaison between members of the board of directors, the district administration, and the medical staff on an ad hoc basis. The joint conference committee shall act in an advisory function and provide a forum for:

(a) maintenance of effective communications to keep the board, medical staff, and the administrator cognizant of any pertinent actions taken or contemplated;

(b) planning for growth and development of the district and the medical staff;

(c) discussion of matters of district and medical staff policy, practice, and planning not related to peer review; and

(d) interaction between the board of directors and the medical staff on such matters as may be referred by the medical executive committee or the board of directors.

The joint conference committee may also meet on an ad hoc basis to act as a deliberative body as described below for:

(a) the resolution of conflicts or disputes between the medical staff and the board of directors or administration; and

(b) the resolution of any dispute related to the medical staff's rights or self-governance or discharge of medical staff responsibilities.

11.8-3 DISPUTE RESOLUTION PROCESS

All disputes between administration or the board of directors and the medical staff that have not been resolved by prior informal meetings and discussions shall be addressed to and mediated by the joint conference committee.

(a) Following written notice of a dispute needing mediation, the committee shall convene within fourteen (14) days after the next regularly scheduled district board meeting.
(b) The committee shall meet and confer in good faith to formulate a recommendation for mediation of the dispute.
(c) If the committee cannot reach a consensus, the committee may appoint an outside professional mediator as a member of the committee, and the mediator shall serve as the chair of the committee but shall have no vote. The parties shall cooperate to select the mediator from a list of candidates provided by services such as the Judicial Arbitration and Mediation Service or the American Arbitration Association. The cost of the mediator shall be covered by the district.

11.8-4 MEETINGS AND REPORTS

The committee shall meet as needed on an ad-hoc basis as described above. The chief of staff, or designee, shall report the committee's activities or discussions to the medical executive committee and to the medical staff via email or at the next regularly scheduled meetings, as appropriate for the subject matter. Minutes shall be kept during meetings as appropriate and a copy maintained in the medical staff office.

11.9 PHARMACY AND THERAPEUTICS COMMITTEE

11.9-1 COMPOSITION

The pharmacy and therapeutics committee shall be composed of at least three (3) active staff members, the pharmacy director (with vote), and the chief nursing officer or other nurse designated by the chief nursing officer (with vote). Ex-officio members serving without vote shall include the administrator, or the administrator's designee, and a representative from clinical informatics. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

11.9-2 DUTIES

The duties of the pharmacy and therapeutics committee shall include:

(a) assisting in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage;

(b) advising the medical staff and the pharmaceutical service on matters pertaining to the choice of available drugs;

(c) making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(d) periodically reviewing and maintaining formulary or drug list for use in the hospital;

(e) evaluating clinical data concerning new drugs or preparations requested for use in the hospital;

(f) establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

(g) maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the medical executive committee concerning those activities; and

(h) reviewing untoward drug reactions.

11.9-3 MEETINGS

The pharmacy and therapeutics committee shall meet at least quarterly. The committee shall report a summary of its activities or findings to the medical executive committee ~~and the quality improvement committee~~ on a regular basis.

11.10 PHYSICIAN WELLNESS COMMITTEE

11.10-1 COMPOSITION

The physician wellness committee shall be composed of at least three (3) medical staff members, one (1) of whom should be a psychiatrist whenever feasible. Insofar as feasible, members of this committee shall not actively participate on other peer review or~~,~~ corrective action ad hoc committees~~, or quality improvement committees~~ while serving on this committee.

Additionally, in order to facilitate open communication about provider wellness, meetings of the physician wellness committee will be limited to the medical staff members of that committee and other participants will be included by invitation of the chair of the committee only.

11.10-2 DUTIES

The committee shall:

(a) Consider general matters related to the health and well-being of medical staff members and, with the approval of the medical executive committee or chief of staff, develop educational programs or staff events for promoting well-being.

(b) Educate staff on illness and impairment recognition issues specific to physicians.

(c) Review, evaluate, and make recommendations as appropriate or otherwise required by the bylaws:

(1) Voluntary disclosures to the committee by members or other practitioners regarding their health status;

(2) Health status referrals or reports from the chief of staff or other medical staff officer or committee regarding a member; and

(3) Responses from applicants concerning physical or mental disabilities.

(d) Investigate any applicant, member, or other practitioner who has or may have physical or mental disability that may affect the practitioner's capability to exercise the privileges applied for and/or held by the practitioner in a manner that meets the patient care quality standards of the district and the medical staff. An investigation may include any or all of the following steps:

(1) Ascertain the health status of the practitioner through committee interview;

(2) Medical examination by an appropriate healthcare professional to evaluate whether the practitioner has a physical or mental disability or other health problem that may affect patient care;

(3) Evaluate the effects of the health status on the practitioner's capability to exercise privileges applied for or held by the practitioner, and when relevant with respect to a qualified physical or mental disability under applicable law, assess if and how reasonable accommodations can be made;

(4) Provide advice, counseling, or referrals as appropriate.

The activities of the physician wellness committee shall be confidential. However, if the committee receives information that demonstrates that the health or impairment of a practitioner may pose a risk of harm to patients, self or others, that information shall be referred to the chief of staff or the medical executive committee. This committee is not disciplinary in nature and does not preclude other review mechanisms as set forth in these bylaws.

11.10-3 MEETINGS, REPORTING AND MINUTES

The physician wellness committee shall meet as often as necessary, but at least quarterly. It shall maintain only such records of its proceedings as it deems advisable and consistent with confidentiality concerns, and shall routinely report on its activities to the medical executive committee.

11.11 UTILIZATION REVIEW AND MEDICAL RECORDS COMMITTEE

11.11-1 COMPOSITION

The utilization review and medical records committee shall consist of at least three (3) medical staff members. Representatives from quality, utilization review, nursing, billing, medical records, and social services shall be invited as non-voting members.

11.11-2 DUTIES

The utilization review and medical records committee shall perform the following functions:

(a) Delineate the scope of utilization review provided within the district;

(b) Develop critical indicators to be used as screening devices in reviewing the utilization of district services;

(c) After cases have been isolated using the critical indicators, evaluate utilization of services administered and identify areas for improvement, if necessary;

(d) Review patient care services to ascertain if utilization of services within the standards of the district and medical staff are being provided in the most cost-effective manner, address overutilization, underutilization, and inefficient scheduling of care and resources;

(e) Review diagnoses, problems, procedures and the practices of practitioners that appear to have utilization-related problems, and examine relevant quality assurance findings and interface with the practitioners as deemed necessary or appropriate;

(f) Determine appropriate action to be taken with respect to identified utilization and other patient care problems, and report such matters to the medical executive committee ~~and the quality improvement committee~~;

(g) Refer problems which cannot reasonably be resolved at the committee level to the appropriate committee;

(h) Develop, implement, and maintain such Utilization Review Plan as approved by the medical executive committee and district board; and

(i) Comply with applicable federal and state regulations.

11.11-3 MEETINGS

The utilization review and medical records committee shall meet at least quarterly. The committee shall report a summary of its activities or findings to the medical executive committee on a regular basis. The committee shall also give notification to the medical executive committee promptly after the committee receives notice of any matter for which a practitioner is required to give notice to the medical staff pursuant to these bylaws, if not already reported.

11.12 DEPARTMENTAL COMMITTEES

11.12-1 COMPOSITION

The departmental committees can represent a single clinical department or a combination of clinical departments. The departmental committees shall be composed of the practitioners assigned to the ~~at least three (3) practitioners from the~~ represented departments. ~~that are designated as core committee members. The majority of core committee members must be physicians. The chair may also be a core committee member.~~

~~Core committee members will be designated by the chair of the departmental committee following consultation with the committee members. Core committee~~ Mm~~m~~embers have the duty to attend all meetings of the department, unless excused for good reason by the chair of the committee.

Additional committee members may be assigned as needed to represent all disciplines of the department at regularly scheduled meetings. ~~All practitioners are encouraged to attend their departmental committees, even if not designated as a core member of the committee.~~

(a) Emergency Services Committee

The emergency services committee shall represent all medical services provided in the emergency department. In addition, the emergency room nurse manager and the administrator (or designee) shall be ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(b) Inpatient Medicine Committee

The inpatient medicine committee represents the adult medical services provided in the medical/surgical and intensive care unit departments. ~~At least one core member of the committee shall be a hospitalist.~~ Whenever possible, the cardiopulmonary medical director and an outpatient medicine committee representative shall serve on the committee. The medical/surgical nurse manager and the administrator (or designee), as well as representatives from the respiratory therapy, physical therapy, dietary, and pharmacy departments shall be non-voting ex-officio members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(c) Outpatient Medicine Committee

The outpatient medicine committee represents the outpatient services including family medicine, internal medicine, outpatient infusion department, and other outpatient medicine departments not represented by other committees. Whenever possible, the cardiopulmonary medical director and an inpatient medicine committee representative shall serve on the committee. The clinical nurse manager, a representative from the outpatient infusion department, and the administrator (or designee) shall be non-voting ex-officio members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(d) Perinatal/Pediatrics Committee

The perinatal/pediatrics committee shall represent the pediatric and obstetrical departments. The nurse managers of the perinatal and pediatrics units and the administrator (or designee) shall be ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(e) Radiology Services Committee

The radiology committee represents the radiology services. The director of diagnostic services and the administrator (or designee) shall be non-voting ex officio members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(f) Surgery/Tissue/Transfusion/Anesthesia Committee

The surgery, tissue, transfusion and anesthesia (STTA) committee represents all surgical, anesthesia, and pathology services. The director of perioperative nursing and the administrator (or designee) shall serve as ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

11.12-2 DUTIES

The medical staff departmental committees listed in Section 11.~~13~~12-1 are responsible for overseeing the quality and appropriateness of patient care rendered in the department by, without limitation:

(a) Using critical indicators to conduct concurrent and retrospective peer review of medical records with referral for committee review as indicated;

(b) Monitoring and evaluating clinical performance of all privileged practitioners attending patients or administering care in the department;

(c) Periodically reviewing and evaluating the medical services provided;

(d) Making recommendations concerning matters for which the committee is responsible to the medical executive committee~~, the quality improvement committee~~ and the administrator or chief medical officer as appropriate;

(e) Reviewing applicants for privileges when requested by the department chief;

(f) Electing annually the departmental committee chair, who presides over the meetings and attends the medical executive committee meetings. This departmental committee chair may or may not be the chief of the department; and

(g) Receiving reports from other committees as appropriate.

11.12-3 MEETINGS AND REPORTS

The medical staff departmental committees shall meet at least quarterly. The committees shall report a summary of their activities or findings to the medical executive committee ~~and quality improvement committee~~ on a regular basis. The committees shall also give notification to the medical executive committee promptly after the committees receive notice of any matter for which a practitioner is required to give notice to the medical staff pursuant to these bylaws, if not already reported.

ARTICLE XII: MEETINGS

12.1 GENERAL MEDICAL STAFF MEETINGS

12.1-1 REGULAR MEETINGS

Regular meetings of the medical staff members shall be held at least quarterly. The date, place and time of the regular meetings shall be determined by the medical executive committee or the chief of staff, and adequate notice shall be given to the members.

12.1-2 AGENDA

The order of business at a meeting of the medical staff shall be determined by the chief of staff and medical executive committee. The agenda shall include, as applicable:

(a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) administrative reports from the chief of staff, departments, ~~and~~ committees, ~~chair of the quality improvement committee~~, and the administrator or designee;

(c) election of officers when required by these bylaws;

(d) old business; and

(e) new business.

12.1-3 SPECIAL MEETINGS

Special meetings of the medical staff may be called at any time by the chief of staff or the medical executive committee, or shall be called upon the written request of ten percent (10%) of the members of the active medical staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled as soon as reasonably possible, but within thirty (30) days after receipt of such request. Notice shall be given to the members of the staff with as much advance notice as possible, which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.2 COMMITTEE AND DEPARTMENT MEETINGS

12.2-1 REGULAR MEETINGS

Except as otherwise specified in these bylaws, the chairs of medical staff and departmental committees may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

12.2-2 SPECIAL MEETINGS

A special meeting of any medical staff committee or department may be called by the chair thereof, the medical executive committee, or the chief of staff.

12.3 QUORUM

12.3-1 GENERAL MEDICAL STAFF MEETINGS

The presence of fifty percent (50%) of the total members of the active medical staff at any regular or special meeting in person or through written (electronic) ballot shall constitute a quorum for the purpose of the election or removal of medical staff officers, or other special votes as determined by the chief of staff. The presence of twenty-five percent (25%) of members shall constitute a quorum for all other actions.

12.3-2 DEPARTMENT MEETINGS

For department committees, a quorum shall consist of ~~all three core members or substitutes as appointed by the departmental chair (in accordance with Section 11.13-1).~~two physicians.

12.3-3 MEDICAL STAFF COMMITTEE MEETINGS

A quorum of fifty percent (50%) of the voting members shall be required for medical executive meetings. For other medical staff committee meetings (e.g., utilization review, pharmacy and therapeutics), the presence of two (2) committee voting members shall constitute a quorum, unless otherwise specified in the committee composition.

12.4 VOTING AND MANNER OF ACTION

12.4-1 VOTING

Unless otherwise specified in these bylaws, only members of the active medical staff may vote in medical staff general meetings and elections. All members of the medical staff and APP staff are entitled to vote at committee and department meetings appropriate to their specialty as described at time of appointment.

12.4-2 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. A meeting in which a quorum is not initially present may be started, though no action may be taken until a quorum is present. Committee and medical staff action may be conducted by telephone conference or other electronic communication. Votes collected by electronic means require a majority vote to be valid.

12.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters.

12.6 ATTENDANCE REQUIREMENTS

12.6-1 REGULAR ATTENDANCE

Members are expected to attend all meetings of the medical staff and of the department or committee to which assigned. Attendance via telephone conference or other electronic communication shall be accepted. Each member of the consulting or courtesy staff shall be required to attend such meetings as may be determined by the medical executive committee.

12.6-2 ABSENCE FROM MEETINGS

Any member who is compelled to be absent from any medical staff, department, or committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence. Unless excused for good cause by the presiding officer of the department or committee, or the medical staff office for medical staff meetings, failure to attend may be included in the practitioner's ongoing professional practice evaluation, reviewed by the medical executive committee, and may be grounds for removal from such committee or for corrective action.

12.6-3 SPECIAL ATTENDANCE

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting to which notice was given, unless excused by the medical executive committee upon a showing of good cause, shall be a basis for corrective action.

12.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

12.8 EXECUTIVE SESSION

The chairperson of any standing, special, or ad hoc committee of the medical staff, including departments, may call an executive session meeting. Only members of the active medical staff holding voting privileges on the committee shall attend the executive session meeting. The chairperson, at his or her discretion, may request other individuals to attend the meeting in an informational capacity. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

ARTICLE XIII: CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within Northern Inyo Healthcare District, an applicant:

(a) authorizes representatives of the district and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

(b) authorizes persons and organizations to provide information concerning such practitioner to the medical staff;

(c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the medical staff or the district who would be immune from liability under Section 13.3 of this Article; and

(d) acknowledges that the provisions of this Article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at this district.

13.2 CONFIDENTIALITY OF INFORMATION

13.2-1 GENERAL

The minutes, files, records and proceedings of the medical staff and all departments and standing or ad hoc committees, including information regarding any applicant, member or other individual exercising clinical privileges or practice privileges, shall be considered medical staff minutes or records and, to the fullest extent permitted by law, shall be confidential and protected from discovery pursuant to California Evidence Code Section 1157 and any other applicable peer review or other policy or privilege. This information shall become part of the medical staff committee files and shall not become part of any patient files, general district records, or any member's personal or office files.

Dissemination of such information and records shall only be made where expressly required by law, as authorized by these bylaws, or pursuant to officially adopted policies of the medical staff or, where no officially adopted policy exists, only with the express approval of the chief of staff and the administrator.

13.2-2 BREACH OF CONFIDENTIALITY

As effective peer review and consideration of the qualifications of medical staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of medical staff departments or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this medical staff, violates the medical staff bylaws, and will be deemed disruptive to the operations of the district. If it is determined that such a breach has occurred, the medical executive committee may undertake such corrective action as it deems appropriate.

13.2-3 ACCESS TO AND RELEASE OF CONFIDENTIAL INFORMATION

All requests for access to medical staff records, including confidential committee records and credential files, shall be presented to an authorized representative. Authorized representatives include the authorized medical staff office personnel and medical staff officers.

(a) Access for Official Purposes

(1) The following individuals may access medical staff records, including confidential committee records and credentials files, to the extent described:

i. Committee members and their authorized representatives, for the purpose of conducting authorized committee functions.

ii. Medical staff and department officials, and their authorized representatives, for the purpose of fulfilling any authorized function of such official.

iii. The administrator, the board of directors, and their authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities. Information which is disclosed to the board of directors or its appointed representatives shall be maintained as confidential.

iv. Consultants or attorneys engaged by the district may be granted access to credential files that are necessary to enable them to perform their functions, if an authorized medical staff representative agrees.

v. Representatives of licensure agencies, accreditation agencies, or auditors from Medicare or Medicaid, if an authorized representative is with them.

(2) All subpoenas pertaining to medical staff records, including confidential committee records and credentials files, shall be referred to the medical staff office, who shall first consult with the administrator, the chief of staff, and legal counsel regarding appropriate response.

(b) Limits on Access to Practitioner's Credentials File

(1) A practitioner can view the contents of his or her credentials file, as described below, during normal business hours upon reasonable prior request to the chief of staff or medical staff officer. The individual only has the right to review and receive a copy of documents provided by or addressed personally to the individual practitioner. The medical staff has discretion to disclose other documents to a member, but in no case shall copies of confidential letters of reference, hospital verifications or other confidential correspondence be disclosed. An individual practitioner may review the above identified parts of his or her credentials file under the following circumstances:

i. Review of the credentials file is accomplished in the presence of one of the following: authorized medical staff office personnel, officer of the medical staff, a member of the credentials committee, or department chief.

ii. The practitioner understands that he or she may not remove any items from the credentials file.

iii. The practitioner understand that, subject to review by the chief of staff, he or she may add an explanatory note or other document to the file.

iv. The practitioner understands that he or she may not review confidential letters of reference, hospital verifications or other confidential correspondence received by the district or the medical staff.

v. Documents provided by the practitioner for inclusion in the credentials file (e.g., Curriculum Vitae, licenses, insurance policy, continuing medical education) may be photocopied. No other items may be photocopied without the express permission of the credentials chair.

(c) Medical Staff Committee Files and Minutes

(1) Any member shall be allowed access to minutes or other medical staff records which describe meetings or activities of the medical staff committees that they were entitled to attend (e.g. their department committees of which they are members). This does not include minutes or records of meeting or activities from which the practitioner was specifically excluded.

13.3 IMMUNITY FROM LIABILITY

13.3-1 FOR ACTION TAKEN

Each representative of the medical staff and district shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the medical staff or district.

13.3-2 FOR PROVIDING INFORMATION

Each representative of the medical staff and district and all third parties shall be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the medical staff or district concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this district.

13.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other healthcare facility's or organization's activities concerning, but not limited to:

(a) application for appointment, reappointment, or clinical privileges;

(b) corrective action;

(c) hearings and appellate reviews;

(d) utilization reviews;

(e) other department, committee or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

(f) queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

13.5 RELEASES

Each applicant or member shall, upon request of the medical staff or district, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

13.6 INDEMNIFICATION

Northern Inyo Healthcare District shall indemnify, defend and hold harmless the medical staff, its individual members, and its appointed representatives (e.g. expert witnesses, lay committee members, hearing officers) from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review, quality assessment, or activities related to establishing standards, policies and/or procedures pursuant to the self-governing medical staff provisions, including, but not limited to:

(a) as a member of or witness for a medical staff department, service, committee or hearing panel;

(b) as a member of or witness for the district board or any district task force, group, or committee, and;

(c) as a person providing information to any medical staff or hospital group, officer, board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a medical staff member or applicant.

The medical staff or member may seek indemnification for such losses and expenses under this bylaws provision, statutory and case law, any available liability insurance or otherwise as the medical staff or member sees fit, and concurrently or in such sequence as the medical staff or member may choose. Payment of any losses or expenses by the medical staff or member is not a condition precedent to the district's indemnification obligations hereunder. In no event will the district indemnify an indemnitee for acts or omissions taken in bad faith or in pursuit of the indemnitee's private economic interests.

ARTICLE XIV: GENERAL PROVISIONS

14.1 DUES OR ASSESSMENTS

The medical executive committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of medical staff membership, subject to the approval of the medical staff, and to determine the manner of expenditure of such funds received.

Failure of a member to pay dues or assessments, without good cause as determined by the medical executive committee, will be included in the member's ongoing professional practice evaluation and may be grounds for corrective action.

14.2 AUTHORITY TO ACT

Any member or members who act in the name of this medical staff without proper authority shall be subject to such disciplinary action as the medical executive committee may deem appropriate.

14.3 DIVISION OF FEES

Any division of fees by members of the medical staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the medical staff.

14.4 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the medical staff or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee
Name of department or committee
[c/o medical staff office, chief of staff]
Hospital name
Street address
City, State, Zip code

Mailed notices to a member, applicant or other party shall be to the addressee at the address as it last appears in the official records of the medical staff or district.

14.5 DISCLOSURE OF INTEREST

All nominees for election or appointment to medical staff offices, department chief, or the medical executive committee shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the medical executive committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff. Further information on conflict of interest may be found in Northern Inyo Healthcare District's compliance program.

14.6 RETALIATION PROHIBITED

Neither the medical staff, its members, committees or department heads, the board of directors, its chief executive officer, or any other employee or agent of the district or medical staff, may engage in any punitive or retaliatory action against any member of the medical staff because that member claims a right or privilege afforded by, or seeks implementation of any provision of, these medical staff bylaws.

ARTICLE XV: ADOPTION AND AMENDMENT OF BYLAWS AND POLICIES

15.1 BYLAWS

15.1-1 PROCEDURE FOR PROPOSALS

Proposals to adopt, amend or repeal the bylaws may be initiated by either of the following methods:

(a) The medical executive committee, with the recommendation of the bylaws committee, or on its own motion, may recommend adoption, amendment or repeal of the bylaws to the voting members of the medical staff as provided in this Article.

(b) The members of the active staff, by a written petition signed by at least twenty percent (20%) of the active staff members, may petition the medical executive committee to initiate a proposal to adopt, amend or repeal the bylaws. Such petition shall identify exact language to be added, changed or deleted. If the medical executive committee agrees with the proposed change, it may recommend the change as provided in subsection (a), above.

15.1-2 APPROVAL BY THE ACTIVE STAFF

If a proposal is initiated as provided above, the chief of staff shall inform the members of the active staff, by mail or by electronic means, of the proposed change. Not less than thirty (30) days and not more than ninety (90) days from the date of such notice, the chief of staff shall either call a special meeting of the medical staff or add it to the agenda of a regular meeting to consider the proposed change.

To be adopted, a proposed change must be approved by a majority of the members of the active staff voting in person or by written ballot. If a written ballot is used, the ballots shall be opened and counted at the meeting and the results shall be announced.

15.1-3 APPROVAL BY THE DISTRICT BOARD

Upon action by the active staff as provided above, the proposed change shall be submitted to the board of directors for approval. The board of board of directors may not unreasonably withhold its approval from the active staff's recommended change. If the board of directors votes to disapprove any part of the recommended change, the board of directors shall give the chief of staff written notice of the reasons for non-approval within ten (10) business days from the board of directors' action. At the request of the medical executive committee, the board of directors' disapproval shall be submitted to the Joint Conference Committee for resolution.

15.2 MEDICAL STAFF POLICIES

15.2-1 PROCEDURE FOR PROPOSALS

Proposals to adopt, amend or repeal the medical staff policies may be initiated by any active medical staff member or medical staff committee.

15.2-2 APPROVAL

(a) Approval by the appropriate medical staff committee(s), as applicable;

(b) Approval by the medical executive committee;

(c) Approval by the active medical staff; and

(d) Submission to the board of directors for approval. If the board of directors disapproves the policy, it will be referred back to the appropriate committee(s).

15.3 TECHNICAL AND EDITORIAL AMENDMENTS

Notwithstanding any other provision of the bylaws to the contrary, the medical executive committee shall have authority on behalf of the medical staff to approve such amendments to the bylaws or policies as the medical executive committee deems to be necessary or appropriate to correct or clarify punctuation, spelling, grammatical or expression errors or ambiguities; cross references; numbering or organization; names or titles of committees, officers, practitioner categories, or other such identifiers. The medical executive committee shall give notice of such amendments to the medical staff members, the administrator, and the district board. Such amendments shall become effective upon approval by the district board.

15.4 DISTRIBUTION OF APPROVED PROPOSALS

Promptly after approval, and if reasonably practical, prior to the proposal's effective date, a copy of an approved proposal for bylaws or policies changes shall be distributed to all members, applicants, and other privileged practitioners and APPs who hold any type of privileges pursuant to the bylaws.

The Northern Inyo Healthcare District Medical Staff Bylaws are:

ADOPTED by the medical staff on

_____, 20_____
Date

_____
Chief of Staff

_____
Vice Chief of Staff

APPROVED by the board of directors on

_____, 20_____
Date

_____
~~President~~Board Chair

_____
Board Secretary

CALL TO ORDER

Northern Inyo Healthcare District (NIHD) Board Chair Melissa Best-Baker called the meeting to order at 5:30 p.m.

PRESENT

Melissa Best-Baker, Chair
Jean Turner, Vice Chair
Ted Gardner, Secretary
David McCoy Barrett, Treasurer
Mary Mae Kilpatrick, Member at Large
Allison Partridge RN, MSN, Chief Operations Officer / Chief Nursing Officer
Adam Hawkins, DO, Chief Medical Officer
Alison Murray, MBA HRM, SHRM-CP, Chief Human Resources Officer
Sierra Bourne, MD, Chief of Staff

ABSENT

Stephen DelRossi, MSA, Chief Executive Officer

OPPORTUNITY FOR PUBLIC COMMENT

Vice Chair Turner reported that at this time, members of the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Public comments shall be received at the beginning of the meeting and are limited to three minutes per speaker, with a total time limit of thirty minutes for all public comment unless otherwise modified by the Chair. 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.

A comment was heard from community member Pam Mitchell who suggested that the regular Board meeting be held at a later time due to many community members' job schedules.

NEW BUSINESS

2023-2024 EMPLOYEE ENGAGEMENT SUREVEY REPORT

Chair Best- Baker called attention to the 2023-2024 Employee Engagement Survey Report.

Marjorie Routt, Human Resources Manager presented the 2023-2024 Employee Engagement Survey.

Discussion ensued.

CHIEF EXECUTIVE OFFICER REPORT

Chair Best-Baker called attention to the CEO report.

- CEO Report – Allison Partridge, COO/CNO presented the CEO

report on behalf of CEO DelRossi.

- Associate CFO – Allison reported the news that Andrea Mossman has accepted the job duties as NIHD's new Associate Chief Financial Officer
- Healthcare Financial Management Association (HFMA) Conference– Allison reported that CEO DelRossi attended the HFMA Conference and will give a more detailed update on the conference upon his return, but he shared a little with the Executive team about the new AI systems are slowing developing within Healthcare are very exciting.
- CEO schedule update – COO/CNO Partridge reported that Mr. DelRossi is currently out of the office and the rest of the Executive team will be covering for him in his absence.
- Board Clerk – COO/CNO Partridge shared with the Board that our current Board clerk will be transitioning out and will be training a new Board Clerk that will be starting in August.

Discussion ensued.

CHIEF FINANCIAL OFFICER REPORT

Chair Best-Baker introduced the Chief Financial Officer report.

- Financial & Statistical Reports:
  - Associate CFO Andrea Mossman to present the Financial & Statistical report. Discussion ensued.

Motion by: Mary Mae Kilpatrick
Seconded by: Jean Turner
Passed 5-0 vote

- California – Cost of living increase – COO/CNO Partridge reported that our employees have recently received an increase and will see it on their first pay period in August.
- Cerner
  - Automation
  - Unified Consumer Communications (U.C.C Well)

Allison Partridge reported that U.C.C. Well is now called Altera, and that we should be live with our new system in about 14 weeks.

Discussion ensued.

CHIEF MEDICAL OFFICER REPORT

Chair Best-Baker called attention to Dr. Adam Hawkins and the Chief Medical Officer Report.

Dr. Hawkins asked if the Board had any question. Discussion ensued.

CHIEF OF STAFF REPORT

Vice Chair Turner called attention to the Chief of Staff report.

POLICIES

Chief of Staff Dr. Sierra Bourne provided an overview of the policies/procedures.

a) Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program
b) NIHD Antibiotic Stewardship Committee Charter
c) NIHD Antibiotic Stewardship Program Plan
d) Chaperone Use for Sensitive Exams
e) Emergency Management Plan
f) Mobile Intensive Care Nurse (MICN)
g) DI – MRI Safety Plan

Discussion ensued.

Motion by: David McCoy Barrett
Seconded by: Ted Gardner
Passed 5-0 vote

MEDICAL STAFF INITIAL APPOINTMENTS 2024-2025

Dr. Bourne introduced the following Initial Appointments for 2024-2025.

a) Talia Luc, PMHNP (psychiatric mental health nurse practitioner) – APP Staff
b) Richard Thunder, MD (orthopedic spine surgery) – Courtesy Staff
c) Jack Kornfeld, MD (emergency medicine) – Active Staff
d) Bradley Clark, MD (diagnostic radiology) – Courtesy Staff
e) Ann Marie Collier, MD (neurology) – Telemedicine Staff

Motion by: Ted Gardner
Seconded by: David McCoy Barrett
Passed 5-0 vote

INITIAL PROXY CREDENTIALING FOR DIRECT RADIOLOGY GROUP – 2024-2025

Dr. Bourne presented the Initial Proxy Credentialing for Direct Radiology Group – 2024-2025

As per the approved Physician Credentialing and Privileging Agreement, and as outlined by the Joint Commission and the Medicare Conditions of Participation, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon Direct Radiology's credentialing and privileging decisions.

a) Sandeep N. Amesure, MD (Diagnostic Radiology)
b) John R. Anderson, DO (Diagnostic Radiology)
c) Asif Anwar, MD (Diagnostic Radiology)
d) David K. Bass, MD (Diagnostic Radiology)
e) Troy A. Belle, MD (Diagnostic Radiology)
f) Robert Berger, MD (Diagnostic Radiology)
g) Michael D. Berven, MD (Diagnostic Radiology)

h) John W. Boardmna, MD (Diagnostic Radiology)
i) Charles W. Westin, MD (Diagnostic Radiology)
j) Alexander R. Vogel, MD (Diagnostic Radiology)
k) James Brull, DO (Diagnostic Radiology)
l) Dennis M. Burton, MD (Diagnostic Radiology)
m) Sanford M. Smoot, MD (Diagnostic Radiology)
n) Courtney C. Carter, MD (Diagnostic Radiology)
o) Lillian W. Cavin, MD (Diagnostic Radiology)
p) Kenneth A Edgar, MD (Diagnostic Radiology)
q) Jeffrey W. Grossman, MD (Diagnostic Radiology)
r) Mark L. Harshany, MD (Diagnostic Radiology)
s) James C. Haug, DO (Diagnostic Radiology)
t) Miriam B. Hulkower, MD (Diagnostic Radiology)
u) Ellen D. Johnson, MD (Diagnostic Radiology)
v) Benjamin R. Park, DO (Diagnostic Radiology)
w) William E. Phillips, MD (Diagnostic Radiology)
x) Teppe Popovich, MD (Diagnostic Radiology)
y) William T. Randazzo, MD (Diagnostic Radiology)
z) Avez A. Rizvi, MD (Diagnostic Radiology)
aa) Faranak Sadri Tafazoli, MD (Diagnostic Radiology)
bb) Dishant G. Shah, MD (Diagnostic Radiology)
cc) Shree J. Shah, MD (Diagnostic Radiology)
dd) Masood A. Siddiqui, DO (Diagnostic Radiology)

Motion by: David McCoy Barrett
Seconded by: Jean Turner
Passed 5-0 vote

CHANGE IN STAFF CATEGORY

Dr. Bourne brought attention to the following Change in Staff:

Gregory Gaskin, MD (emergency medicine) – change from Active Staff to Courtesy Staff

Discussion ensued.

Motion by: Jean Turner
Seconded by: Mary Mae Kilpatrick
Passed 5-0 vote

MEDICAL STAFF GOVERNANCE STRUCTURE FOR FISCAL YEAR 2024-2025

Chair Best-Baker called attention to the Medical Staff Governance Structure for Fiscal Year 2024-2025

Dr. Bourne asked if there were any questions. Discussion ensued.

MEDICAL EXECUTIVE COMMITTEE REPORT

Dr. Sierra Bourne provided the Medical Executive Committee meeting report.

Discussion ensued.

CONSENT AGENDA

Chair Best-Baker called attention to the consent agenda that contained the following items.

- Approval of minutes of the June 19, 2024 Regular Board Meeting
- Approval of minutes of the July 3, 2024 Special Board Meeting
- CEO Credit Card Statements
- Approval of Policies and Procedures
    a) Laboratory Biosafety Plan
    b) Environmental Tours

Motion by: Mary Mae Kilpatrick
Seconded by: Jean Turner
Passed 5-0 vote

GENERAL INFORMATION FROM BOARD MEMBERS

Chair Best-Baker brought attention to the information from Board Members.

Discussion ensued.

ADJOURNMENT

Adjournment at 07:02 p.m.

_____
Melissa Best-Baker, Northern Inyo Healthcare District, Chair

Attest: _____
Ted Gardner, Northern Inyo Healthcare District, Secretary

August 2024 Statement

Open Date: 07/06/2024 Closing Date: 08/06/2024

[redacted]

U.S. Bank Business Platinum Card
NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

New Balance	**$2,108.88**
Minimum Payment Due	**$22.00**
Payment Due Date	**09/01/2024**

[redacted]

Activity Summary

Previous Balance	+	$5,173.77
Payments	-	$5,173.77CR
Other Credits		$0.00
Purchases	+	$2,108.88
Balance Transfers		$0.00
Advances		$0.00
Other Debits		$0.00
Fees Charged		$0.00
Interest Charged		$0.00
New Balance	**=**	**$2,108.88**
Past Due		**$0.00**
Minimum Payment Due		**$22.00**
Credit Line		$37,500.00
Available Credit		$35,391.12
Days in Billing Period		32

[redacted]

[redacted]

[redacted]

Payment Due Date	9/01/2024
New Balance	$2,108.88
Minimum Payment Due	$22.00

Amount Enclosed $_____

[redacted]

NORTHERN INYO HOSPITA
STEPHEN DELROSSI
150 PIONEER LN
BISHOP CA 93514-2556

[redacted]

[redacted]

[redacted]

What To Do If You Think You Find A Mistake On Your Statement

If you think there is an error on your statement, please call us at the telephone number on the front of this statement, or write to us at:

In your letter or call, give us the following information:

▶ *Account information:* Your name and account number.

▶ *Dollar amount:* The dollar amount of the suspected error.

▶ *Description of Problem:* If you think there is an error on your bill, describe what you believe is wrong and why you believe it is a mistake.

You must contact us within 60 days after the error appeared on your statement. While we investigate whether or not there has been an error, the following are true:

▶ We cannot try to collect the amount in question, or report you as delinquent on that amount.

▶ The charge in question may remain on your statement, and we may continue to charge you interest on that amount. But, if we determine that we made a mistake, you will not have to pay the amount in question or any interest or other fees related to that amount.

▶ While you do not have to pay the amount in question, you are responsible for the remainder of your balance.

▶ We can apply any unpaid amount against your credit limit.

Your Rights If You Are Dissatisfied With Your Credit Card Purchases

If you are dissatisfied with the goods or services that you have purchased with your credit card, and you have tried in good faith to correct the problem with the merchant, you may have the right not to pay the remaining amount due on the purchase.

To use this right, all of the following must be true:

1. The purchase must have been made in your home state or within 100 miles of your current mailing address, and the purchase price must have been more than $50. (Note: Neither of these are necessary if your purchase was based on an advertisement we mailed to you, or if we own the company that sold you the goods or services.)
2. You must have used your credit card for the purchase. Purchases made with cash advances from an ATM or with a check that accesses your credit card account do not qualify.
3. You must not yet have fully paid for the purchase.

If all of the criteria above are met and you are still dissatisfied with the purchase, contact us in writing at: Cardmember Service,

While we investigate, the same rules apply to the disputed amount as discussed above. After we finish our investigation, we will tell you our decision. At that point, if we think you owe an amount and you do not pay we may report you as delinquent.

Important Information Regarding Your Account

1. **INTEREST CHARGE:** Method of Computing Balance Subject to Interest Rate: We calculate the periodic rate or interest portion of the **INTEREST CHARGE** by multiplying the applicable Daily Periodic Rate (**"DPR"**) by the Average Daily Balance (**"ADB"**) (including new transactions) of the Purchase, Advance and Balance Transfer categories subject to interest, and then adding together the resulting interest from each category. We determine the **ADB** separately for the Purchases, Advances and Balance Transfer categories. To get the **ADB** in each category, we add together the daily balances in those categories for the billing cycle and divide the result by the number of days in the billing cycle. We determine the daily balances each day by taking the beginning balance of those Account categories (including any billed but unpaid interest, fees, credit insurance and other charges), adding any new interest, fees, and charges, and subtracting any payments or credits applied against your Account balances that day. We add a Purchase, Advance or Balance Transfer to the appropriate balances for those categories on the later of the transaction date or the first day of the statement period. Billed but unpaid interest on Purchases, Advances and Balance Transfers is added to the appropriate balances for those categories each month on the statement date. Billed but unpaid Advance Transaction Fees are added to the Advance balance of your Account on the date they are charged to your Account. Any billed but unpaid fees on Purchases, credit insurance charges, and other charges are added to the Purchase balance of the Account on the date they are charged to the Account. Billed but unpaid fees on Balance Transfers are added to the Balance Transfer balance of the Account on the date they are charged to the Account. In other words, billed and unpaid interest, fees, and charges will be included in the **ADB** of your Account that accrues interest and will reduce the amount of credit available to you.To the extent credit insurance charges, overlimit fees, Annual Fees, and/or Travel Membership Fees may be applied to your Account, such charges and/or fees are not included in the ADB calculation for Purchases until the first day of the billing cycle following the date the credit insurance charges, overlimit fees, Annual Fees and/or Travel Membership Fees (as applicable) are charged to the Account. Prior statement balances subject to an interest-free period that have been paid on or before the payment due date in the current billing cycle are not included in the **ADB** calculation.
2. **Payment Information:** We will accept payment via check, money order, the internet (including mobile and online) or phone or previously established automatic payment transaction. You must pay us in U.S. Dollars. If you make a payment from a foreign financial institution, you will be charged and agree to pay any collection fees added in connection with that transaction. The date you mail a payment is different than the date we receive the payment. The payment date is the day we receive your check or money order at or the day we receive your internet or phone payment. All payments by check or money order accompanied by a payment coupon and received at this payment address will be credited to your Account on the day of receipt if received by 5:00 p.m. CT on any banking day. Payments sent without the payment coupon or to an incorrect address will be processed and credited to your Account within 5 banking days of receipt. Payments sent without a payment coupon or to an incorrect address may result in a delayed credit to your Account, additional interest charges, fees, and/or Account suspension. The deadline for on-time internet and phone payments varies, but generally must be made before 5:00 p.m. CT to 8 p.m. CT depending on what day and how the payment is made. Please contact Cardmember Service for internet, phone, and mobile crediting times specific to your Account and your payment option. Banking days are all calendar days except Saturday, Sunday and federal holidays. Payments due on a Saturday, Sunday or federal holiday and received on those days will be credited on the day of receipt. There is no prepayment penalty if you pay your balance at any time prior to your payment due date.
3. **Credit Reporting:** We may report information on your Account to Credit Bureaus. Late payments, missed payments or other defaults on your Account may be reflected in your credit report.

[redacted]
NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

[redacted]

Important Messages

Paying Interest: You have a 24 to 30 day interest-free period for Purchases provided you have paid your previous balance in full by the Payment Due Date shown on your monthly Account statement. In order to avoid additional INTEREST CHARGES on Purchases, you must pay your new balance in full by the Payment Due Date shown on the front of your monthly Account statement.

There is no interest-free period for transactions that post to the Account as Advances or Balance Transfers except as provided in any Offer Materials. Those transactions are subject to interest from the date they post to the Account until the date they are paid in full.

Skip the mailbox. Switch to e-statements and securely access your statements online. Get started at usbank.com/login.

Transactions

Payments and Other Credits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
07/25	07/25	[redacted]	INTERNET PAYMENT THANK YOU	$5,173.77CR	
08/02			CHARGE OFF	$0.00CR	
			TOTAL THIS PERIOD	**$5,173.77CR**	

Purchases and Other Debits

Post Date	Trans Date	Ref #	Transaction Description		Amount	Notation
07/22	07/19	[redacted]	4IMPRINT, INC [redacted]	Coats for resale	$1,811.26	
08/01	07/31		FACEBK [redacted]	Marketing	$203.84	
08/06	08/01		OPTIMUM 7715 [redacted]	Cable	$93.78	
			TOTAL THIS PERIOD		**$2,108.88**	

2024 Totals Year-to-Date	
Total Fees Charged in 2024	$78.00
Total Interest Charged in 2024	$255.74

Company Approval *(This area for use by your company)*

Signature/Approval: _____ Accounting Code: _____

Interest Charge Calculation

Your Annual Percentage Rate (APR) is the annual interest rate on your account.

**APR for current and future transactions.

Balance Type	Balance By Type	Balance Subject to Interest Rate	Variable	Interest Charge	Annual Percentage Rate	Expires with Statement
**BALANCE TRANSFER	$0.00	$0.00	YES	$0.00	24.24%	
**PURCHASES	$2,108.88	$0.00	YES	$0.00	24.24%	
**ADVANCES	$0.00	$0.00	YES	$0.00	29.99%	

Continued on Next Page

NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

[redacted]

Contact Us

[redacted]

End of Statement

NORTHERN INYO HOSPITA

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL PROCEDURE

Title: Bulk Oxygen Systems		
Owner: Maintenance Manager	Department: Maintenance	
Scope: Facilities		
Date Last Modified: 07/19/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/16/2015	

PURPOSE

The purpose of this policy and procedure is to ensure the safe and effective management, operation, and maintenance of bulk oxygen systems for Norther Inyo Healthcare District (NIHD). This policy aims to ensure compliance with The Joint Commission standards, national codes, and local regulations to guarantee an adequate oxygen supply and ensure the safety of patients, staff, and visitors.

SCOPE

This policy applies to NIHD's bulk oxygen systems. It covers design, installation, operation, maintenance, and emergency procedures related to bulk oxygen systems.

POLICY

1. Design and Installation

1.1. All bulk oxygen systems must be designed and installed in compliance with NFPA 99 (Health Care Facilities Code), NFPA 55 (Compressed Gases and Cryogenic Fluids Code), and The Joint Commission standards.
1.2. The system must be installed in a secure, well-ventilated area away from sources of ignition and easily accessible for maintenance and refilling.

2. Operation

2.1. Only trained and authorized personnel are permitted to operate the bulk oxygen system.
2.2. Continuous monitoring of oxygen levels to ensure an adequate supply.
2.3. Documentation and communication of any system adjustments to relevant staff.

3. Maintenance

3.1. Conduct regular maintenance as per manufacturer's recommendations and regulatory requirements**.**
3.2. Maintain logs for all inspections, repairs, and refills.
3.3. Promptly address any issues detected during maintenance.

3.4. Adhere to The Joint Commission's Environment of Care (EC) standards, particularly EC.02.05.09 concerning medical gas and vacuum systems.

4. Safety and Emergency Procedures

4.1. Ensure all staff are trained in the safe handling of oxygen and are aware of potential hazards.
4.2. Conduct regular emergency drills, including procedures for oxygen leaks, fires, and system failures.
4.3. Establish and communicate a clear evacuation plan in case of emergencies involving the oxygen system.
4.4. Provide appropriate firefighting equipment near the oxygen storage area.
4.5. Follow The Joint Commission's standards on emergency management (EM) for preparedness.

5. Training

5.1. Provide initial and ongoing training for all staff involved in operating and maintaining the bulk oxygen system.
5.2. Training should cover the proper use of personal protective equipment (PPE), emergency response procedures, and safe handling practices.
5.3. Align training programs with The Joint Commission's standards on staff competency (HR).

6. Documentation

6.1. Maintain comprehensive records of system design, installation, maintenance, and training.
6.2. Ensure all documentation is up to date and readily available for inspection by regulatory authorities.
6.3. Comply with The Joint Commission's documentation requirements for medical gas systems.

7. Compliance and Auditing

7.1. Regularly audit the bulk oxygen system and management practices to ensure compliance with this policy, The Joint Commission standards, and relevant regulations.
7.2. Address any deficiencies identified during audits promptly.
7.3. Utilize The Joint Commission's tracer methodology during audits to identify and correct issues.

8. Review and Revision

8.1. Review this policy annually and revise it as necessary to reflect changes in regulations, standards, and operational practices.
8.2. Approve and communicate any changes to the policy to all relevant staff.
8.3. Ensure alignment with The Joint Commission's periodic performance review (PPR) process.

PROCEDURE

1. Design and Installation

1.1. Ensure design compliance with NFPA 99, NFPA 55, and The Joint Commission standards.
1.2. Select a secure and well-ventilated location for installation.
1.3. Conduct and document a risk assessment for the selected location.
1.4. Install the system per manufacturer guidelines and regulatory requirements.
1.5. Inspect and test the system post-installation to ensure functionality.

2. Operation

2.1. Train authorized personnel on the operation of the bulk oxygen system.
2.2. Regularly monitor oxygen levels and document readings.
2.3. Report any irregularities or system malfunctions immediately.
2.4. Record all adjustments made to the system.

3. Maintenance

3.1. Schedule regular maintenance according to manufacturer's recommendations.
3.2. Perform and document all inspections, repairs, and refills.
3.3. Immediately address any identified issues.
3.4. Ensure compliance with The Joint Commission's EC.02.05.09 standards.

4. Safety and Emergency Procedures

4.1. Train all staff on the potential hazards of oxygen and safety procedures.
4.2. Conduct regular emergency drills, including for oxygen leaks and fires.
4.3. Establish and communicate an evacuation plan.
4.4. Ensure firefighting equipment is accessible and functional.

5. Training

5.1. Develop training programs per The Joint Commission's standards.
5.2. Provide initial and ongoing training to relevant staff.
5.3. Assess staff competency regularly and provide refresher training as needed.

6. Documentation

6.1. Maintain accurate and up-to-date records of system design, installation, maintenance, and training.
6.2. Ensure documentation is accessible for regulatory inspections.
6.3. Regularly review and update documentation practices to ensure compliance.

7. Compliance and Auditing

7.1. Conduct regular audits using The Joint Commission's tracer methodology.
7.2. Identify and address any deficiencies promptly.
7.3. Document and report audit findings and corrective actions.

8. Review and Revision

8.1. Review the policy annually.
8.2. Revise the policy as necessary to reflect changes in regulations, standards, and practices.
8.3. Obtain approval for changes from facility management.
8.4. Communicate changes to all relevant staff

REFERENCES:

1. The Joint Commission Standards Manual – EC.02.05.09 EP 8-9

2. NFPA 99: Health Care Facilities Code
3. NFPA 55: Compressed Gases and Cryogenic Fluids Code
4. OSHA guidelines on oxygen safety
5. Manufacturer's guidelines for the bulk oxygen system

RECORD RETENTION AND DESTRUCTION:
The rounding record will be maintained for 39 months.

CROSS-REFERENCED POLICIES AND PROCEDURES:

1. Bulk Oxygen Systems

Supersedes: v.2 Bulk Oxygen Systems EC.02.05.09 EP8-9

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Cell Phone Procurement and Issuance		
Owner: ITS Director - CISO	Department: Information Technology	
Scope: District Wide		
Date Last Modified: 07/25/2024	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/16/2021	

PURPOSE: Northern Inyo Healthcare District (NIHD) acquires and oversees cell phones for use by district staff to ensure the privacy of hospital communications. This policy outlines the process for providing cell phones to meet the hospital team's needs.

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 ATT 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.
5. IT will reset the phone to factory defaults.
6. Any NIHD Cell phone that is lost or damaged will be reported to the Service Desk immediately and an Unusual Occurrence Report (UOR) will be opened by the end user to record the incident.

REFERENCES:

1. N/A

CROSS REFERENCE P&P:

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

RECORD RETENTION AND DESTRUCTION: N/A

Supersedes: v.3 Cell Phone Procurement and Issuance

Title: Collective Bargaining Agreement Disclaimer		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 07/29/2024	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
The policies and procedures outlined in the Employee Handbook have been designed to comply with all existing written and unwritten policy statements; all requirements of existing labor laws and, if applicable, a Collective Bargaining Agreement with an employee organization. Where conflicts exist, the Collective Bargaining Agreement will take precedence over this policy. The Chief Human Resources Officer (CHRO) has responsibility for the interpretation of this policy, and any exceptions to this policy will be made with Executive Team approval. All policies and procedures may be modified or changed at any time with Board and Executive Leadership approval.

RECORD RETENTION AND DESTRUCTION:
Human Resources records are kept for the life of the employment, plus ten years

Supersedes: v.3 02-01.5 COLLECTIVE BARGAINING AGREEMENT DISCLAIMER
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Computer Screen Lock Policy		
Owner: ITS Director - CISO	Department: Information Technology Services	
Scope: District Wide		
Date Last Modified: 07/09/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/01/2014	

PURPOSE:

The aim of this policy is to establish a baseline standard for safeguarding unattended computers against unauthorized access. This measure is crucial in preventing unauthorized users from accessing or viewing protected health information stored on unattended electronic information system devices. It fulfills the addressable security safeguard requirement under HIPAA and is mandated by provisions of the HITECH Act.

Definitions:

Locking: Locking a computer desktop is a way to secure a logon session, preventing others from accessing it when the computer is left unattended. Applications remain active and uninterrupted during this process. To unlock the computer, users must re-enter their username and password, or tap their employee badge on the badge reader and enter their PIN.

Locking Screensaver: A locking screensaver activates after a specified period of inactivity. To disable the screensaver and regain access to the desktop, users must enter a username and password or use their employee badge to tap and enter their PIN number. The application state is preserved as it is when locking a desktop. At NIHD, this locking screensaver is employed as a fail-safe to protect PHI and other sensitive information on unattended computers.

Log off: When logging off a computer, the user's session and all open applications are closed. Logging off is appropriate when the user has finished working on the computer, properly exited all applications, and saved their data. At NIHD, automated controls are NOT configured to log users off.

Secure Area: Work areas within NIHD that are located in an access-controlled space and are not accessible by non-approved staff or the public. Identified secure areas are Pharmacy, Lab and Medical Records

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

POLICY:

1. **Manual log off or locking:**
   Workforce members must manually log off or lock the computer when leaving it unattended, which means stepping away from the computer's immediate supervision. Manually locking or logging off is the primary method for securing protected health information on unattended computers.

2. **Automated locking:**
   The ITS department will configure computers to enable password-protected screensavers on all workforce computers, except those in designated secure areas, to automatically activate after 10 minutes of inactivity. To regain access, users must reenter their password or tap their badge and enter their PIN. Automated locking serves as a fail-safe to secure PHI if a workforce member forgets to lock or log off the system before leaving its immediate vicinity.
3. **Application of policy:**
   This policy applies to all District workforce computers except those in the designated secure areas.

4. **Exceptions to the policy:**
   Any exceptions to this policy must be submitted in writing with a business justification and submitted to the NIHD Security Officer or NIHD Privacy Officer. A list will be kept by the Privacy Officer or the Privacy Officer's designee and will be updated from time to time as exceptions are approved.

5. **Regulatory Reference:**
   HIPAA Security rule 45 CFR 164.312(a)(2)(iii) Implementation Specification for Access Control Standard

REFERENCE:

1. The Joint Commission (CAMCAH Manual) Jan. 2022; Standard IM.02.01.01 – EP 1, 3 and 4.
2. The Joint Commission (CAMCAH Manual) Jan. 2022; Standard IM.2.01.03 – EP 6.

RECORD RETENTION AND DESTRUCTION:

Records of business justification for additional areas should be filed with annual District Security Risk Assessment and maintained for 7 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. InQuiseek - #390 Health Information Technology/IT
2. Computer Screen Lock Policy

Supersedes: v.1 Computer Screen Lock Policy

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Consent for Medical Treatment		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 02/04/2022	Last Review Date: 07/31/2024	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/1995	

PURPOSE:
Consent is regulated by complex laws that apply to routine and unusual instances. This document provides support to Northern Inyo Healthcare District (NIHD) workforce for better understanding of consent requirements. This does not cover all situations and the California Hospital Association Consent Manual should be utilized for complex situations that are not covered within this document.

POLICY:

The hospital may not permit any treatment, without the risk of liability, unless the patient, or a person legally authorized to act on the patient's behalf, has consented to the treatment. Every competent adult has the fundamental right of self-determination over his or her body and property.

Patients have the right to:
1. Make care decisions
2. Receive adequate disclosure
3. Choose treatment options
4. Refuse medical intervention
5. Withdraw consent
6. Receive answers to all questions

After assuring the signer understands, every effort must be made to obtain written consent from the legally responsible party. If unable to obtain consent, failed efforts shall be fully documented in the medical record. Service should never be refused for patients presenting to the Emergency or Perinatal Departments. (see EMTALA Policy.) In general, it is better to err on the side of treatment than non-treatment.

DEFINITIONS:
Adequate Disclosure: The medical provider responsible for the treatment may not delegate this duty. Adequate Disclosure must include explaining: what is involved with the treatment, anticipated results, benefits, and harms of the treatment, possible complications and foreseeable risks, and whether the procedure is experimental.
Emancipated Minor: A minor 14 years or older may petition the court for emancipation. If approved, DMV provides the Emancipated Minor with an identification care that states the minor is emancipated. This is used as evidence of the court's decisions and should be copied and placed into the patient's medical record.
Emergency Treatment: Treatment of a medical emergency may be provided without consent where the provider reasonably believes that a medical procedure should be undertaken immediately, and that there is insufficient time to obtain the consent of the patient or of a person authorized to consent for the patient. A

medical emergency exists when: Immediate services are required for the alleviation of severe pain; or immediate diagnosis and treatment of unforeseeable medical conditions are required, if such conditions would lead to serious disability or death if not immediately diagnosed and treated.
Expressed Consent: The patient verbally expresses to the practitioner that he/she consents to treatment.
Implied Consent: There are no words of consent but the actions of the patient are sufficient to imply to any reasonable person that the patient has consented to treatment or would consent if he/she were able. (Example – unconscious patient whose presence in the emergency department implies consent.) This cannot include treatment that has previously been validly refused.
Informed Consent: a process of communication between the patient, or the patient's legal representative, and the healthcare practitioner in which the nature of the illness and the purpose of the procedure are discussed and an opportunity for questions is allowed.
Minors: are all persons under 18 years of age (per family law Code Section 6500).

PROCEDURE:

I. General consent for treatment or admission.
   A. This includes *condition of admission* form(s).
      i. Gives consent for routine nursing care, blood tests, non-invasive diagnostic imaging, etc.
      ii. Does not require formal informed consent by a medical provider.
      iii. Competent adult patients have the right to refuse any service and should be notified and included in their plan of care decisions.
   B. Information is provided to the patient or their legally authorized representative and questions answered prior to obtaining signature.
   C. Admission services personnel commonly perform this function at NIHD.

II. Accommodating patients' communication needs for consents.
   A. Utilize interpreter services for Limited English Proficiency (LEP) patient communication.
   B. NIHD utilizes documents translated into Spanish per Language Access Services Policy. These are utilized for primary Spanish speakers due to LEP or preference.
   C. Visual aids may be utilized for better understanding.
   D. Reading assistance may be provided when reading level of patient or authorized signer is low.

III. Representatives authorized to make decisions on behalf of adult (age 18 years or greater) patients.
   A. Agent appointed by the patient.
      i. Named in an Advanced Directive or similar document.
      ii. May be named verbally.
   B. Conservator appointed by a court.
   C. Court appointed surrogate decision maker.
   D. Closest available relative.
      i. Closest available relative does not include a specific order by case law.
      ii. The person who seems most familiar with the patient's values, demonstrates concern for the patient, has had recent contact prior to the illness, and is able to understand the information should be chosen.

IV. Minors
   A. Consent for minors – special circumstances.
      i. The person able to consent for a minor patient, is also able to refuse care on behalf of the minor.
      ii. Minors on active duty in the armed services have authority to consent to medical care.
      iii. Minors who are married, divorced or widowed have the authority to consent to medical care.

iv. Minors 15 years of age or over, living away from home and managing his/her own finances have the authority to consent to medical care.
v. Emancipated minors have the ability to consent to medical care.

B. Financial responsibility for minor's care.
i. The person(s) responsible for the minor is generally responsible for the financial obligation related to medical care. (parent/guardian)
ii. Parent/guardian are not financially responsible for health care services to which the minor may legally consent. (Exception for Emancipated minors living at home.)

C. Parental Consent for Treatment of Minors.
i. Minors with married parents in agreement either are able to consent for medical treatment.
ii. Minors with divorced parents.
a. If in agreement, both parents should sign the consent.
b. If in disagreement, custody order should be obtained to determine which parent has the authority to make health care decisions for the minor. Place a copy of court orders into the minor's medical record.
c. If the parents have joint legal custody and disagree regarding treatment of the minor, they will be required to obtain a court order to resolve the dispute. If delay in care might harm the minor, the physician and NIHD may decide that treatment should be provided, notwithstanding one parent's objection.
i. Minors with Stepparents- Unless legally adopted by the stepparent, the consent may not be provided by a stepparent, except with written authorization from the parent with legal rights to consent.

D. Adopted Minors-When the minor has been legally adopted, the adoptive parents assume all rights to consent for medical treatment. The birth parents then lose their parental rights post adoption.

E. Minors Born Out of Wedlock
i. Mother has full rights to consent for treatment of the minor child.
ii. Father has full rights unless there is doubt to the status of someone claiming to be a child's father; in which case the birth certificate or court judgement document should be requested to determine legal rights to consent.

F. Minors with a Registered Domestic Partner Parent-These parents have the same rights as married persons and can consent for treatment of the minor child.

G. Guardian Consent for Treatment of Minor – Obtain a copy of the official certified letters of guardianship to determine legal authority to consent for the minor.

H. Third-Party Consent for Treatment – This includes consent being given by the parent or guardian to a third party in their absence. There are specific requirements for a variety of different issues that fall under this category. Refer to the CHA Consent Manual.

I. Minors who are parents while living at home-are not allowed to give consent for their own medical treatment; while being able to consent for their own child.

J. Minors who are suspected victims of child abuse – Physician may order x-rays without consent of the parent under this circumstance. If further treatment is required and the parents object, a court order is required.

V. Telephone Consent – NIHD has ability to record a verbal consent for treatment. The recording equipment is maintained in the Emergency Department Admission area. Admission staff members are

trained on this process. A telephone consent takes the place of a written consent. Staff document in the patient record the information related to the consent.

VI. California Hospital Association Consent Manual should be utilized for complex situations that are not covered within this document.
   A. This manual is located on the NIHD intranet>Resources (top of page)>Information>Compliance>CHA Manuals>CHA Consent Manual.
   B. Workforce should be empowered to utilize the Compliance Manual when they have questions on consent.
   C. Unusual situations related to consents must be discussed with NIHD Leadership via the chain of command.

REFERENCES:

1. California Hospital Association Consent Manual (2021).

RECORD RETENTION AND DESTRUCTION:

Consents are maintained within the patient's medical record and are retained for a minimum of 15 years for adults and 25 years for minors.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Informed Consent Policy – Practitioner's Responsibility
2. Minors with Legal Authority to Consent
3. Surgical Procedures that Require Special Consents
4. Consent for Medical Treatment

Supersedes: v.2 Consent for Medical Treatment

Title: Hiring - Anniversary Date		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 08/12/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:	

POLICY:
All employees establish an anniversary date on the initial date of employment. Upon employment the anniversary date that is initially the hire date is used to determine the next possible incremental pay increase date.

An employee's anniversary date changes if they change positions, either through a significant change to their position through a transfer, demotion, or promotion. There will be no anniversary date change for a reclassification.

RECORD RETENTION AND DESTRUCTION:
Human Resources records are kept for the life of employment, plus ten years

CROSS REFERENCE POLICIES AND PROCEDURES: 1 - Hiring - Anniversary Date

Supersedes: v.2 Hiring - Anniversary Date
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

Title: Hiring - Background Screening		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 07/30/2024	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

To provide a formal process and guidelines for Department Managers and Human Resources to follow in requesting important background information for all final candidates for positions.

Hiring qualified individuals to fill positions contributes to the overall strategic success of the organization. Background screenings serve as an important part of the applicant selection process at Northern Inyo Healthcare District. This type of information is collected as a means of promoting a safe work environment for current and future employees. Background screenings also help obtain additional applicant-related information that helps determine the applicant's overall employability, ensuring the protection of our patients, current staff, property, and information.

To ensure that Northern Inyo Healthcare District obtains a criminal background check on applicants as required by law and regulation as Northern Inyo District cannot employ individuals who— (A) have been found guilty of abusing, neglecting, or mistreating patients by a court of law; or (B) have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of patients or misappropriation of patient's property.

POLICY:

Current staff who have been convicted of Medicaid/Medicare fraud or abuse, child/dependent adult or sexual abuse must report that information to Human Resources so that employment status can be evaluated.

All conditional offers of employment are contingent upon meeting all pre-employment conditions, including a criminal background check.

Background screenings are conducted on every job applicant, regardless of the position for which they are applying. This process is conducted to verify the accuracy of the information provided by the applicant. Information provided by the applicant and found in the various background screenings will serve as additional criteria in making employment/hiring decisions. Staff employed through a temporary employment agency must have the same screening completed by their agency and documentation of these screenings provided to Human Resources or Human Resources must complete the background screenings.

Once a decision has been made regarding interest in hiring an applicant, a conditional offer will be made in writing contingent upon satisfactory completion of background screenings.

At a minimum, all employees regardless of date of hire will have a background check that will include:

- Office of Inspector General (OIG) of the U.S. Department of Health & Human Services (HHS) List of Excluded Individuals/Entities Search
- Instant Criminal Database Search or County Criminal Records Search

Employee background screenings may also generally include the following:

- Personal and Professional References: Calls may be placed to individuals listed as references by an applicant.
- Social Security validates the applicant's social security number, date of birth and former addresses.
- Multi-County Criminal will be run on counties that applicants have listed on the release form as well as counties of past residences for seven years.
- Prior Employment Verification confirms applicant's employment with the provided companies, including dates of employment, position held and additional information available pertaining to salary/wages, performance rating, reason for departure and eligibility for rehire. This will be run on at least one employer.
- Educational Verification confirms the applicant's claimed educational institution, including the years attended and the degree/diploma received.
- Primary source verification of professional licenses, registrations, certifications, if applicable.

Per California Law, the District may not consider any of the following:

- Arrest not followed by conviction;
- Referral to or participation in a pretrial or post trial diversion program; or
- Convictions that have been sealed, dismissed, expunged, or pardoned.

The following additional searches may be required if applicable:

- Military service records check
- Motor Vehicle provides a report on an individual's driving history in the state requested. This search may be run when driving is an essential requirement of the position.
- Credit History confirms candidate's credit history. This search may be run for positions that involve management of District funds, handling of cash, and as otherwise allowed by law.

PROCEDURE:

After a written, conditional, employment offer is made, the chosen candidate must have completed an employment application as well as the authorization form and return it to Human Resources. The chosen candidate is not to begin work prior to the hiring manager receiving approval from Human Resources.

Human Resources will order the background check upon receipt of the signed employment application and authorization form, and an employment screening service will conduct the check. Human Resources will review all results.

Human Resources will notify the hiring manager regarding the results of the check. In instances where negative or incomplete information is obtained, the appropriate management and the Director of Human Resources will assess the potential risks and liabilities related to the job's requirements and determine whether the individual should be hired. After reviewing a candidate’s conviction history report, the District will either:

a. Notify the candidate that this conditional job offer has become final; or

b. Notify the candidate in writing that we intend to revoke (take back) this job offer because of the candidate's conviction history.

Per California Law, the District may not consider any of the following:

- Arrest not followed by conviction;
- Referral to or participation in a pretrial or post-trial diversion program; or
- Convictions that have been sealed, dismissed, expunged, or pardoned.

As required by the California Fair Chance Act, the District will consider whether the applicant's conviction history is directly related to the duties of the position that they received the conditional offer for.

The District will consider all of the following:

- The nature and seriousness of the offense
- The amount of time since the offense
- The nature of the job

Human Resources will notify the hiring manager regarding the results of the check. In instances where negative or incomplete information is obtained, the appropriate management and the Human Resources Manager will assess the potential risks and liabilities related to the job's requirements and determine whether the individual should be hired

The candidate will be notified in writing if the job offer will be revoked after reviewing the candidate's conviction history. That decision will be preliminary, and candidates will have an opportunity to respond before it becomes final. Human Resources will identify conviction(s) that are of concern, give the candidate a copy of the background check report, and allow the candidate at least 5 business days to respond with information showing the conviction history report is inaccurate and/or with information about their rehabilitation or mitigating circumstances. The Human Resources Manager will review any information submitted in a timely manner by the candidate, and then decide whether to finalize or take back this conditional job offer. Human Resources will notify the candidate of a withdrawn offer in writing.

If a decision not to hire a candidate is made based on the results of a background check, there may be certain additional Fair Credit Reporting Act (FCRA) and/or State law requirements. Human Resources will be responsible for handling such requirements as necessary. Northern Inyo Healthcare District will follow all applicable requirements throughout the background check process. Background check information will be handled confidentially and maintained in a file separate from employees' personnel files.

Northern Inyo Healthcare District reserves the right to modify this policy at any time without notice.

REFERENCES:

1. California Senate Bill 1345
2. 15 U.S.C. §§ 1681-1681x (Fair Credit Reporting Act)

RECORD RETENTION AND DESTRUCTION:

Human Resources records are kept for the life of employment, or duration of recruitment, plus 10 years

Supersedes: Hiring – Background Screening v.3

Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

Title: Involuntary Leave of Absence		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 07/29/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

POLICY:
The District reserves the right to place an employee on involuntary leave of absence in the event there is reason to believe that, in performing assigned work, the employee may endanger the physical well-being of patients, co-workers or self. The District may also place an employee on involuntary leave of absence if there is reason to believe that the employee's presence on site will impact or influence any internal investigations involving the employee.

The District will notify the employee of the involuntary leave in writing and will allow sufficient time for correction of the problem. However, the hospital cannot guarantee re-employment if the leave extends beyond 30 days.

REFERENCES:

RECORD RETENTION AND DESTRUCTION:
Employee records, including those involving investigation or termination will be held for:

- The length of employment, plus 10 years.

CROSS REFERENCE POLICIES AND PROCEDURES:

- Workplace Investigations

Supersedes: v.1 INVOLUNTARY LEAVE OF ABSENCE
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: ITS Service Desk Work Order		
Owner: ITS Director - CISO	Department: Information Technology Services	
Scope: District Wide		
Date Last Modified: 07/25/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/01/2004	

PURPOSE:

This policy establishes a streamlined process for requesting, coordinating, and resolving Information Technology Service Desk tickets. By doing so, it enhances the efficiency of daily district operations and upholds the integrity of the facility's IT infrastructure.

POLICY:

Ticket Request Process: Requests for Service Desk assistance, including system maintenance, upgrades, new installations, and troubleshooting, must adhere to the following:

- Service Desk tickets encompass a range of tasks such as system maintenance, PC and printer repairs, equipment installations, programming, network upkeep, and more.
- All requests must align with this policy.

Ticket Creation: Service Desk tickets should be initiated via:

- Email,
- Phone call,
- In-person request.

Service Desk operates during business hours: Monday – Friday, 7am – 5pm.

Ticket Categorization: The ITS Department classifies Service Desk tickets into the following categories:

- **URGENT:** Critical issues affecting patient care or business operations hospital-wide. (Phone call followed by email to servicedesk@nih.org)
- **HIGH:** System or application-wide interruptions affecting daily workflow. (Phone call followed by email to servicedesk@nih.org)
- **MEDIUM:** Issues addressable within reasonable time during business hours. (Email to servicedesk@nih.org, SMS, or chat)
- **LOW:** Initiatives by supervisors or department heads for enhancements, improvements, or projects. (Email to servicedesk@nih.org)

Non-critical issues should be reported via email, intranet quick link, SMS (without PHI), or chat to keep phone lines available for critical matters.

- **Ticket Monitoring and Prioritization:** Service Desk tickets are monitored and prioritized by Junior Network Systems Analysts, with oversight from the ITS Coordinator, Manager, and/or Director, supported occasionally by other ITS staff members.
- **Communication Protocols:** During business hours, telephone and paging for the ITS Department are reserved for urgent cases only, such as critical system access issues.
- **After-Hours Procedure:** Emergency calls outside business hours should be directed to the Nursing House Supervisor. Calls will be evaluated using the ITS On Call flowsheet and forwarded to on-call ITS personnel as necessary. Reference Information Technology Services After Hours Call Policy.
- Requests for ITS equipment moves involving multiple service departments should be submitted via the NIHD Project form accessible on the intranet.
- Requests for new ITS equipment or new user access must be initiated by opening a service desk ticket at least 2 weeks prior to the start date.

PROCEDURE:

Incoming service desk tickets will be addressed by the Jr. Network Systems Analysts for Tier 1 troubleshooting and if escalation is needed this person will route the issue to the correct ITS or Informatics staff personnel after initial troubleshooting and/or collecting information.

<u>Service Desk ticket requestors must provide the following information:</u>

- Full Name
- Department
- Call Back Number
- Ticket priority (Urgent, High, Medium, Low)
- **Detailed** description of incident/request
  Identify application name (i.e. Outlook, EMR, Windows)
- Patient Identifiers (if applicable)
- Computer Name / Equipment Model numbers (if applicable)
- EMR Order descriptions; accession #'s, time stamp, screen shots, etc (if applicable)
- Troubleshooting steps taken

Tickets will be directed and prioritized according to the aforementioned policy.

Response times for Service Desk Tickets will be as follows (subject to change depending on staffing levels and projects):

URGENT: Requires immediate attention.
HIGH: 45-minute response time.
MEDIUM: 1-3 business day response time.
LOW: 1 to 2-week response time.

The response process involves the Service Desk personnel addressing the initial call through email, ticket updates, reassignment, or a phone call.

After the creation of a service desk ticket, requestors may contact the assigned technician directly for status updates or to furnish additional information, referencing the ticket number. Correspondence regarding service desk tickets can be managed through the ticketing system, email, phone, or chat.

Escalations within the service desk will be handled by the ITS Assistant Manager, or ITS Director as necessary.

REFERENCES: Information Technology Services – After hours call

RECORD RETENTION AND DESTRUCTION: All service desk tickets are saved on the network and backed up on the server. They will be maintained for a minimum of 5 years.

CROSS REFERENCED POLICIES AND PROCEDURES: N/A

Supersedes: v.2 ITS Service Desk Work Order

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Managing Biological Agents EC.02.05.01 EP 14a		
Owner: Maintenance Manager	Department: Maintenance	
Scope:		
Date Last Modified: 08/12/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

To establish a comprehensive water management program aimed at preventing the growth and spread of biological agents, such as Legionella and other waterborne pathogens, within the hospital's water system. This is in compliance with Joint Commission standards and applicable regulations.

POLICY:

Northern Inyo Healthcare District (NIHD) is committed to ensuring the safety and quality of its water supply through rigorous management practices designed to control and prevent the proliferation of biological agents in water systems

PROCEDURE:

Development and Implementation of the Water Management Program

1. Formation of a Water Management Team (WMT)

1.1. Assemble a multidisciplinary team including representatives from Facilities Management, Infection Control, Environmental Services, and clinical staff.
1.2. Define roles and responsibilities within the team.

2. System Mapping

2.1. Develop detailed schematics of the hospital's water systems, including potable water, cooling towers, decorative fountains, and other water features.
2.2. Identify all points where water enters the facility, is treated, stored, and used.

3. Risk Assessment

3.1. Evaluate the potential for biological agent growth at various points in the water system.

3.2. Identify areas with high-risk factors, such as stagnant water, optimal growth temperatures, and locations serving immunocompromised patients.

4. Control Measures

4.1. Implement engineering controls such as maintaining appropriate water temperatures, ensuring proper disinfection, and minimizing stagnant water.
4.2. Regularly flush unused water outlets and maintain water treatment equipment.

5. Monitoring and Verification

5.1. Establish routine monitoring protocols for water quality, including temperature checks, residual disinfectant levels, and microbial testing.
5.2. Validated testing methods are used to detect biological agents, particularly Legionella species.
5.3. Record and analyze monitoring data to ensure control measures are effective.

6. Corrective Actions

6.1. Develop a response plan for when monitoring indicates potential contamination.
6.2. Actions may include hyperchlorination, thermal eradication, or point-of-use filtration.
6.3. Document and evaluate the effectiveness of corrective measures.

Routine Maintenance and Monitoring

7. Scheduled Maintenance

7.1. Perform regular maintenance on water systems, including cleaning and disinfecting cooling towers, storage tanks, and other components.
7.2. Inspect and service backflow prevention devices.

8. Water Sampling

8.1. Conduct regular water sampling at strategic points in the water system.
8.2. Follow guidelines for frequency and methodology from recognized authorities, such as the CDC and the Joint Commission.

9. Documentation

9.1. Maintain detailed records of all maintenance activities, monitoring results, and corrective actions.
9.2. Ensure documentation is readily accessible for review by internal auditors and regulatory agencies.

Training and Education

10. Staff Training

10.1. Provide comprehensive training for staff on the water management program, focusing on the identification and prevention of waterborne pathogens.
10.2. Include training on proper procedures for cleaning, disinfection, and emergency response

11. Education Programs

11.1. Develop educational materials and conduct regular sessions to update staff on the latest best practices and regulatory requirements.
11.2. Engage with clinical staff to ensure they understand the importance of the water management program in infection control.

Emergency Procedures

12. Outbreak Response

12.1. Immediately notify the Infection Control Team and relevant authorities in the event of a suspected or confirmed outbreak.
12.2. Implement the outbreak response plan, which includes investigation, communication, and mitigation steps.

13. Communication

13.1. Establish clear lines of communication within the hospital and with external partners, such as public health agencies.
13.2. Provide timely updates to staff and patients as needed.

REFERENCES:

1. The Joint Commission. (2024). *Hospital Accreditation Standards.*
2. Centers for Disease Control and Prevention (CDC). (2023). *Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings.*
3. American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE). (2020). *ASHRAE Standard 188: Legionellosis: Risk Management for Building Water Systems.*

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: v.1 Managing Biological Agents EC.02.05.01 EP 14a

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Medical Gas Storage Rooms		
Owner: Maintenance Manager	Department: Maintenance	
Scope:		
Date Last Modified: 07/29/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

To ensure the safe storage, handling, and usage of medical gases within Norther Inyo Healthcare District (NIHD) in compliance with Joint Commission standards, NFPA 99 (Health Care Facilities Code), and other applicable regulations.

POLICY:

This policy applies to all NIHD personnel involved in the storage, handling, and usage of medical gases, including oxygen, nitrous oxide, nitrogen, carbon dioxide, and medical air. Medical gases shall be stored and handled in a manner that ensures safety, regulatory compliance, and continuous availability for patient care.

RESPONSIBILITIES:

Facilities Management:
Ensure the storage rooms meet regulatory requirements and are maintained appropriately.

Nursing and Clinical Staff:
Properly handle and report any issues related to medical gases.

Safety Officer:
Monitor compliance with safety regulations and conduct regular training.

PROCEDURE:

Storage Room Requirements

1. Location and Design

1.1. Storage rooms must be located away from areas with high traffic and potential ignition sources.
1.2. Rooms should be constructed of fire-resistant materials and equipped with appropriate ventilation systems.
1.3. Signs indicating "Medical Gas Storage" and "No Smoking" must be prominently displayed.

2. Temperature and Ventilation

2.1. Maintain storage room temperatures between 15°C and 25°C (59°F and 77°F).
2.2. Ensure adequate ventilation to prevent accumulation of gas, especially in the event of a leak.

3. Cylinder Storage

3.1. Full and empty cylinders must be stored separately and clearly labeled.
3.2. Cylinders must be secured to prevent tipping and damage, using chains, racks, or stands.
3.3. All empty cylinders should be clearly labeled and stored separately (different rack) from full cylinders. An opened or partial full cylinder will be considered empty by terms of definition
3.4. Cylinders containing flammable gases must be stored at least 20 feet from oxidizers unless separated by a noncombustible barrier.
3.5. Storage can include up to 300 cubic feet of oxygen, or any non-flammable compressed gas, stored incidentally in any smoke compartment or zone. This zone is defined as less than 22,500 square feet.
3.6. An "E" cylinder contains about 25 cubic feet of oxygen and an "H" cylinder contains about 250 cubic feet. Therefore, "no more than 12 E cylinders, or one H and two E cylinders can be stored "unprotected" in a zone."
3.7. Cylinders that are ready for use or being used by a patient, such as secured on a crash cart (with regulator in place), under a patient's gurney, or on a wheelchair, are not counted in the 300 cubic feet total.
3.8. Storage of more than 300 cubic feet of non-flammable gases, but less than 3000 cubic feet, will be stored in an interior space within the facility. Requirements for that storage area will be predetermined before designating that area.

4. Signage and Labeling

4.1. Ensure all cylinders are clearly labeled with the contents and the associated hazards.
4.2. Emergency contact information and handling instructions should be displayed in the storage area.

Handling and Usage

5. Training

5.1. All personnel handling medical gases must undergo training on safe handling procedures and emergency response.
5.2. Training records must be maintained and reviewed annually.

6. Inspection and Maintenance

6.1. Conduct regular inspections of storage rooms and cylinders for signs of damage, leaks, or other hazards.
6.2. Document and address any issues identified during inspections promptly.
6.3. Usage and Transport
6.4. Use appropriate carts and restraints when transporting cylinders.
6.5. Ensure proper connections and fittings when administering medical gases to patients.

7. Emergency Procedures

7.1. Leak Response

7.1.1. Evacuate the area immediately if a gas leak is detected.

7.1.2. Shut off the gas supply if it is safe to do so and contact emergency services.

7.2. Fire Response

7.2.1. Follow the hospital's fire response plan, including the use of fire extinguishers and alarm activation.
7.2.2. Do not attempt to extinguish a gas-fed fire without professional assistance.

8. Documentation and Compliance

8.1. Record Keeping

8.1.1. Maintain logs of inspections, maintenance, and training activities.
8.1.2. Ensure compliance with Joint Commission standards and NFPA 99 requirements.

8.2 Audits

8.2.1. Conduct regular audits of storage practices and address any non-compliance issues.
8.2.2. Report audit findings to the hospital safety committee.

Color Coordination Chart for Medical Gases
To ensure quick and accurate identification of medical gases, the following color coordination chart will be used:

Gas Type	Cylinder Color	Label Color	Common Usage
Oxygen	**Green**	**White**	**Respiratory therapy, anesthesia**
Nitrous Oxide	**Blue**	**White**	**Anesthesia**
Nitrogen	**Black**	**White**	**Cryosurgery, equipment testing**
Carbon Dioxide	**Gray**	**White**	**Insufflation during surgery**
Medical Air	**Yellow**	**White**	**Respiratory therapy**
Helium	**Brown**	**White**	**Breathing mixtures, MRI cooling**

REFERENCES:

1. The Joint Commission. (2024). *Hospital Accreditation Standards.*
2. National Fire Protection Association. (2021). *NFPA 99: Health Care Facilities Code.*
3. Occupational Safety and Health Administration. (2023). *Safety and Health Topics: Compressed Gas and Equipment.*

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: v.1 Medical Gas Storage Rooms EC.02.05.01 EP 18

Title: Paid Absence		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 07/30/2024	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 1/20/2002	

POLICY:

All requests for paid absences must be made through and approved by your supervisor and/or department head. Requests for various types of paid absences will be considered for full-time and regular part-time employees as follows:

1. Bereavement Leave: Upon completion of thirty (30) days of employment, up to five days absence, with up to 24 hours paid, may be authorized for full-time employees following the death of an immediate family member as outlined below:

a. Parents
b. Siblings
c. Spouse
d. Children
e. Domestic partner
f. Mother/father-in-law
g. Sister/brother in-law
h. Daughter/son-in-law
i. Grandparent
j. Grandchild
k. Domestic partner's mother, father, sister, brother, son, or daughter
l. Spouse's or domestic partner's grandparent or grandchild
m. An adult who stood "in loco parentis" during an employee's childhood
n. Step-children
o. Step-parents

Regular part-time employees may be authorized up to five days absence, prorated, with up to 19.2 hours paid, following a death in the family. Bereavement leave must be taken within 180 calendar days of the date of the death. Time off without pay may be arranged with the supervisor or department head for an employee who wishes to attend a funeral of a relative or close friend.

2. Reproductive Loss Leave

Upon completion of thirty (30) days of employment, up to five days absence, with up to 24 hours paid, may be authorized for any reproductive loss event as listed:

- Miscarriage
- Stillbirth
- Failed surrogacy
- Failed adoption
- An unsuccessful assisted reproduction

This leave must be taken within 90 days of the event and is available to both persons who would have been a parent in the event of a successful reproductive event. The leave days may be taken non-consecutively. PTO may be utilized to cover any time exceeding 24 working hours.

3. Jury Duty: Upon completion of thirty (30) days of employment, full-time and regular part-time employees are eligible for jury duty pay from the District. If you are called for jury duty, your department head should be notified immediately. If you are not excused from jury duty, and you have completed thirty (30) days of employment, the District will pay your normal base compensation, exclusive of differential pay, up to a maximum of 20 working days a year.

4. Other: Paid absences may be authorized on an individual basis for employees selected to participate in meetings relating to their District work.

REFERENCES:

RECORD RETENTION AND DESTRUCTION:
Human Resource records are maintained life of employment plus ten years
Payroll records maintained: Employees not entitled to pension: 15 years Employees entitled to pension: life of employment plus six years

CROSS REFERENCED POLICIES AND PROCEDURES:
1. InQuiseek – General Employment Policies
2. Leaves of Absence – Leaves of Absence

Supersedes: v.4 Paid Absence
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Cleaning Procedures: Room/Building Components: Floor Care		
Owner: MANAGER OF ENVIRONMENTAL SERVICES	Department: Environmental Services	
Scope: Environmental Services		
Date Last Modified: 08/14/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

To establish timeframes and appropriate methods for maintaining the cleanliness and appearance of hard surface and carpeted floors.

POLICY:

Floors will be maintained in accordance with the following schedule, except as provided in cleaning procedures of specific areas:

1. Dust Mopping: will be done daily in all areas.
2. Wet Mopping: will be done daily in all areas.
3. Machine Scrubbing: will be done as needed or as specified in cleaning procedures for specific areas.
4. Machine Buffing: will be done as needed in all areas.
5. Stripping of Floor Finishes: will be done as needed.
6. Floor Finish Application: will be done as needed.
7. Vacuuming: will be done daily in all areas except offices, which will be vacuumed routinely depending on need.
8. Carpet shampooing or spin bonneting: will be done semi-annually in all areas or as specified in cleaning procedures for specific areas.
9. Carpet Extraction: will be done at least annually in all areas.

PROCEDURE: N/A

REFERENCES: N/A

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCED POLICIES AND PROCEDURES: N/A

Supersedes: v.1 Cleaning Procedures: Room/Building Components: Floor Care

Title: Employee Attendance		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 07/15/2024	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: Maintaining a stable and reliable workforce is critical to the effective and efficient delivery of health care services at Northern Inyo Healthcare District (NIHD). It is recognized that unplanned time away from work will be necessary. The following policy sets forth the expectations for attendance and establishes corrective action standards for unacceptable attendance. These expectations apply to all shifts an employee is scheduled to work, including regular shifts, voluntary shifts, mandatory overtime shifts, and scheduled classes.

POLICY: Employees are expected to report to work as scheduled, on time and prepared to start work. Employees also are expected to remain at work for their entire work schedule. Late arrival, early departure or other absences from scheduled hours are disruptive and must be avoided. This policy details how absences and tardiness are counted for the purposes of maintaining excellent customer service.

Protected Absences:

1. Absences due to a serious health condition, including those covered under the Family Medical Leave Act (FMLA), California Family Rights Act (CFRA), and/or Americans with Disability Act (ADA) and/or time spent on any approved Job Protected Leave of Absence (reference Leaves of Absence policy), will be considered a protected absence. Such conditions must be documented through the Human Resources Department.
2. The District maintains the right to request documentation in cases of a pattern of absences due to employee illness – pattern as defined below in Pattern of Absences. Patterns of absences documented as requested shall be protected. Patterns of absences not documented as requested shall not be protected.
3. Pre-approved appointments, vacation, personal holiday, scheduled sick leave, bereavement leave, jury duty, and military leave will be considered protected absences. If employees must be absent, regardless of reason, they must notify their immediate supervisor or department head at the earliest possible time.
4. Absences due to work-related injury and approved as an on-the-job (workers' compensation) injury will be considered protected.
5. Any scheduled shifts or work that are called-off, or otherwise not worked due to a management-initiated decision relative to low census, safety concerns, failure to meet a condition of employment, will be considered as protected absences.
6. Absences due to verified natural disasters such as floods, wildfires, earthquakes, or other conditions, natural or man-made, that make it impossible for employees to report for scheduled work will be considered as protected absences.
7. Absences due to a verified medical emergency, not covered by FMLA or work related, will be considered protected absences and not be counted as "occurrences". Employees must provide

documentation supporting such emergencies and inform their immediate supervisor or Department Head at the earliest possible time.

a. This section shall sunset on October 31, 2025, unless extended.

8. Absences due to a diagnosed or suspected communicable disease, including but not limited to flu-like illnesses as defined by Health Care Workers with Influenza like Illness policy (fever greater than 100 degrees, cough and/or sore throat), or infectious gastroenteritis, will be considered protected absences and not be counted as "occurrences." Employees must inform their supervisor at the time of the callout that they are experiencing symptoms that are covered above or the absence will not be considered protected and the occurrence will be applied. For absences of more than three days, management may require documentation in the form of a doctor's note or FMLA paperwork for those who qualify.
    a. This section shall sunset on October 31, 2025, unless extended.

Patterns of Absences. Four (4) incidents of the following within a 6-month time period will constitute a pattern:

1. A pattern of unscheduled absences on Fridays, Mondays, weekends, or preceding or following a holiday or scheduled day(s) off, or
2. A pattern of unscheduled absences on days that were requested off but could not be accommodated.

No call/No show and Job abandonment/AWOL. An employee who fails to call or report for a scheduled shift is considered a no call/no show. The District will attempt to contact the employee to ensure that the employee is safe and that there has not been any miscommunication regarding the schedule. Three (3) consecutive shifts of no call/no show will be considered a resignation.

Punctuality. Each employee is expected to report for work and be ready to start the employee's shift at the employee's scheduled start time. Similarly, each employee is expected to leave for, and return from, scheduled breaks and lunch periods in a timely manner. A tardy is any time an employee fails to be at the employee's work station ready to begin work more than three (3) minutes after ~~at~~ the employee's scheduled start time, as well as returning more than 3 minutes late from a meal break. Each employee will have the option to use the Time-keeping station outside the cafeteria when clocking in and out for the employee's meal break.

Failure to "swipe" (clock in and out). Employees are expected to swipe in or out to reflect actual hours worked. If the employee misses a swipe, the employee will utilize a Time-keeping edit sheet. However, employees are expected to miss less than 10% of an employee's required punches over a rolling six (6) month period.

Under no circumstances shall an employee clock in or out for another employee.

Time period for attendance management. A *rolling twelve (12) month period* will be considered in monitoring attendance. Attendance will be monitored with the most recent occurrence and subsequent disciplinary action taken for additional occurrences.

Count of occurrences:

Unscheduled unprotected absences - Attendance issues that meet the definition of an unscheduled absence (as noted above) will count as one (1) occurrence.

Tardy ~~Late arrival/returning from meal/break,~~ arrival to work, early departure, or late return from meal/break will count as a half (1/2) occurrence

~~m~~Missed punches or edited punches exceeding 10% over a rolling 6-month period, excluding technical issues with the time clock which are brought to the attention of the Supervisor immediately, will count as half (1/2) occurrence.

One willful no call/no show will count as six (6) occurrences and result in a written warning. A second will ful no call/no show will result in one (1) additional occurrence, for a total of seven, resulting in probation. A third occurrence of willful no call/no show will count as one (1) additional occurrence for a total of eight (8), resulting in termination.

Failure to notify the Supervisor that the employee is unable to work their scheduled shift at least one (1) hour before the start of shift, will count as half (1/2) occurrence.

Occurrences for attendance will be counted as follows:

1. Total of four (4) occurrences (for any reason) = Coaching
2. Total of five (5) occurrences (for any reason) = Documented verbal counseling
3. Additional full occurrences, total of six (6) occurrences (for any reason) = written warning
4. Additional full occurrences, total of seven (7) occurrences (for any reason) = probation
5. Additional full occurrences, total of eight (8) occurrences (for any reason) = termination

Exception: Movement through the steps above are to be executed in full increments of an occurrence and not with a half (1/2) occurrence. For example: if an employee receives a documented verbal counseling at 4.5 occurrences, then a written warning could not be given until the employee had reached 5.5 or more occurrences.

Initial employment period/introductory period. An employee in the initial employment/introductory period, who has three (3) occurrences, will receive a written warning. If the employee has one or more additional occurrences within the remainder of the initial employment/introductory period or extended initial employment introductory period, the employee may be subject to termination of employment. This excludes those employees who are in an introductory period due to a transfer. If the initial employment/introductory warning is given and the remainder of the initial employment is completed successfully, the employee will be at the written warning step of the disciplinary process at the end of the initial employment/introductory period.

Note. The policies and procedures outlined herein have been designed to comply with all existing written and unwritten policy statements; all requirements of existing labor laws and, if applicable, a Collective Bargaining Agreement with an employee organization. Where conflicts exist, the Collective Bargaining Agreement will take precedence over this policy. The ~~Director of Human Resources~~ Chief Human Resources Officer, or designee has responsibility for the interpretation of this policy, and any exceptions to this policy will be made with Executive Team approval. All policies and procedures may be modified or changed at any time with Board and Executive Team approval.

RECORD RETENTION AND DESTRUCTION:

Employee records, including those involving termination will be held for:

- The length of employment, plus 10 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

Employee Conduct – Performance Improvement and Progressive Discipline
Leaving Without Notice

Supersedes: v.3 Employee Conduct - Attendance, v.2 Absence from Work, v.2 Unexcused Absence
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Environmental Services: Dress Code Policy		
Owner: MANAGER OF ENVIRONMENTAL SERVICES	Department: Environmental Services	
Scope: Environmental Services		
Date Last Modified: 12/08/2022	Last Review Date: 2/2017	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: Not Approved Yet	

PURPOSE:

To establish a standard for attire and grooming in the Environmental Services Department.

POLICY:

Clothing:

1. Uniforms shall be worn by all Environmental Services Staff and shall be kept clean and in good repair by the employee. If contamination occurs, uniforms can be laundered onsite.

2. Uniforms consist of provided scrub tops, and non-provided black or grey pants, preferably scrub pants, but not jeans or leggings. Black jeans may be worn on "casual Fridays" but they must be black only.

3. Sunglasses (other than prescription) may not be worn inside the facility.

Shoes:

1. Environmental Services Staff shall wear clean, fully enclosed shoes made of durable, protective material.
2. Specifically prohibited are:
    a. backless shoes
    b. sandals
    c. thongs/flip flops

Jewelry:

1. Jewelry that presents a safety hazard to the wearer or interferes with work activity in any way shall not be worn, such as extremely long or big hoop earrings.

Personal Grooming:

1. Hair must be kept neat and clean. Long hair that presents a safety hazard to the wearer or interferes with work activity must be contained while working. A hairnet or other acceptable covering may be used. Beards, moustaches, and sideburns must be kept neatly trimmed.

Perfumes and colognes:

1. Environmental Services staff will not wear strong or over whelming scents due to sensitivity of patients and other staff.

REFERENCE: N/A

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCED POLICIES AND PROCEDURES: N/A

Supersedes: v.2 General Administrative: Personnel Policies: Dress Code

NORTHERN INYO HEALTHCARE DISTRICT
EMPLOYEE HANDBOOK

Title: Identification Badges		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 05/10/2024	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

Identification badges function as electronic keys, cash cards and allow access to other important job functions; therefore, the purpose of this policy is to define controls and safeguards of identification badges.

POLICY:

When working, shadowing, interning, or volunteering at Northern Inyo Hospital, you will be issued an identification badge. Identification badges may function as an electronic key to secured doors and may have a barcode badge number that allows using the hospital's time and attendance system, charging cafeteria purchases, and carrying out other important job functions.

You are required to wear your identification badge while on hospital properties. This allows you to get to know those you work with and them to know you, and it helps patients and the public to identify you. If on property outside of working hours, you may not use your badge to access patient care or staff only areas.

Worn or outdated badges must be replaced. Requests for badges may be placed with your immediate supervisor, department head, the Medical Staff Office (physicians), or Human Resources.

You must take care to handle your identification badge as you would a cash card or key that must be protected and secured. Do not share or lend your badge or provide unauthorized access to another with your badge. Please report lost/misplaced or forgotten identification badges immediately to your supervisor or department head or Medical Staff Office (physicians) and report to Human Resources (Nursing Supervisor outside of HR office hours) for a replacement.

There will be a fee associated with replacing a badge that has been forgotten, lost or damaged by the employee. A fee will also be assessed for non-essential badge reprints requested by employees.

REFERENCES:

Identification of Individuals EC.02.01.01EP7

RECORD RETENTION AND DESTRUCTION:

Records related to acknowledgement of Employee Handbook policies will be held in perpetuity.

CROSS REFERENCE POLICIES AND PROCEDURES:

Emergency Management Plan
Identification of Individuals EC.02.01.01EP7
Security Management Plan

Supersedes: v.4 Hiring - IDENTIFICATION BADGES (03-04)
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

Title: Introductory Period		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 05/28/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/20/2002	

POLICY:

Your first ~~90~~ 180 calendar days of employment represent an introductory period. This period is a time for you to be oriented to your job and to adjust to new surroundings and co-workers. During your introductory period you will be trained in your new job and evaluated by your supervisor so that you know how you are doing. Your introductory period may be extended beyond ~~90~~ 180 calendar days if your supervisor determines that such an extension is appropriate.

Successful completion of the introductory period is not a guarantee of a right to long-term or continued employment. During the introductory period, as well as the entire period of employment with the District, the District is free to change the employee's terms and conditions of employment with or without notice and with or without cause, including, but not limited to, termination, demotion, promotion, transfer, compensation, benefits, duties, and location of work.

Employees are eligible for benefits during their introductory period as follows: Newly hired benefited employees may use Paid Time Off (PTO) immediately after it is accrued. They are also eligible to enroll in the District's health plan, and life and long-term disability plans beginning the first day of the month following a 30 ~~their hire date~~day eligibility waiting period. In the event an employee was initially hired into a non-benefited position, and then transferred into a benefited position, eligibility for the District's health plan and life and long-term disability plans will be the first day of the month following 30 days after their ~~benefited~~ transfer date.

REFERENCES:

1. The Joint Commission (CAMCAH Manual) January 2023; Standard HR.01.04.01 EP 1 & 3.

RECORD RETENTION AND DESTRUCTION:

Employee records, including those involving termination will be held for:

- The length of employment, plus 10 years.

~~Retention of documents related to orientation, training or competency validation is for length of employment, plus six (6) years.~~

CROSS REFERENCED POLICIES AND PROCEDURES:

1. InQuiseek – General Employment Policies
2. Employee Conduct - Attendance

3. Orientation
4. Performance Evaluations

Supersedes: v.2 Introductory Period
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Roles and Responsibilities – Competency EC.03.01.01EP2		
Owner: Director of Facilities	Department: Plant Services	
Scope: NIHD		
Date Last Modified: 08/07/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE
To ensure that all staff are properly trained on the environment of care functions.

POLICY
It is the policy of Northern Inyo Hospital to provide all staff and licensed independent practitioners (LIP) with training on their roles and responsibility for managing risk in the environment.

FUNDEMENTALS
The staff and LIPs will receive education and training so that they can describe or demonstrate:

- Methods for eliminating and minimizing physical risks in the environment
- Actions to take in the event of an incident in the environment
- Methods to report environment of care risks

This training and education will be accomplished through new employee orientation, periodic refresher training, online training program, and departmental training on environment of care risks, programs, and protocol as well as specific hazards they may encounter during the course of their employment.

In addition, contractors and outside vendors must receive training related to risks they may encounter while providing services. The training will be deemed appropriate by the head of the department for which services are being provided.

PROCEDURE

1. At the time of hire, every new employee (including LIP) must attend new employee orientation that includes information on identifying and dealing with risk in the environment.

2. Before performing a task with any prior potential identified risks, employees must receive appropriate departmental safety orientation from his/her supervisor or their designee.

3. Staff that are responsible for maintenance, inspection, testing, and use medical equipment, utility systems and equipment, fire safety systems and equipment, and safe handling of hazardous materials are competent and receive ongoing education and training.

4. On an annual basis, all employees must complete their online training offered via computer based training.

5. Training for contractors and vendors will be arranged by the department affected.

6. Supplemental training for specific hazards will be arranged by the Department where the potential hazard exists.

7. All training programs require the attendee to sign an attendance sheet that will be maintained by Human Resources Department or the department that is sponsoring the training.

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Sanctions for Breach of Patient Privacy Policies		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 07/01/2024	Last Review Date: No Review Date	Version: 8
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/20/2011	

PURPOSE:
To comply with 45 CFR 164.530(e)(1) which requires, "a covered entity must have and apply appropriate sanctions against members of its workforce who fail to comply with the privacy policies and procedures of the covered entity".

POLICY:

1. Workforce members must guard against improper access, use, or disclosure of PHI.
2. A workforce member who inadvertently releases protected health information incorrectly is required to report the incident as soon as the incident is known to have occurred via an Unusual Occurrence Report (UOR), phone call to Compliance, or email to Compliance@nih.org.

~~1.~~3. Northern Inyo Healthcare District's (NIHD) sanctions are instituted based upon the determined level of breach of patient's protected information in a consistent process that is specifically determined by the severity of incident, utilizing a scale. All workforce members who commit a privacy breach will be treated per this process, regardless of rank or position. The action level may lead to termination, if appropriate.

DEFINITIONS:

Sanction - training with documentation in the employee record, disciplinary action or termination.

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

Incidental Disclosure – Federal law recognizes and permits incidental uses and disclosures. An incidental disclosure is defined as a disclosure that occurs as a by-product of another permissible or required use or disclosure, as long as the covered entity has applied reasonable safeguards and implemented the minimum necessary standard where applicable, with respect to the primary use or disclosure.

Inadvertent Violation - an error that results in a breach of privacy made while following District policies and procedures.

Intentional Violation – willful or deliberate violation of law or District policies,

Negligent Violation - a breach of privacy made while incorrectly following or not following District policies and procedures.

Deliberate Violation - a breach of privacy made while willfully not following District policy.

Protected Health Information (PHI) - any individually identifiable health information regarding a patient's medical or physical condition or treatment in any form created or collected as a consequence of the provision of health care, in any format including verbal communication.

Unauthorized - the inappropriate acquisition, access of, use or disclosure of protected health information without a direct need to know for medical diagnosis, treatment, or lawful use as permitted the California Medical Information Act or any other statute or regulation governing the lawful access, use, or disclosure of medical information. (California Health and Safety Code Sec. 2 1280.15)

Malicious – willful or criminal act by employee, deliberate or willful violation of District policies, violation may be harmful, or done for personal gain

~~with intent to harm or with intent to gain personally.~~

PROCEDURE:

I. Breach Incident Determination of Severity

A. Minor Breach – an accidental ~~inadvertent and non-malicious~~ breach, a singular instance or incident of an inadvertent breach
Examples include but are not limited to ~~distributing, emailing or faxing protected health information (PHI) to the wrong individual unintentionally.~~accidentally sending an email to the incorrect person while following NIHD policies, or accidentally sending a fax to the incorrect destination while following NIHD policies (verified fax number, used programmed button, double checked number, failing to check that the provider selected for an outpatient order matches the written order presented by the patient, etc.)

B. Moderate Breach – a breach that occurs while not following District policy, or a pattern of minor breaches, or a pattern of inattention to detail resulting in privacy breaches. ~~th~~
Examples include but are not limited to failing to log off computer systems OR failing to check a guarantor or insurance provider when registering a patient OR- access of patient lists without a work related reason OR failing to check that the provider selected for an outpatient order matches the written order presented by the patient OR faxing PHI to an unverified fax number OR a pattern of minor violations.

C. Major/Severe Breach – a pattern of moderate breaches OR a willful violation of law or District policy OR "snooping," or intentional inappropriate access of a chart of family or friend due to concern OR inappropriate access of multiple patient charts due to curiosity or concern OR inappropriate access of multiple patient charts for whom you are not involved in their care.~~is a deliberate violation that purposefully or maliciously violates a patient's privacy or disregards NIHD policy.~~
Examples include but are not limited to: intentional access of emergency patient charts without being involved in their care/covering in the unit, or without being informed the

patient will be admitted OR releasing or using data for personal gain, destroying or altering data OR purposefully accessing or attempting to gain access to patient information which the workforce member does not need to access to perform their job OR maliciously attacking or hacking District information systems OR releasing patient data with the intent to harm an individual or the District OR posting PHI on social media OR a pattern of repeated moderate violations.

II. Whistleblower Protection

A. Neither the District nor any workforce member of the District may intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual who reports any conduct that is unlawful or otherwise violates professional or clinical standards including, but not limited to the reporting of conduct that results in the breach of privacy of any patient of NIHD.

B. Proven violation of this section will result in immediate loss of employment.

III. Disciplinary Action

A. Disciplinary action, up to and including termination, based on recommended corrective actions in **"Sanctions for Breach of Patient Privacy – Incident Severity Scale**", will be taken for any workforce member for a violation of privacy and security policies and procedures. NIHD prohibits the use of District property for illegal purposes and for purposes not in support of Civil Code 56.36/Health and Safety Code 130200 and 1280.15.

IV. Standard Sanctions – Levels

A. Level 1: Re-training and/or coaching memo.

B. Level 2: Documented verbal counseling or written warning, as determined by leadership in conjunction with Human Resources, placed into workforce member's Human Resources (HR) File.

C. Level 3: Written warning, probation, or suspension, including notification that further violation of the privacy of PHI will result in termination, as determined by leadership in conjunction with HR. Documentation will be placed into workforce member's HR file.

D. Level 4: Termination.

V. Modification of Sanction Levels

A. Action level may be modified by the consensus of the Privacy Officer, Chief Human Resources DirectorOfficer, and the employee's manager by considering the following:

1. Previous history or corrective action (level of action may increase based on repeat offenses)
2. Whether or not the individual caused an inadvertent violation based upon a situation or operation that the individual did not know caused the breach.

Sanctions for Breach of Patient Privacy – Incident Severity Scale Tool

Guidelines with recommended corrective actions, once an incident and individual are identified.

		Action Level		
Level	**Intention of the Individual** Responsible for the privacy breach	**Minor**	**Moderate**	**Major/Severe**
A	**Inadvertent, examples including, but not limited to:** • A mistake made while following District policy, OR • An error made due to a mistake by a patient	1	1	2
B	**Negligent/Unintentional, examples including, but not limited to:** • Carelessness or negligence, OR • Misdirected fax while not following District policy	2	3	3-4
C	**Intentional, examples including, but not limited to:** • Due to curiosity or concern, OR • Access of patient charts without a work related reason	2	3	3-4
D	**Intentional , examples including, but not limited to:** • Willful or reckless disregard of policies, procedures or law, OR • Malicious intent, including accessing or use of information in a domestic dispute, OR • Personal financial gain	4	4	4

REFERENCES:

1. Health Insurance Portability and Accountability Act (HIPAA) of 1996 as amended
2. Health Information Technology for Economic and Clinical Health (HITECH) Act as implemented through the revised HIPAA Omnibus Rule published on January 17, 2013, see 78 Fed. Reg. 5565 (Jan. 25, 2013) amending C.F.R. Parts 160 and 164
3. California Confidentiality of Medical Information Act (CMIA)
4. 45 CFR 164.530(e)(1)
5. California Health and Safety Code Sec. 2 1280.15
6. Civil Code 56.36
7. California Health and Safety Code 130200

RECORD RETENTION AND DESTRUCTION:

Records related to documentation placed in the workforce member's HR file are maintained for the length of employment, plus six (6) years.
Unusual Occurrence Reports are maintained for ten (10) years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Sanctions for Breach of Patient Privacy Policies
2. Privacy Screen Policy
3. Password Policy
4. Sanctions for Breach of Patient Privacy Policies
5. Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information

Supersedes: v6 Sanctions for Breach of Patient Privacy

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Minimum Necessary Access, Use and Disclosure of Protected Health Information (PHI)		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 06/22/2022	Last Review Date: 07/31/2024	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 07/17/2013	

PURPOSE: To provide guidance with the identification of the Northern Inyo Healthcare District (NIHD) workforce members that need access to PHI to perform their job. Only the information needed to deliver the healthcare service required shall be used for that business service.

DEFINITIONS:

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

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

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

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

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

POLICY: When using or disclosing Protected Health Information (PHI), or when requesting PHI, Northern Inyo Healthcare District will make reasonable efforts to limit the PHI used, disclosed, or requested, to the minimum necessary. Generally, requests for PHI shall be forwarded to the Health Information Management (HIM) department, unless it is an emergency or outside the HIM department hours of operation.

PROCEDURES:

1. **When the Minimum Necessary Standard Does Not Apply**

The use and disclosure of patient PHI minimum necessary standard does not apply in the following circumstances:

a. The PHI is for use by or a disclosure to a healthcare provider for treatment purposes;
b. The disclosure is to the patient or the patient's legally authorized representative;
c. The disclosure is pursuant to a valid authorization, in which case, the disclosure will be limited to the PHI specified on the authorization;
d. The disclosure is to the California Department of Public Health; or
e. The disclosure is required by law.

2. **Accessibility by Workforce Members to PHI**
Each Department is responsible for identifying those individuals in the Department who need access to PHI in order to carry out their duties and the PHI or types of PHI to which access is needed.

a. Each Department is responsible for identifying any conditions that would have an impact on a workforce members' ability to access and/or disclose the PHI is authorized to access.
b. Each Department is responsible for making reasonable efforts to limit the access to PHI that is necessary to carry out the job duties, functions and/or responsibilities.
c. Questions about PHI and its access by workforce members of NIHD should be directed to the HIPAA Privacy Officer.

3. **Requests for PHI**
Each Department is responsible for reviewing requests for PHI from internal and/or external sources to determine whether the request is one to which the Minimum Necessary Standard applies.

a. If the request is made by another health care provider in order to obtain PHI necessary to treat the patient, the Minimum Necessary Standard **does not** apply, and the PHI that is requested will be released as quickly as possible.
b. If the request is not made for purposes of providing treatment to the patient, but it is also a type of request to which the Minimum Necessary Standard does not apply, the Department will refer the request to Health Information Management (HIM, formerly known as Medical Records), who will release the PHI in accordance with the policies of NIHD.
c. If the request is not made for purposes of providing treatment to the patient, and it is a type of request to which the Minimum Necessary Standard applies, the Department will:
    i. Evaluate to determine that the request includes a statement of purpose and release only the minimum amount of information necessary to meet the purpose of the request; or
    ii. If the request does not include a statement of purpose, contact the requestor to obtain the purpose for the request, document the contact, and take appropriate action.

d. If the request for PHI is one that occurs on a routine or recurring basis, the Department is responsible for reviewing the request to determine if the Minimum Necessary Standard applies. Routine or recurring requests should be reviewed by the HIM department to determine whether the Minimum Necessary Standard applies only the first time received and after each time the request is modified.

e. Northern Inyo Healthcare District will request only the minimum amount of PHI necessary to accomplish the purpose for which the request is made.

i. Any questions about how to limit a request for PHI to request for only the minimum amount necessary should be directed to the HIPAA Privacy Officer.
ii. The HIPAA Privacy Officer is responsible for conducting audits on an "as needed" basis to confirm NIHD is in compliance with the Minimum Necessary Policy.

f. Northern Inyo Healthcare District will rely on requests for PHI as requesting only that PHI that is minimally necessary to meet the purpose of the request if:
   i. The request is from a public official and the public official represents that the information requested is the minimum necessary for the stated purpose(s); or
   ii. The information is requested by another covered entity (health care provider, health care clearinghouse, or health plan); or
   iii. The information is requested by an employee or a business associate of NIHD and the individual represents that the information requested is the minimum necessary for the stated purpose(s).

4. **Responses to Requests for PHI**
   If a request for PHI is reviewed to determine whether the Minimum Necessary Standard applies to it, but it is then forwarded to another workforce member at NIHD for processing, the individual forwarding the request is responsible for advising the individual who will respond to the request whether the Minimum Necessary Standard applies.

   a. The person who responds to a request for PHI to which the Minimum Necessary Standard applies is responsible to determine that the PHI disclosed is limited to the minimum amount of information necessary to meet the stated purpose of the request.

REFERENCES:
1. 45 CFR 164.510(b)(1)(ii) and 164.510(b)(4).
2. 45 CFR 165.502(b)
3. 45 CFR 165.514(d)
4. The Joint Commission (CAMCAH Manual) Jan. 2022; Standard IM.02.01.01 EP 1, 3, and 4.

RECORD RETENTION AND DESTRUCTION:
Release of records consents are maintained in the patient medical record. Medical Records are managed by the NIHD Medical Records Department and maintained and destroyed for adults for a minimum of 15 years; for minors a minimum of 25 years.

CROSS REFERENCED POLICIES AND PROCEDURES:
1. InQuiseek - #380 Medical Records Policy
2. Authorization for the Release of Laboratory Results to the Patient
3. Communicating Protected Health Information Via Electronic Mail (Email)
4. Disclosures of Protected Health Information Over the Telephone
5. Using and Disclosing Protected Health Information for Treatment, Payment and Health Care Operations
6. Workforce Access to His or Her Own Protected Health Information

Supersedes: v.2 Minimum Necessary Access, Use and Disclosure of Protected Health Information (PHI)