Northern Inyo Healthcare District

Board Meetings

November 20, 2024 Regular Board Meeting

NORTHERN INYO HEALTHCARE DISTRICT
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AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

November 20, 2024 at 5:00 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 meets 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 Melissa Best-Baker will attend from 191 North Paso Robles Ave. Pasadena, CA 91101.

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1. Call to Order at 5:00 p.m.
2. Public comments on closed session items
3. Adjournment to closed session too/for:
    a. Discuss trade secrets (Health & Safety. Code § 32106 and Civ. Code 3426.1). Discussion will concern a new service line. Estimated date of public disclosure is May 2025.
4. Return to open session.
5. Report on any actions taken in closed session
6. 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 comments 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.

7. New Business:
    a. First addendum to CEO employment agreement
    b. Compliance Report – *Action item*
    c. Compliance Regulatory Changes and Hot Topics – *Information item*
    d. Chief Executive Officer Report *(Board will receive this report)*
        i. Transfer of ownership RCTMD Inc. from Cromer-Tyler to Loy
        ii. Cooperation with Foundation
        iii. Orthopedic Physician Jeb Reid started on Nov 4, 2024
        iv. Inyo Associates Dinner
        v. Easter Sierra Cancer Alliance Walk Oct 19, 2024
    e. Chief Financial Officer Report
        i. CFO Departmental Report
        ii. Financial & Statistical Reports (*Board will consider the approval of these reports)*
    f. Chief Medical Officer Report – No report out
    g. Chief Business Development Officer / Chief Human Resource Officer
        i. Strategic Plan
        ii. CBDO/CHRO Departmental Report
    h. Chief of Staff Reports, Sierra Bourne MD
        i. Perinatal/Pediatrics Chair Dr. Ricci

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8. 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 October 16, 2024 Regular Board Meeting
    b. Credit Card Statement – DelRossi
    c. Approval of Policies and Procedures
        i. Anesthesia Clinical Standards and Professional Conduct
        ii. Billing, Coding, and Compliance Committee Charter
        iii. Coroner's Cases

iv. Handling of Soiled Linens
v. Information Technology Services After-Hours Call
vi. Inventory Control obsolescence
vii. ITS Service Desk Work Order
viii. Maintaining Temperature & Humidity in Anesthetizing Locations
ix. Medical Staff Peer Review and Professional Practice Evaluations
x. Monitoring Conditions
xi. NIHD Candidate Interviews
xii. Standardized Procedure - Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife
xiii. Standardized Procedure - General Policy for the Nurse Practitioner or Certified Nurse Midwife
xiv. Standardized Procedure - Medical Screening Exam for the Obstetrical Patient
xv. Standardized Procedure for Admission of the Well Newborn
xvi. Standardized Procedures for Medical Functions by RN in the Emergency Department
xvii. Standardized Protocol - Emergency Care Policy for the Physician Assistant
xviii. Standardized Protocol – Physician Assistant in the Operating Room
xix. Rural Health Clinic Policies and Procedures – Packet
xx. Compliance Program for Northern Inyo Healthcare District

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9. General Information from Board Members (*Board will provide this information)*
10. Adjournment

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact the administration at (760) 873-2838 at least 24 hours prior to the meeting.

FIRST ADDENDUM TO EMPLOYMENT AGREEMENT OF CHIEF EXECUTIVE OFFICER

This First Addendum to Employment Agreement of Chief Executive Officer (the "First Addendum") is entered into between the Northern Inyo Healthcare District ("District") and Stephen DelRossi (DelRossi) effective November 20, 2024 (the "Effective Date of First Addendum", in reference to the following facts:

WHEREAS, the District entered into an Employment Agreement (the "Agreement for Employment of Chief Executive Officer") with DelRossi on or about November 15, 2023, wherein DelRossi would serve as the Chief Executive Officer ("CEO") of the District from November 15, 2023 until November 8, 2026;

WHEREAS, the District desires to provide DelRossi with modified compensation set forth in the CEO Employment Agreement;

WHEREAS, the parties have agreed to amend the CEO Employment Agreement as set forth herein; and

WHEREAS, capitalized terms used, but not defined, herein shall have the meaning set forth in the CEO Employment Agreement.

NOW, THEREFORE, in consideration of the mutual covenants set forth below, the District and DelRossi mutually agree that the CEO Employment Agreement shall be modified as follows:

I. COMPENSATION.

Section 6.1 shall be modified to read as follows:

"*As of the Effective Date, DelRossi shall be paid an annual salary of Four Hundred and Forty Thousand Dollars ($440,000) ("Base Salary"). Said sum shall be paid in equal installments structured, and on the same schedule as, pay periods for DISTRICT employees*."

The Third sentence "*DelRossi is also expected to perform the duties of the CFO during the term of this Agreement and this Base Salary encompasses this expectation*." shall be stricken in entirety.

Except as expressly modified above, all other language in the CEO Employment Agreement shall remain unchanged.

This First Addendum is hereby approved by the District as of November 20, 2024.

NORTHERN INYO HEALTHCARE DISTRICT	**CHIEF EXECUTIVE OFFICER**
By_____	_____
Name_____	Stephen Del Rossi
Title_____	

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

Date: November 7, 2024

Title: **Compliance Department Report**

Synopsis: The Compliance Department Quarterly Report provides information needed for the Board of Directors to provide the oversight required by the Health and Human Services Office of Inspector General (OIG). It provides specific insight into the work occurring in all areas of the seven essential elements of a Compliance Program as outlined by the HHS OIG. All information in the report has been summarized; however, additional details will be provided to the Board of Directors upon request.

This report provides the Northern Inyo Healthcare District Board of Directors insight into NIHD's compliance with the NIHD Compliance Program.

It is recommended that the Board of Directors approve this action item.

Prepared by: Patty Dickson, Compliance Officer

Reviewed by: _____
Name
Title of Chief who reviewed

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: _____ Submitted by: _____
Chief Officer

COMPLIANCE REPORT SUMMARY

- NIHD has reported six privacy breaches to the California Department of Public Health (CDPH) through October 2024. 100% of alleged privacy breaches were reported to the California Department of Public Health, Office of Civil Rights, and the affected patient(s) within 15 days of discovery. (p. 7)

- CDPH Medical Breach Enforcement Section has assigned a $45,000 administrative penalty to NIHD. Compliance appealed and was able to negotiate a Settlement Stipulation for $30,000. NIHD has paid this penalty. This was for a 2022 breach that intentionally disregarded law and policies. (p. 7)

- In August 2024, the Centers for Medicare and Medicaid Services notified NIHD that our price transparency website is out of compliance with the Price Transparency Rules. NIHD was notified on November 8, 2024, that we are compliant and their case is closed. (p. 10)

- An unusual occurrence is an event not within our "usual" actions or outcomes. The Compliance team processed 446 unusual occurrence reports (UORs) through October CY2024. Some of the "take-away" points for NIHD and the patients we serve (p. 12):

    - Patient complaints make up 26% of unusual occurrence reports.
        - We are actively working on customer service training.
        - We are actively reviewing billing concerns related to annual wellness visits and annual preventative care.
    - NIHD has had 8 workplace violence events in 2024.
    - We provide responses to patient complaints and concerns within 7 days 97% of the time.
    - **We have implemented fourteen (14) systemic changes at NIHD based on responses to UORs. Five of the systemic changes were the result of patient complaints.**

- The NIHD team has a medication-administration accuracy rate greater than 99.95%, which is outstanding, especially compared to the national average of 75-92% accuracy.

- Compliance assigned additional customer service education and training to the Patient Access Team based on the number of concerns brought to our attention through UORs.

- Compliance work-plan audits and reviews show no indication of fraud, waste, or abuse.

- Compliance has responded to eleven public record requests in 2024.

- NIHD has provided 75,267 minutes of interpretive services to patients, in more than 10 different languages. (p. 4)

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Quarterly Compliance Report –Q4 2024
November 7, 2024

Comprehensive Compliance Program Definitions:

1. **Audits** - A wide variety of audits in the Compliance Program review for privacy concerns, language access issues, and fraud, waste, and abuse. Auditing and monitoring is one of the seven essential elements of an effective Compliance Program.
2. **Security Risk Assessment** - District HIPAA (Health Insurance Portability and Accountability Act) Security Risk Assessment is completed annually, and as needed, by Compliance and IT Security.
3. **SAFER** - Office of National Coordinator of Health Information Technology SAFER ((Safety Assurance Factors for EHR (Electronic Health Record) Resilience)) is completed annually by IT, Informatics, and Compliance.
4. **Compliance Workplan** - The Compliance Workplan is updated annually, and as needed, to adjust the focus of certain audits, in alignment with the Office of Inspector General of the Department of Health and Human Services, and our local Medicare Administrative Contractor (MAC), Noridian's audit priorities.
5. **Conflicts of Interest** – This component of the Compliance Program ensures that no parties use or conduct District business for personal financial gain.
6. **Privacy Investigations –** Privacy investigations can arise due to complaints, access audits, HIMS audits, and anonymous reporting.
7. **Investigations –** Other compliance related investigations are conducted to avoid regulatory non-compliance and respond to regulatory agency inquiries and investigations.
8. **Compliance Committees –** This section provides a brief overview of the work of the Compliance committees and sub-committees.
9. **Issues and Prevention** – The compliance team researches numerous questions, concerns and regulatory issues to allow other NIHD team members to take a proactive approach.
10. **California Public Records Act (CPRA) Requests** – The Compliance Officer is responsible for intake and review of public records requests, and research, investigation, redaction and fulfillment of those requests.

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11. **Policies and Procedures –** Policies and procedures are vital to the organization as they outline expectations and processes for members of the workforce. Having written policies and procedures is one of the seven essential elements of an effective Compliance Program.
12. **Unusual Occurrence Reports** – The Compliance Team processes and tracks all unusual occurrence reports for the District. Compliance provides the quality data to leadership and teams for monitoring and trending. Compliance manages the software, reporting, user configuration and resolution of all UORs.

The Compliance Department consists of a team of two full time employees, Conor Vaughan, Compliance Analyst, and Patty Dickson, Compliance Officer.

Report

1. Audits

A. Electronic Health Record Access Audits - The Compliance Department Analyst, Conor Vaughan, completes audits for access of patient information systems to ensure employees, providers, and vendors access records only on a work-related, need-to-know, and minimum necessary basis.

i. Cerner semi-automated auditing software tracks all workforce interactions and provides a summary dashboard for the compliance team. The dashboard provides "flags" for unusual activity. Flags require further investigation and review by the Compliance Team.

ii. The following is CY24 August through October activity

a. New Employee Audits (30 day): 22

I. Flags: 0

II. Flags resulting in policy violations: 0

III. This 30 day audit for new employees was added following a PHI breach corrective action plan.

b. New Employee Audits (90 day): 36

I. Flags: 1

II. Flags resulting in policy violations: 0

c. For-Cause Audits: 9

I. Flags: 0

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II. Flags resulting in policy violations: 0
III. Flags resulting in disciplinary action: 0

d. In "own" chart flags: 8
   I. Flags resulting in policy violations: 2
      i. Provided education and training: 2
      ii. Repeat violations: 0
e. Same Last Name Search Flags: 224
   I. Resulted in follow up with employee: 3
   II. Flags resulting in policy violations: 0
f. 3rd Party Vendors (ex. Our billing or coding company): 0
   I. Flags: 0
   II. Flags resulting in policy violations: 0
g. High Profile Persons: 4
   I. Flags: 0
   II. Flags resulting in policy violations: 0
h. Random Employee Audits: 24
   I. Flags: 0
   II. Flags resulting in policy violations: 0

B. <u>Business Associates Agreements (BAA) audit</u>
   i. Business Associates are vendors who access, transmit, receive, disclose, use, or store protected health information to provide business services to the District. These vendors range from our billing and coding companies to companies that provide medical equipment that transmits protected health information to the electronic health record. The Business Associates Agreements assure NIHD that the vendor meets the strict governmental regulations regarding how to handle, transmit, and store protected information to protect NIHD and NIHD patient information.

C. <u>Compliance Department Contract and Agreement reviews/audit</u>
   i. Documents processed for CY 24 (through August)
      a. 165 Agreements, Amendments or Termination Notices have been completed.
      b. ~8 are currently in progress

D. <u>HIMs (Health Information Management) scanning audit</u>
   i. To be conducted by HIMS and summary reports will be sent to Compliance

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ii. No reports received in to date

E. Email security audit/reviews
   i. Reviewed at least once a month
   ii. Review email security systems for violations of data loss prevention rules
      a. Typically results in reminder emails to use email encryption sent to members of workforce.
      b. Occasionally results in full investigations of potential privacy violations.
      c. 4 instances of education provided

F. Language Access Services Audit
   i. The Compliance Department is reviewing several language access tools that may be able to provide medically certified interpretive and translation services for a reduced cost.
   ii. Interpretive (spoken word) services are provided via telephone and video interpreting units from third parties, CyraCom and Language Line.
      a. NIHD has provided a total of 75,267 minutes of interpreting services, through October 31, 2024, to our patients at a cost to the District of $83,521.43. (See attached Language Access Services spreadsheet)
      b. We have been working to troubleshoot issues with Cyracom services as they are nearly half the price of Language Line services, although many of our clinicians prefer Language Line. We made a big push with our clinical teams, assisted by ITS in June 2024.
      c. Through education and troubleshooting with Cyracom, the NIHD team has realized a significant decrease in costs to provide interpreter services
         I. CY24 Q3 – average price per minute - $1.02
         II. CY24 (July/Aug) – 0.94
         III. CY24 Q2 average price per minute - $1.197
         IV. CY24 Q1 average price per minute – $1.197
   iii. Translation services (written word) services are provided via Language Line Translation Services.
   iv. NIHD provided services in the following languages in 2024
      a. Spanish (21 countries claim Spanish as an official language),
      b. American Sign Language,

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c. Mandarin (China, Taiwan, and Singapore),
d. Gujarati (India/Pakistan),
e. Thai (Thailand)
f. Arabic (25 countries claim Arabic as an official language),
g. Armenian (Armenia)
h. Vietnamese (Vietnam)
i. Quechua (Andean regions of South America
j. French

v. Laws require providing language access services to all limited English proficiency patients at no cost to the patient.
vi. Language Access regulations are enforced by the HHS (US Department of Health and Human Services) Office of Civil Rights.

G. 340B program audits
   i. The 340B drug program is designed to provide rural and underserved communities access to discount drug prices, allowing the facility to save several hundred thousand dollars annually. Those funds are used by the District to improve services provided to the community.
   ii. Annual 340B audit has been scheduled by SpendMend (formerly TurnKey)
      a. The Compliance Department recognizes Becky Wanamaker and Jeff Kneip for their excellent work on the 340B program.

H. Narcotic Administration/Reconciliation Audit
   i. Working in conjunction with Pharmacy to review narcotic administration.

I. Vendor Diversity Audit – NIHD has approximately 1400 vendors.
   i. NIHD currently has one certified diverse vendor.
   ii. Health and Safety Code Section 1339.85-1339.87 required the Department of Health Care Access and Information (HCAI, formerly OSHPD) to develop and administer a program to collect hospital supplier diversity reports, including certified diverse vendors in the following categories: minority-owned, women-owned, lesbian/gay/bisexual/transgender-owned, and disabled veteran-owned businesses.
   iii. There are currently no regulatory requirements for utilizing diverse vendors or outreach to diverse vendors.

J. Provider Verification Audits

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i. More than 380 referring providers were verified and were checked for state and federal exclusions so far in calendar year 2024
ii. No exclusions were found for verified providers.
iii. NIHD may not bill for referrals for designated health services from excluded providers. Billing for referrals from excluded providers could put NIHD at risk for false claims.

K. Coding Audits and Charge Master Audits
i. Evaluation and Management (E & M) code audit completed for providers. Information shared with leadership team to discuss with coding trainers and providers.
a. UASI has provided coding quality reports.
ii. Charge Master Audit
a. Conducted by CliftonLarsonAllen identified areas of opportunity in the multiple areas. These are the focus of multiple revenue cycle committees.

L. Collectively in 2024, NIHD employees have read 98.2% of assigned Compliance and Privacy policies.

2. **HIPAA Security Risk Assessment (SRA)** – Due in November 2024
A. This is a mandatory risk assessment under the jurisdiction of the HHS OIG
3. **Office of National Coordinator of Health Information Technology SAFER Audit** ((Safety Assurance Factors for EHR (Electronic Health Record) Resilience))
A. Nine of nine sections of the SAFER audit were completed by June 1, 2024.
B. Completion of all nine sections is required for MIPS data submission.
C. MIPS data is the quality data being submitted by the Quality Team. MIPS documents improvement in patient care measures and outcomes, and is worth millions of dollars for NIHD.
4. **Compliance Work Plan** – Updated October 2024 see attached
5. **Conflicts of Interest**
A. All new employees complete and return COI questionnaire forms.
B. Compliance, in conjunction with a significant amount of work from Lynda Vance, has rolled out a new process for completing and reviewing Conflict of Interest Questionnaires. This new process allows the data entered in a form by the employee to populate automatically a Smartsheet. Notifications are sent to notify members of the Business Compliance Team of action needed. The reviews occur independently

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via Smartsheet, unless there is disagreement. Once a determination is made for a conflict, conflict of interest letters of findings are virtually auto-generated to email the employee and their supervisor.

i. Roll-out occurred in July 2024
ii. We have received over 350 completed forms.
iii. We have reduced the time spent by the Compliance Department on this process by approximately 85%. This creates a savings to the District of over $25,000.

C. No COI forms submitted to the Compliance Department noted any knowledge or concern for the following:

i. Business transactions with an aim for personal gain.
ii. Gifts, loans, tips, or discounts to create real or perceived obligations.
iii. Use of NIHD resources for purposes other than NIHD business, NIHD sponsored business activities, or activities allowed by policy.
iv. Bribes, kickbacks, or rewards with the intent to interfere with NIHD business or workforce.
v. Use of NIHD money, goods, or services to influence government employees, or for special consideration or political contribution.
vi. False or misleading accounting practices or improper documentation of assets, liabilities, or financial transactions.

6. Privacy Investigations- see attached

A. Privacy investigations/potential breaches through October 31, 2024

i. Reported to Compliance – 28
ii. Reported to CDPH/OCR – 6
iii. Investigations still active in the Compliance Department - 2
iv. Investigations closed by the Compliance Department with no reporting required - 22

B. CDPH reported breach case status update

i. CDPH has notified NIHD that the Medical Breach Enforcement Section (MBES) will begin investigating their backlog of breaches. MBES can review and investigate breaches for 7 years. The MBES team were reassigned to contact tracing during the pandemic, and are now working to resolve oldest reported potential breaches first.

a. Privacy investigations from 2023

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I. Reported – 10
    i. 4 are closed

b. Privacy investigations from 2022
    I. Reported – 6
        i. 3 are closed
        ii. NIHD has received notice that CDPH has assigned a $45,000 administrative penalty for a breach that occurred in 2022.
            1. This was an intentional breach by the former-employee.
            2. Compliance was able to negotiate a Settlement Stipulation at $30,000. This Administrative Penalty has been paid by NIHD.

c. Privacy investigations from 2021
    I. Reported – 4
        i. 3 are closed

d. Privacy investigations from 2020
    I. Reported – 17
        i. 11 are closed
        ii. 3 may be assigned administrative penalty or fine

e. Privacy investigations from 2019
    I. Reported - 11
        i. 7 are closed

f. Privacy investigations from 2018
    I. Reported - 23
        i. 22 are closed

g. Privacy investigations from 2017
    I. Reported -22
        i. 17 are closed

h. Privacy investigations from 2016
        i. 1 is still being investigated by CDPH

ii. CDPH Status definitions
    a. Closed – CDPH investigation completed and a determination has been rendered.

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b. In Progress – CDPH has assigned an intake ID and may have completed some portion of the investigation.
c. Submitted – CDPH has not assigned an intake ID or reviewed the case.

iii. CDPH Determination definitions
a. Unsubstantiated – CDPH was unable to prove a violation of the privacy laws occurred (or the privacy law was updated in the interim between submission and their processing of the report)
b. Substantiated without deficiencies – CDPH found that a violation of the privacy laws occurred, but NIHD had the correct policies/procedures, training/education, and took corrective actions to ensure any harm had been mitigated and reduced risk for recurrence.
c. Substantiated with deficiencies – CDPH has found that a violation of the privacy laws occurred. CDPH has determined that further action by NIHD is needed to ensure reduced risk for recurrence. CDPH requires a corrective action plan to be submitted within a few days of receipt of the determination letter. Once the corrective action plan has been accepted, CDPH sends the case to CDPH Administration to determine if fines and administrative penalties will be assessed.

7. Investigations

A. Compliance conducted or assisted with around over 38 investigations through October 2024 including, but not limited to, the following:
i. California Department of Labor, Department of Industrial Relations
a. Response to investigation regarding California Labor Code, Division 2, Part 7 relating to a contractor participating in the Pharmacy/Infusion Construction Project.
ii. Health and Human Services Office of Inspector General
a. Business Associate Data Breach - Keenan
iii. California Department of Public Health, Licensing and Certification
iv. Internal investigations

B. Regulatory Submissions
i. Health Care Access and Information (HCAI – formerly OSHPD)
a. Vendor Diversity – On June 3, 2024, Compliance reported the information for the required vendor diversity reporting that was due by July 1, 2024. NIHD had three certified diverse vendors. NIHD spent

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~$66k with certified diverse vendors, which is approximately 0.08% of NIHD total procurement.

b. Hospital Fair Billing Practices – On June 11, 2024, Compliance reported NIHD's Financial Assistance and Charity Care Programs, along with postings in all registration areas of the District to HCAI. Additionally, all information was submitted explaining how NIHD complies with all language access regulations, as required.

c. CMS Hospital Price Transparency – on August 7, 2024, NIHD received a Notice of Non-Compliance from CMS. NIHD's Price Transparency webpage did not meet regulatory requirements. NIHD had 90 days to have a fully functional and compliant Price Estimator and Machine Readable Chargemaster file.

I. An NIHD team was assembled, led by Project Manager Lynda Vance, to assess, create and execute a corrective action plan.

II. NIHD received notification on November 8, 2024 that NIHD is now in compliance with Hospital Price Transparency regulations.

III. Thanks to Lynda's continuous follow-up and pressure on internal and external teams, NIHD avoided tens of thousands of dollars in fines.

C. Subpoenas

i. The Compliance Department also accepts and completes service for subpoenas for cases related to District business. This includes subpoenas for NIHD business records and appearances. Subpoenas for Medical Records are usually sent to the Health Information Department (HIM) for processing.

ii. The Compliance team has facilitated 70 subpoenas for records or appearances through 10/31/2024.

8. Compliance Committees

A. Compliance and Business Ethics Committee (CBEC)

i. No meetings since March 17, 2023

B. Billing and Coding Compliance Committee (BCCC) reports to the CBEC committee.

i. This group reviews billing/coding issues, chargemaster changes, and policies that affect billing/coding/accounting. Chair of this meeting is in the process of transitioning to the Billing Office Manager for this bi-weekly meeting.

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C. Business Compliance Team (BCT) reports to the CBEC Committee.
    i. This group reviews all Conflict of Interest questionnaires with potential conflicts to determine the appropriate and consistent method to address the conflict. This subcommittee is chaired by the Compliance Officer and meets on an ad hoc basis or via serial meetings using Smartsheet.

D. Forms Committee
    i. NIHD develops forms in compliance with our Forms Control Policy. Forms are branded with NIHD logos. There are standardized templates, designated fonts, official translations, and mandatory non-discrimination and language access information.
    ii. We have added Barbara Laughon to this committee to ensure her review and approval of all signage and postings, other than those posters legally required by employment law.
    iii. One meeting has been held in 2024. District reorganization has slowed the Forms development and approval process.
    iv. The Forms Committee is transitioning to serial meetings via Smartsheet processes to facilitate faster forms approvals.

9. Issues and Prevention

A. Compliance researched over 100 issues for the District in 2024. They include adolescent privacy regulations; billing issues, and regulatory reporting. The compliance team takes a proactive approach for all issues brought to our attention.

10. CPRA (California Public Records Act) Requests

A. Compliance has received eleven (11) CPRA thus far in CY 2024.
    i. All eleven completed timely.

11. Policy and Procedures

A. Clear and current policies are the basis of an effective and efficient organization.

B. Policies are required to be reviewed and approved by the Board every two years. Procedures are required to be reviewed and approved by the Executive Team or the Medical Executive Committee every two years.

C. Having written policies and procedures is one of the seven essential elements of an effective Compliance Program, per the Health and Human Services Office of Inspector General. User set up, policy administration, and other software optimization is managed by the Compliance Officer.

A. Policy and Procedure Audits:

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i. NIHD has approximately 1155 policies and procedures.
ii. Executive leadership was made aware of policies and procedures significantly overdue for review on September 9, 2024.

B. Leaders can also use reporting from the system to ensure NIHD team members are current with reviewing policies.
C. There is an administrative group that tracks policy life cycle and approval process, consisting of Ashley Reed, Sarah Rice, Dianne Picken, Cori Stearns, Patty Dickson, and Veronica Gonzalez.

12. Unusual Occurrence Reports (UOR)

A. UOR quality report data for January 1, 2024 through October 31, 2024, see attached
i. Notable trends out of 446 UORs received so far in CY 2024:
a. UORs regarding complaints and requests to review billing and care continue to be the highest volume. Communication issues and complaints represent 116 of the 446 UORs (26%).
I. We are addressing some trending issues:
i. Billing complaints – particularly wellness/annual visits
1. This is under review by the Executive team.
ii. Communication concerns - these are internal and external communication issues
b. NIHD has had 8 reported workplace violence occurrences.
c. Medication Occurrences and errors are the third highest volume in UORs. However, NIHD's medication error rates are well below national averages for error rates. Medication Errors are administration errors that reach the patient. See additional (see attached) data for NIHD Medication Administration accuracy following the UOR report.
d. Fourteen (14) systemic changes have been put into place based on action plans developed during UOR review and investigation.
I. Five systemic changes were the result of patient complaints.
II. Three systemic changes resulted from safety and security occurrence reports.

B. The UOR process involves significant work and time from the Compliance team.
i. All UORs in Complytrack are currently received by the Compliance Team.
a. Many patient complaint and concern phone calls are transferred to the Compliance team for intake and assistance.

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b. The Compliance team provides response letters for the patient complaints, although the CMO assists on specific clinical matters.

ii. UORs are triaged and assigned to appropriate department leaders for review. Emails and phone calls are placed to leaders for urgent UORs.

iii. The Compliance team reviews replies, ensures thorough responses and corrective actions, provides follow up letters to patients, and ensures the executive team is aware of all areas of concern.

iv. The Compliance Officer follows up with leaders who are having difficulty with timely responses and attempts to assist them with resolution.

v. The Compliance team ensures UORs are closed after thorough review, corrective actions and, in most cases, resolution.

Language Acess Services

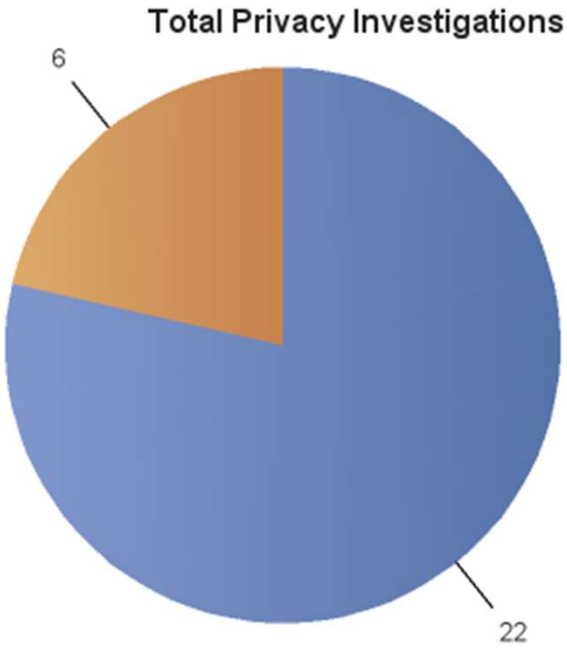
Interpreting	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Total
Language Line - Phone minutes provided	1,221	1,453	1,626	1,705	1,630	999	345	273	330	436	
Language Line - Phone - cost	$1,159.95	$1,380.35	$1,544.70	$1,619.75	$1,548.50	$949.05	$327.75	$259.35	$313.50	$414.20	
Language Line - Video - minutes provided	3,689	2,952	4,247	4,948	5,861	2,547	2,097	2,288	2,224	3,277	
Language Line - Video - Cost	$5,533.50	$4,426.00	$6,366.65	$7,422.00	$8,800.50	$3,820.50	$3,145.50	$3,432.00	$3,656.04	$4,915.20	
Cyracom - Phone - minutes provided	1,415	1,201	1,754	959	719	2,294	3,186	4,577	3,329	4,014	
Cyracom - Phone - Cost	$1,035.03	$855.15	$1,315.50	$616.65	$469.14	$1,720.50	$2,297.73	$3,183.48	$2,391.30	$2,841.21	
Cyracom - Video - minutes provided	154	142	232	77	243	1,692	1,689	1,844	775	823	
Cyracom - Video - Cost	$115.50	$106.50	$174.00	$57.75	$182.25	$1,269.00	$1,267.75	$1,389.50	$581.25	$617.25	
Total Minutes of interpretive services provided	**6479**	**5748**	**7859**	**7689**	**8453**	**7532**	**7317**	**8982**	**6658**	**8550**	**75267**
Total Cost of interpretive services provided	**$7,843.98**	**$6,768.00**	**$9,400.85**	**$9,716.15**	**$11,000.39**	**$7,759.05**	**$7,038.73**	**$8,264.33**	**$6,942.09**	**$8,787.86**	**$83,521.43**
Translation											
Language Line Translation Services - Cost	$1,000.85	$0.00	$107.55	$268.31	$1,265.07	$2,861.00	$99.00	$0.00	$1,105.86		**$6,707.64**
											$90,229.07

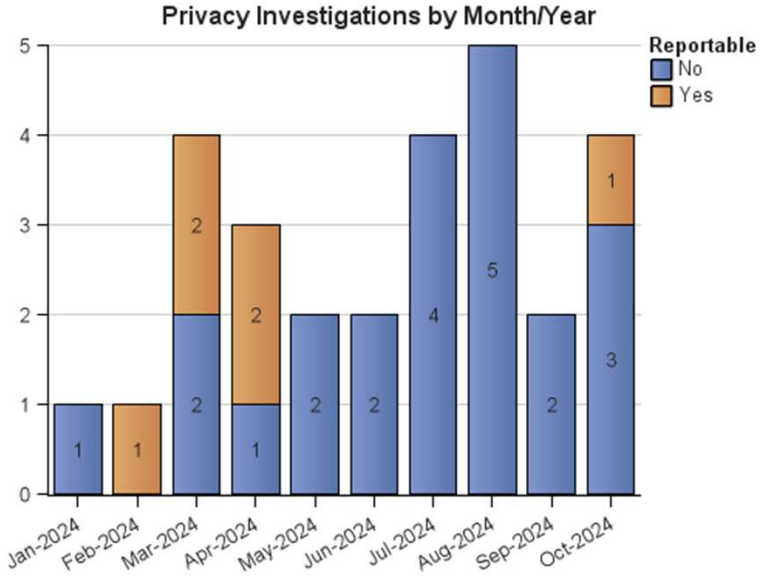
No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	Due Quarter 3 CY 2024
2.	Develop and deliver the annual briefing and training for the Board on changes in the regulatory and legal environment, along with their duties and responsibilities in oversight of the Compliance Program.	NIHD Compliance Program (p.17)	Presentation in June 2024
3.	Develop a Compliance Department budget to ensure sufficient staff and other resources to fully meet obligations and responsibilities.		In progress
4.	District Policy and Procedure management		Policy Audit completed June 2024
Written Compliance Guidance			
4.	Audit of required Compliance related policies.		Policies for Compliance are in the review process as of May 2024
5.	Annual review of Code of Conduct to ensure that it currently meets the needs of the organization and is consistent with current policies. (Note: Less than 12 pages, 10 grade reading level or below)		Scheduled for August 2024
6.	Verify that the Code of Conduct has been disseminated to all new employees and workforce.		Ongoing in conjunction with HR. Current to date.
Compliance Education and Training			
7.	Verify all workforce receive compliance training and that documentation exists to support results. Report results to Compliance and Business Ethics Committee.		Relias reports, Policy Manager Reports due July 2024
8.	Ensure all claims processing staff receive specialized training programs on proper documentation and coding.		Deferred to claims processing companies - 2024
9.	Review and assess role-based access for EHR (electronic health record) and partner programs. Implement/evaluate standardized process to assign role-based access.		In progress – also reviewing census lists access (May 2024
10.	Compliance training programs: fraud and abuse laws, coding requirements, claim development and submission processes, general prohibitions on paying or	Completed at Orientation.	Completed at orientation. False Claims Act Policy assigned annually.

	receiving remuneration to induce referrals and other current legal standards.		
Compliance Communication			
11.	Review unusual occurrence report trends and compliance concerns. Prepare summary report for Compliance Committee on types of issues reported and resolution		Annual and quarterly reports submitted to appropriate committees and Board of Directors.
12.	Develop a report that evidences prompt documenting, processing, and resolution of complaints and allegations received by the Compliance Department.	Complytrack	Annual and quarterly reports submitted to appropriate committees and Board of Directors.
13.	Document test and review of Compliance Hotline.		Completed 02/2024 Due 08/2024
14.	Physically verify Compliance hotline posters appear prominently on employee boards in work areas.		Due 09/2024
Compliance Enforcement and Sanction Screening			
15.	Verify that sanction screening of all employees/workforce and others engaged by NIHD against Office of Inspector General (OIG) List of Excluded Individuals and Entities has been performed in a timely manner, and is documented by a responsible party.	Ongoing – HR performs employees/travelers/temps monthly. Compliance verifies new referring providers. Medical Staff Office (MSO) verifies all medical staff. Accounting and Compliance verifies all vendors.	Current through 5/31/2024 Annual re-validation for vendor exclusions completed for 2023.
16.	Develop a review and prepare a report regarding whether all actions relating to the enforcement of disciplinary standards are properly documented.		On hold due to current reorganization.
17.	Audits		
	a. Arrangements with physician (database)	Physician Contracts are now in a review cycle. All templates created/reviewed in conjunction with legal counsel (BBK).	Review in Q4 CY 2024
	b. EMTALA (Emergency Medical Treatment and Active Labor Act)		All EMTALA concerns immediately reviewed. Current through 05/31/2024

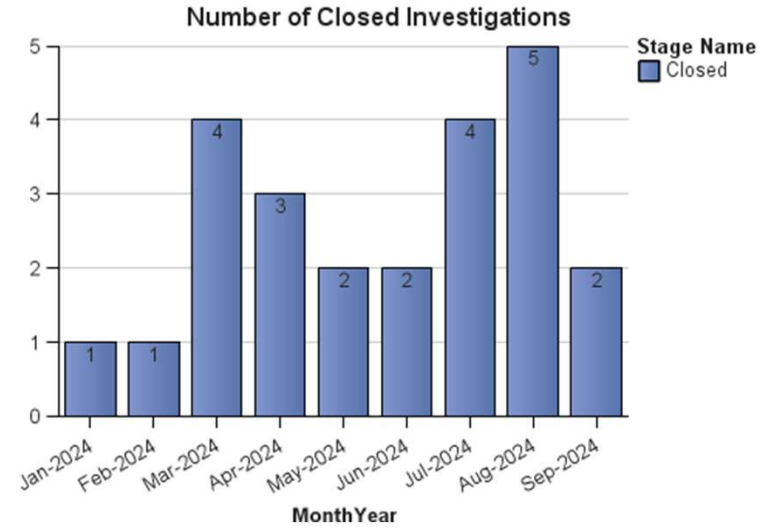
	c. Financial Audits	FY 2024	CLA Audit completed. Cost Report and audit completed.
	d. Payment patterns		Due quarter Q3 CY 2024
	e. Bad debt/ credit balances, AR days		Monitored weekly by Revenue Cycle and Business Office
	f. Non-Physician vendor contract/payment audit	Incidental finding	Q3 – in progress - July
	g. DME (Durable Medical Equipment)	HHS OIG target	NIHD may provide and charge for "off-the-shelf, non-customized" medical equipment. Chargemaster is being updated. Review Q3 2024
	h. Lab services	MAC target	Deferred
	i. Imaging services (high cost/high usage)	MAC target	Deferred
	j. Rehab services	HHS OIG workplan	Deferred
	k. Language Access Audits	OIG target	Due Q3 2024 – in progress
18.	Ensure that high risks associated with HIPAA and HITECH Privacy and Security requirements for protecting health information undergo a compliance review.		Security risk assessment November 2024 with Cybersecurity Officer.
	a. Annual Security Risk Assessment		Due Oct/Nov 2024
	b. Periodic update to Security Risk Assessment		As needed
	c. Monthly employee access audits		Daily, ongoing
19.	Audit required signage		Deferred to 2024
20.	Audit HIMS (Health Information Management) scanned document accuracy		Deferred
21.	Develop metrics to assess the effectiveness and progress of the Compliance Program		Deferred
22.	Review CMS Conditions of Participation		Ongoing
23.	CMS Hospital Price Transparency Audit	MRF, SSPE, PE	Weekly
Response to Detected Problems and Corrective Action			
23.	Verify that all identified issues related to potential fraud are promptly investigated and documented		Current through May 2024
24.	Conduct a review that ensures all identified overpayments are promptly reported and repaid.		Monitored by Revenue Cycle Team and Accounting.

			Reporting to Compliance as needed.
25.	UOR tracking and trending – UOR/Unusual occurrence reporting is now a function of the Compliance Department.		See UOR reporting attached to Board Report for Q2 CY 2024, attached.
	a. Provide trend feedback to leadership to allow for data-driven decision-making		Quarterly
	I. Overall UOR process		Nov 2024
	II. Workplace Violence		Nov 2024
	III. Falls		Nov 2024
26.	Patient complaints		Documented and tracked in Unusual Occurrence Reporting system
27.	Breach Investigations	HIPAA, HITECH, CMIA	4 ongoing privacy investigations as of 6/6/2024. CDPH has started completing reported breach investigations from before 2021.

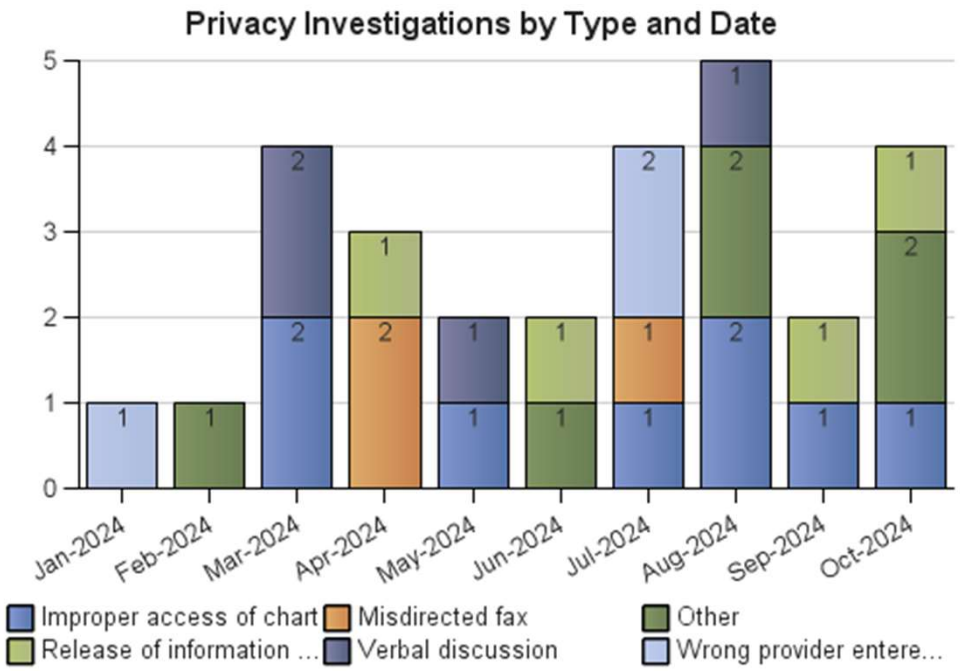




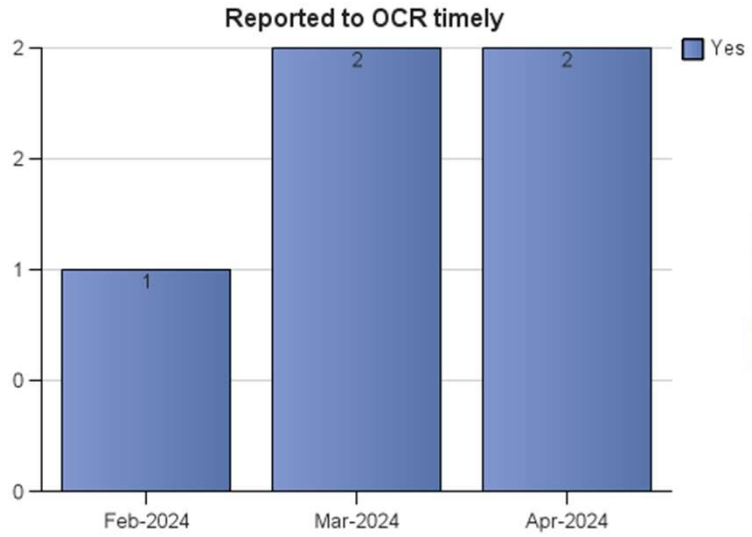
	No	Yes	Total
Jan-2024	1		1
Feb-2024		1	1
Mar-2024	2	2	4
Apr-2024	1	2	3
May-2024	2		2
Jun-2024	2		2
Jul-2024	4		4
Aug-2024	5		5
Sep-2024	2		2
Oct-2024	3	1	4
Total	**22**	**6**	**28**



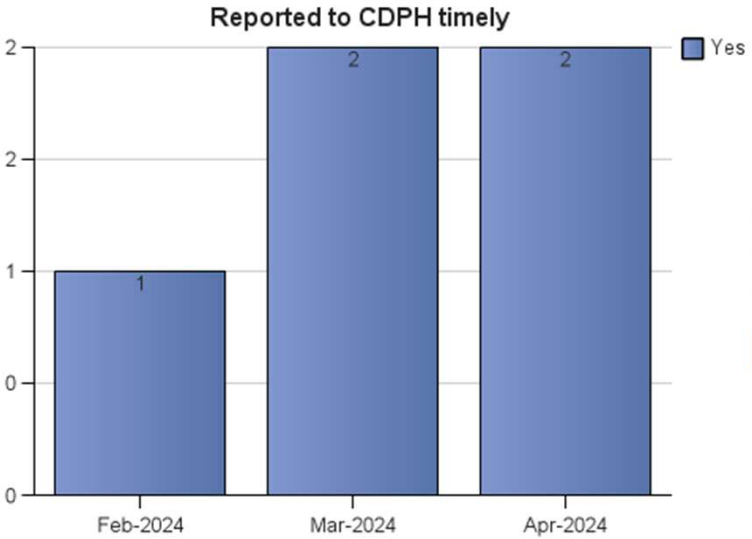
	Closed	Total
Sep-2024	2	2
May-2024	2	2
Mar-2024	4	4
Jun-2024	2	2
Jul-2024	4	4
Jan-2024	1	1
Feb-2024	1	1
Aug-2024	5	5
Apr-2024	3	3
Total	**24**	**24**



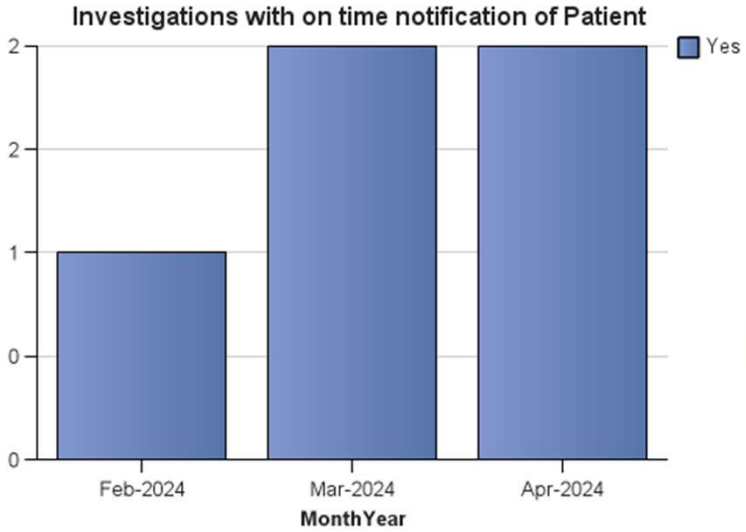
	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Total
Improper access of chart			2		1		1	2	1	1	8
Misdirected fax				2			1				3
Other		1				1		2		2	6
Release of information concern				1		1			1	1	4
Verbal discussion			2		1			1			4
Wrong provider entered/selected	1						2				3
Total	**1**	**1**	**4**	**3**	**2**	**2**	**4**	**5**	**2**	**4**	**28**



	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	2	2
Total	5	5



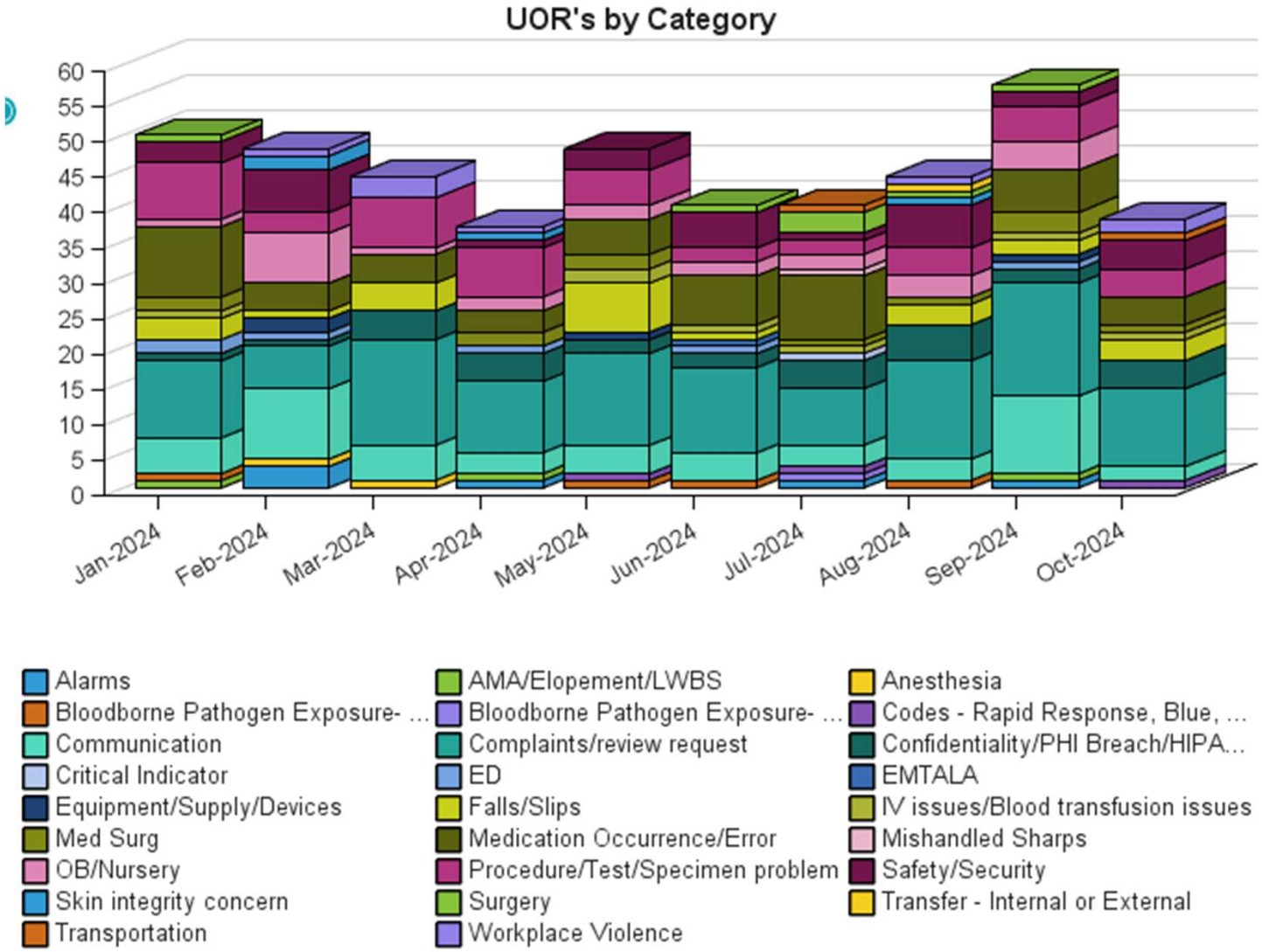
	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	2	2
Total	5	5



	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	2	2
Total	5	5

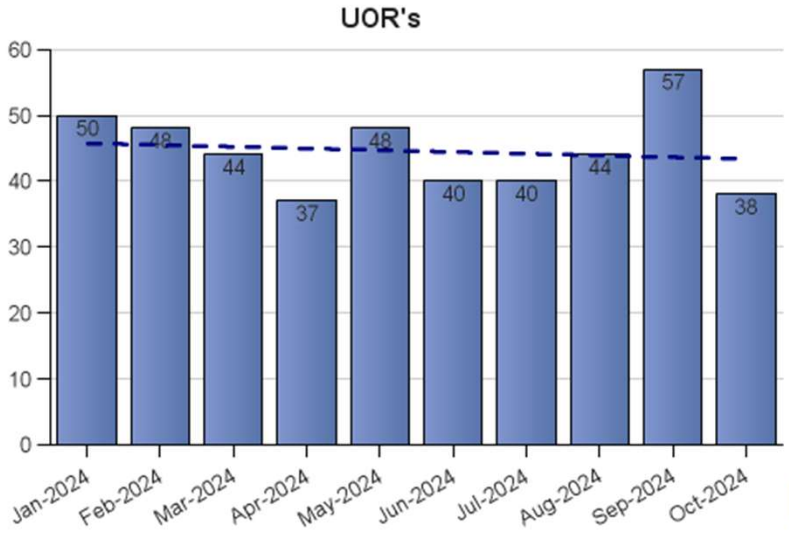
No new reportable breaches for May through September. October data is not completed yet.

Calendar Year 2024
Unusual Occurrence Report
(UOR) Data

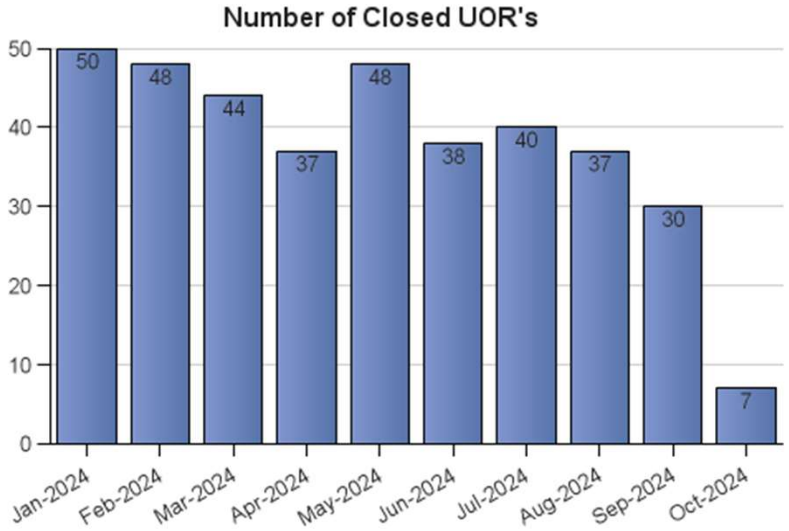

UOR's by Category
60
55
50
45
40
35
30
25
20
15
10
5
0
Jan-2024
Feb-2024
Mar-2024
Apr-2024
May-2024
Jun-2024
Jul-2024
Aug-2024
Sep-2024
Oct-2024
Alarms
AMA/Elopement/LWBS
Anesthesia
Bloodborne Pathogen Exposure- ...
Bloodborne Pathogen Exposure- ...
Codes - Rapid Response, Blue, ...
Communication
Complaints/review request
Confidentiality/PHI Breach/HIPA...
Critical Indicator
ED
EMTALA
Equipment/Supply/Devices
Falls/Slips
IV issues/Blood transfusion issues
Med Surg
Medication Occurrence/Error
Mishandled Sharps
OB/Nursery
Procedure/Test/Specimen problem
Safety/Security
Skin integrity concern
Surgery
Transfer - Internal or External
Transportation
Workplace Violence

Data for previous slide

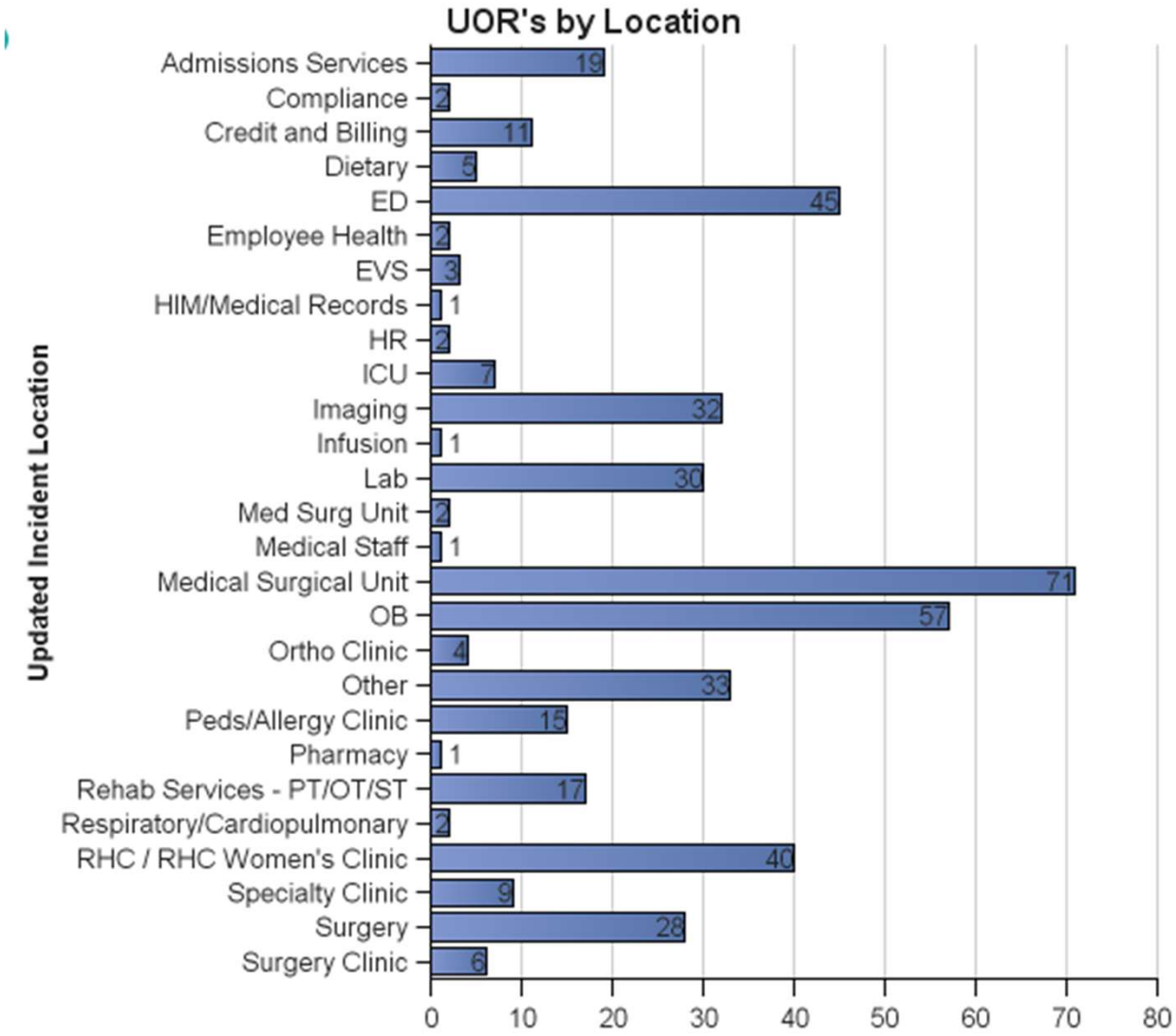
	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Total
Alarms		3		1			1		1		6
AMA/Elopement/LWBS	1			1					1		3
Anesthesia		1	1								2
Bloodborne Pathogen Exposure- Sharps Injury	1				1	1		1			4
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane							1				1
Codes - Rapid Response, Blue, Deescalation					1		1			1	3
Communication	5	10	5	3	4	4	3	3	11	2	50
Complaints/review request	11	6	15	10	13	12	8	14	16	11	116
Confidentiality/PHI Breach/HIPAA violation	1	1	4	4	2	2	4	5	2	4	29
Critical Indicator							1				1
ED	2	1		1		1			1		6
EMTALA						1					1
Equipment/Supply/Devices		2			1				1		4
Falls/Slips	3	1	4		7	1		3	2	3	24
IV issues/Blood transfusion issues	1				2	1	1		1	1	7
Med Surg	2			2	2		1	1	3	1	12
Medication Occurrence/Error	10	4	4	3	5	7	9		6	4	52
Mishandled Sharps							1				1
OB/Nursery	1	7	1	2	2	2	2	3	4		24
Procedure/Test/Specimen problem	8	3	7	7	5	2	2	4	5	4	47
Safety/Security	3	6		1	3	5	1	6	2	4	31
Skin integrity concern		2		1				1			4
Surgery	1					1	3	1	1		7
Transfer - Internal or External								1			1
Transportation							1			1	2
Workplace Violence		1	3	1				1		2	8
Total	**50**	**48**	**44**	**37**	**48**	**40**	**40**	**44**	**57**	**38**	**446**



Jan-2024	50
Feb-2024	48
Mar-2024	44
Apr-2024	37
May-2024	48
Jun-2024	40
Jul-2024	40
Aug-2024	44
Sep-2024	57
Oct-2024	38
Total	**446**



	Closed
Jan-2024	50
Feb-2024	48
Mar-2024	44
Apr-2024	37
May-2024	48
Jun-2024	38
Jul-2024	40
Aug-2024	37
Sep-2024	30

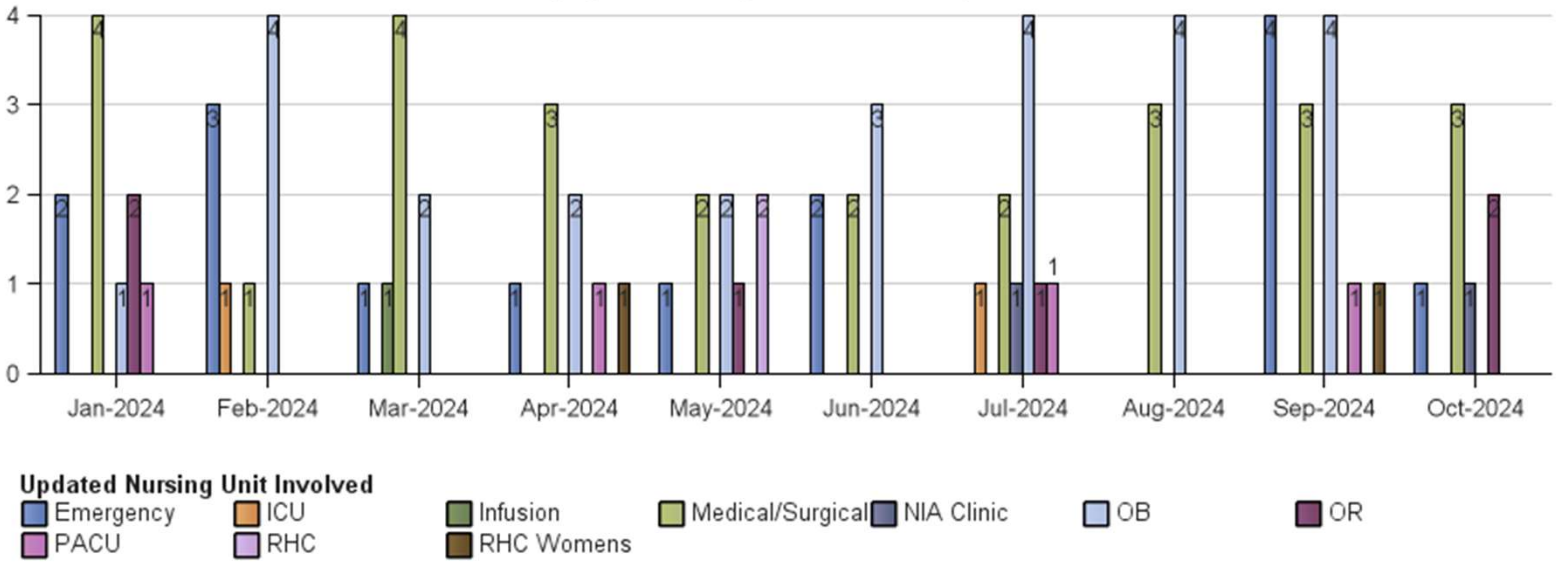

UOR's by Location
Updated Incident Location
Admissions Services 19
Compliance 2
Credit and Billing 11
Dietary 5
ED 45
Employee Health 2
EVS 3
HIM/Medical Records 1
HR 2
ICU 7
Imaging 32
Infusion 1
Lab 30
Med Surg Unit 2
Medical Staff 1
Medical Surgical Unit 71
OB 57
Ortho Clinic 4
Other 33
Peds/Allergy Clinic 15
Pharmacy 1
Rehab Services - PT/OT/ST 17
Respiratory/Cardiopulmonary 2
RHC / RHC Women's Clinic 40
Specialty Clinic 9
Surgery 28
Surgery Clinic 6
0 10 20 30 40 50 60 70 80

Data for previous slide

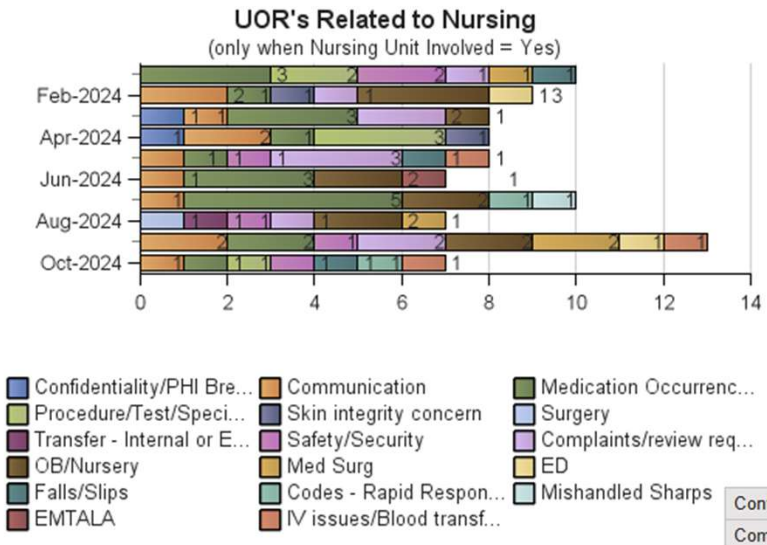
Admissions Services	19
Compliance	2
Credit and Billing	11
Dietary	5
ED	45
Employee Health	2
EVS	3
HIM/Medical Records	1
HR	2
ICU	7
Imaging	32
Infusion	1
Lab	30
Med Surg Unit	2
Medical Staff	1
Medical Surgical Unit	71
OB	57
Ortho Clinic	4
Other	33
Peds/Allergy Clinic	15
Pharmacy	1
Rehab Services - PT/OT/ST	17
Respiratory/Cardiopulmonary	2
RHC / RHC Women's Clinic	40
Specialty Clinic	9
Surgery	28
Surgery Clinic	6
Total	**446**

UOR's Related to Nursing by Nursing Unit Involved

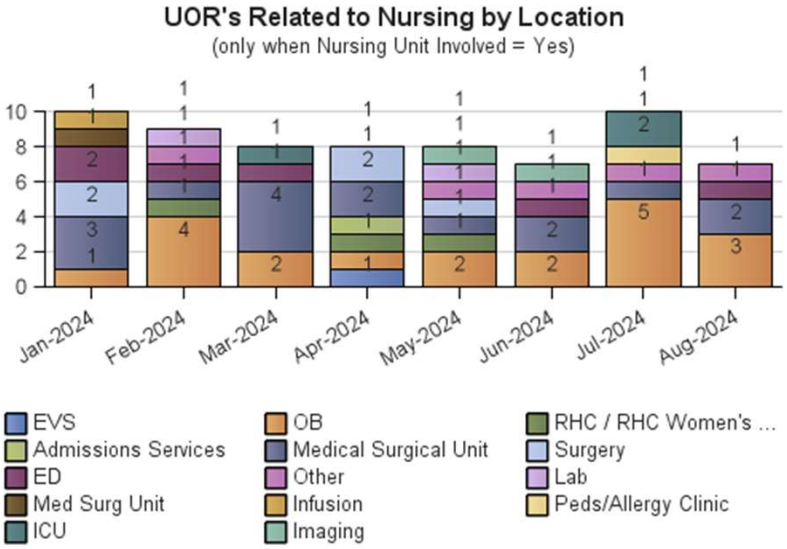
(only when Nursing Unit Involved = Yes)



	Yes
Emergency	15
ICU	2
Infusion	1
Medical/Surgical	27
NIA Clinic	2
OB	26
OR	6
PACU	4
RHC	2
RHC Womens	2
Total	**87**

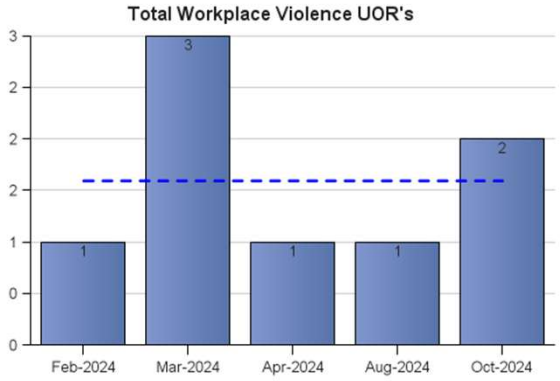


	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Total
Confidentiality/PHI Breach/HIPAA violation			1	1							2
Communication		2	1	2	1	1	1		2	1	11
Medication Occurrence/Error	3	1	3	1	1	3	5		2	1	20
Procedure/Test/Specimen problem	2			3						1	6
Skin integrity concern		1		1							2
Surgery								1			1
Transfer - Internal or External								1			1
Safety/Security	2				1			1	1	1	6
Complaints/review request	1	1	2		3			1	2		10
OB/Nursery		3	1			2	2	2	2		12
Med Surg	1							1	2		4
ED		1							1		2
Falls/Slips	1				1					1	3
Codes - Rapid Response, Blue, Deescalation							1			1	2
Mishandled Sharps							1				1
EMTALA						1					1
IV issues/Blood transfusion issues					1				1	1	3
Total	**10**	**9**	**8**	**8**	**8**	**7**	**10**	**7**	**13**	**7**	**87**

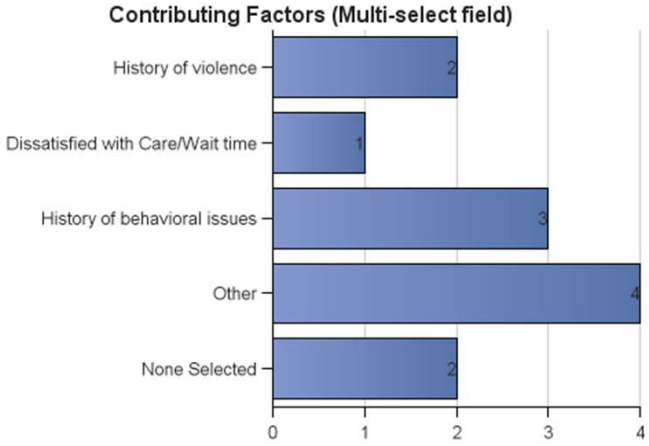


	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
EVS				1					**1**
OB	1	4	2	1	2	2	5	3	**20**
RHC / RHC Women's Clinic		1		1	1				**3**
Admissions Services				1					**1**
Medical Surgical Unit	3	1	4	2	1	2	1	2	**16**
Surgery	2			2	1				**5**
ED	2	1	1			1		1	**6**
Other		1			1	1	1	1	**5**
Lab		1			1				**2**
Med Surg Unit	1								**1**
Infusion	1								**1**
Peds/Allergy Clinic							1		**1**
ICU			1				2		**3**
Imaging					1	1			**2**
Total	**10**	**9**	**8**	**8**	**8**	**7**	**10**	**7**	**67**

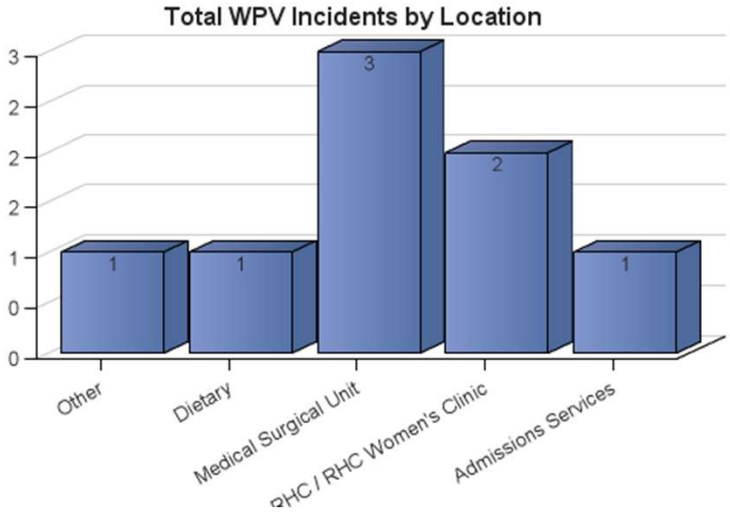
WORKPLACE VIOLENCE



	Feb-2024	Mar-2024	Apr-2024	Aug-2024	Oct-2024	Total
Workplace Violence	1	3	1	1	2	8
Total	**1**	**3**	**1**	**1**	**2**	**8**

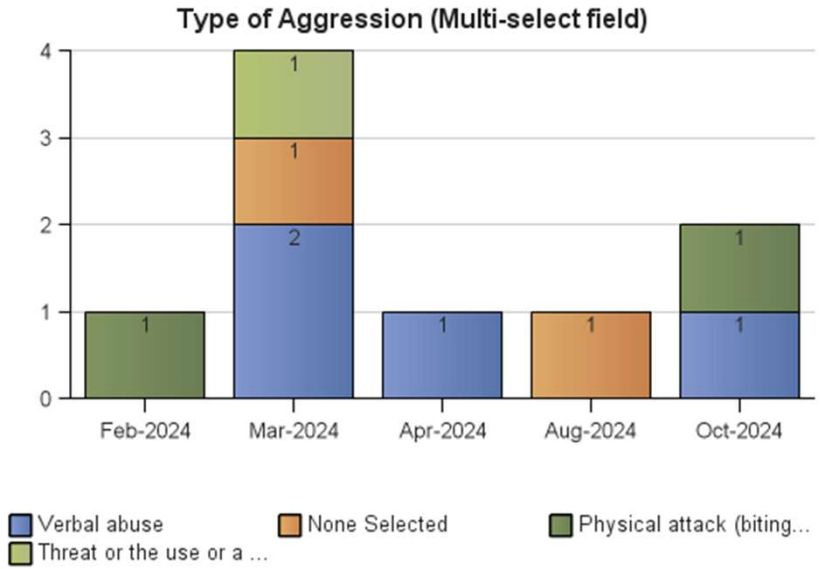


None Selected	2
Dissatisfied with Care/Wait time	1
History of behavioral issues	3
History of violence	2
Other	3
Total	**11**



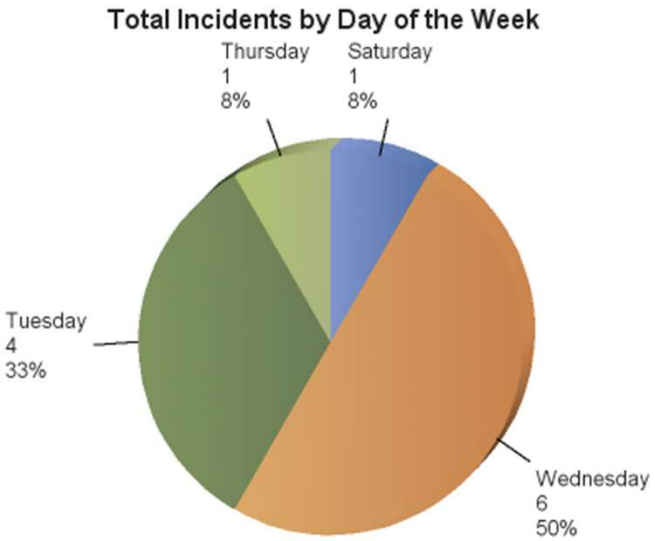
Other	1
Dietary	1
Medical Surgical Unit	3
RHC / RHC Women's Clinic	2
Admissions Services	1
Total	**8**

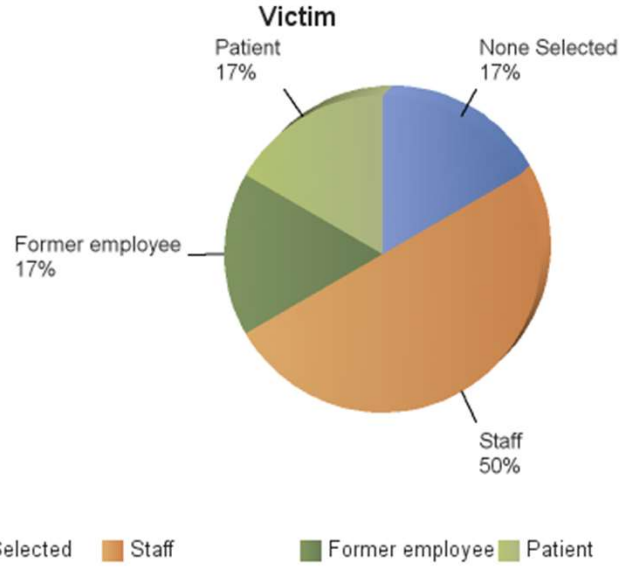
WORKPLACE VIOLENCE

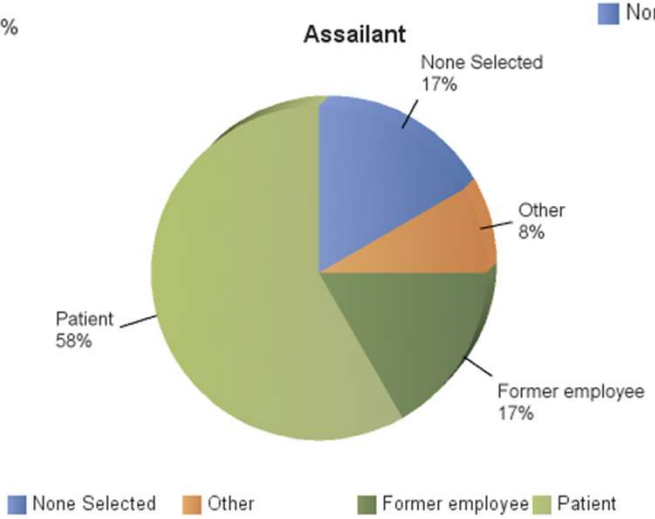


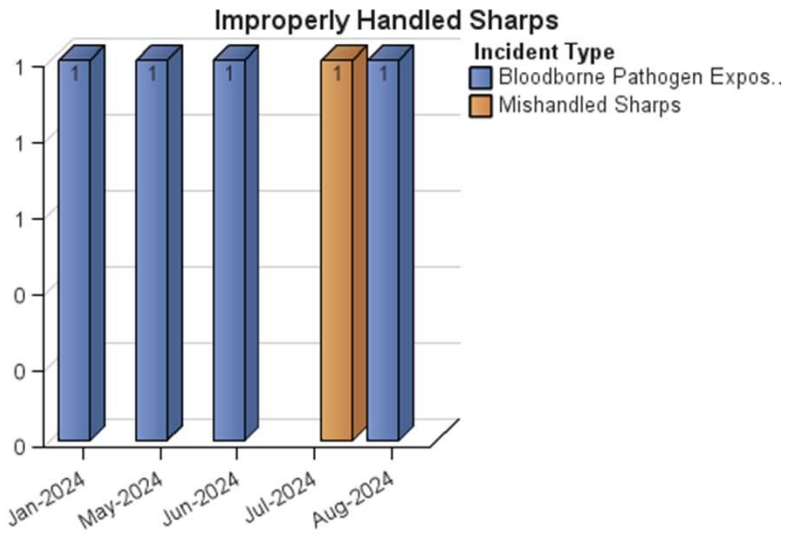
	Feb-2024	Mar-2024	Apr-2024	Aug-2024	Oct-2024	Total
Verbal abuse		2	1		1	4
None Selected		1		1		2
Physical attack (biting, choking, grabbing, hair pulling, kicking, punching/slapping, scratching, spitting, striking, etc)	1				1	2
Threat or the use or a weapon/object		1				1
Total	**1**	**4**	**1**	**1**	**2**	**9**

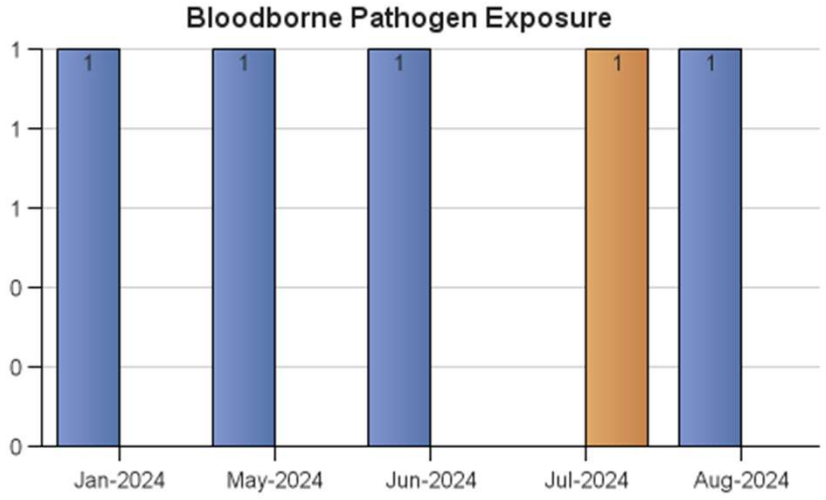
WORKPLACE VIOLENCE







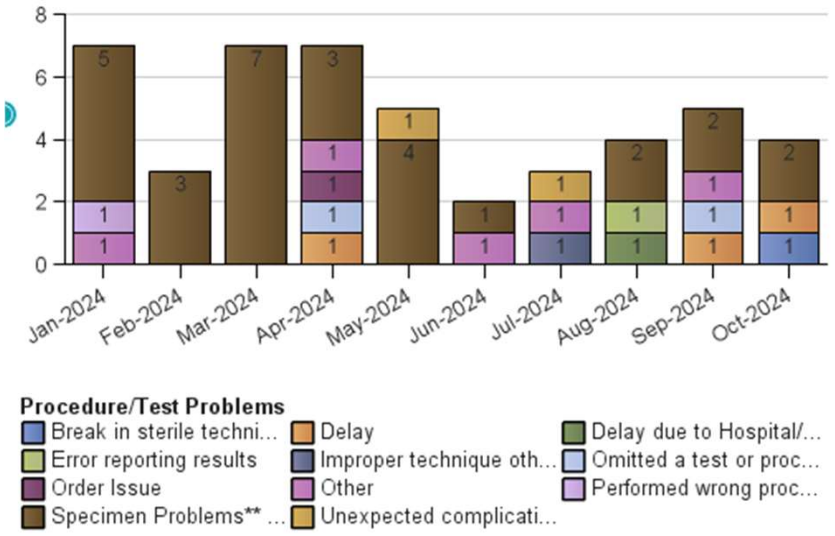




	Jan-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
Bloodborne Pathogen Exposure- Sharps Injury	1	1	1		1	4
Mishandled Sharps				1		1
Total	**1**	**1**	**1**	**1**	**1**	5

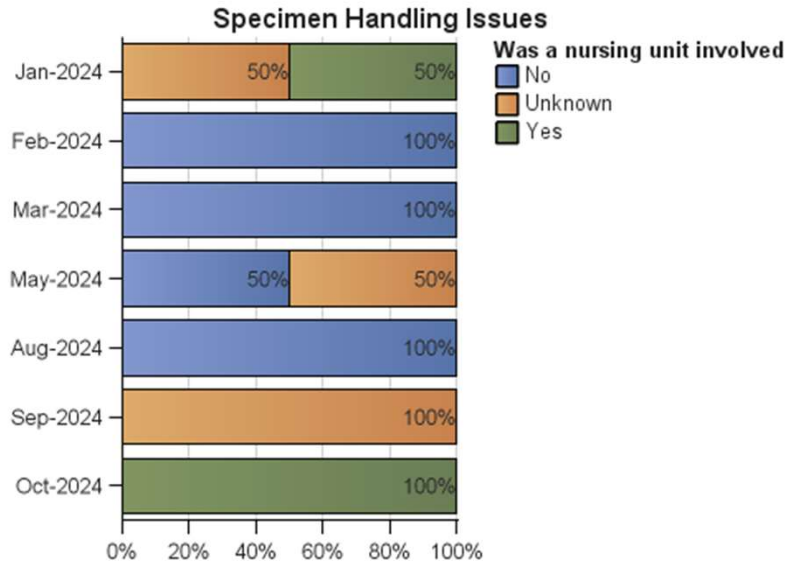
	Jan-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
Bloodborne Pathogen Exposure- Sharps Injury	1	1	1		1	4
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane				1		1
Total	**1**	**1**	**1**	**1**	**1**	5

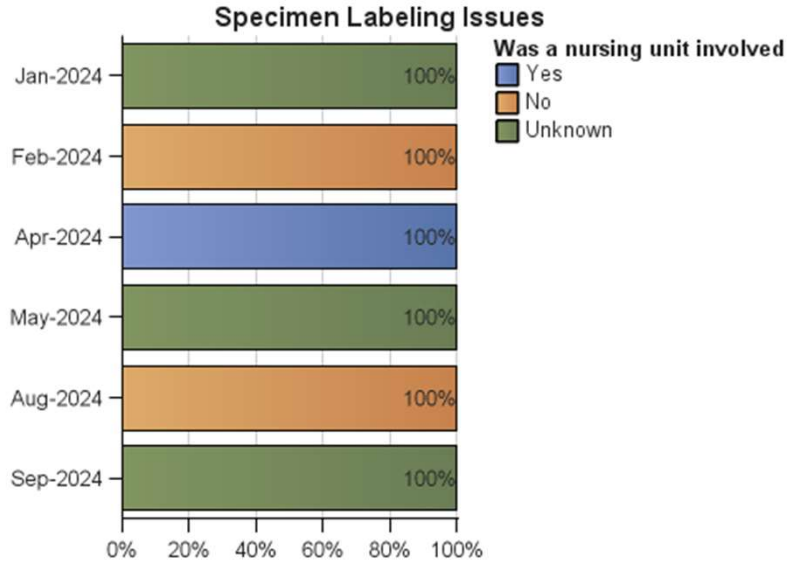
UOR's Related Diagnostic Services



	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Sep-2024	Oct-2024	Total
Break in sterile technique										1	1
Delay				1					1	1	3
Delay due to Hospital/Radiology systems problems or communication issues								1			1
Error reporting results								1			1
Improper technique other than a break in sterile technique							1				1
Omitted a test or procedure				1					1		2
Order Issue				1							1
Other	1			1		1	1		1		5
Performed wrong procedure	1										1
Specimen Problems** LAB ALWAYS SELECT THIS ONE***	5	3	7	3	4	1		2	2	2	29
Unexpected complications					1		1				2
Total	**7**	**3**	**7**	**7**	**5**	**2**	**3**	**4**	**5**	**4**	**47**

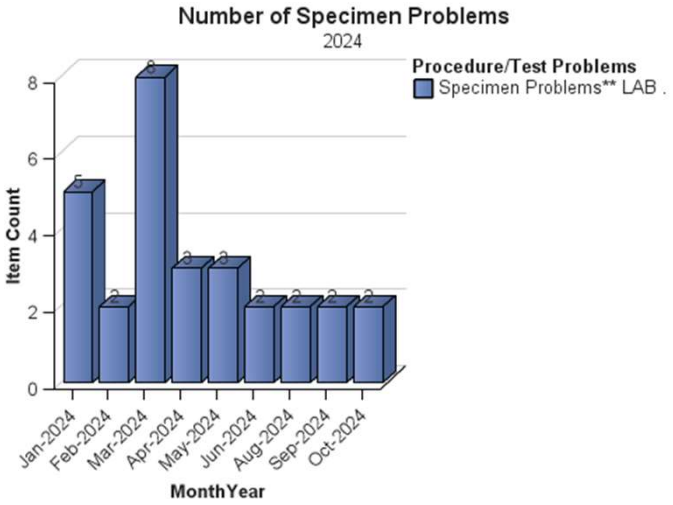
See new reports in the following pages

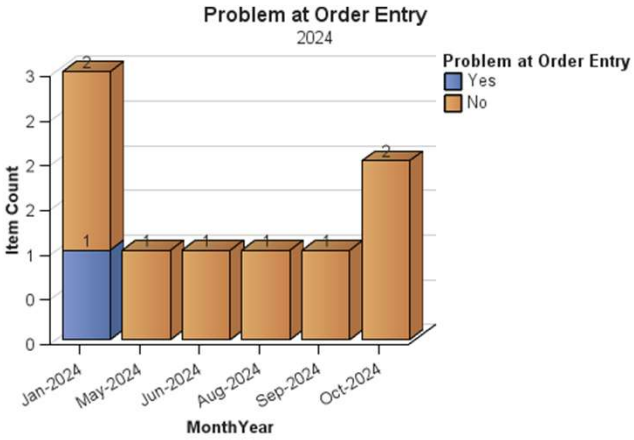


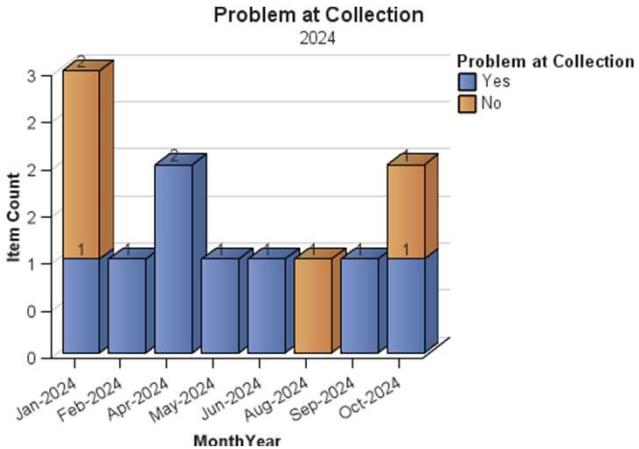


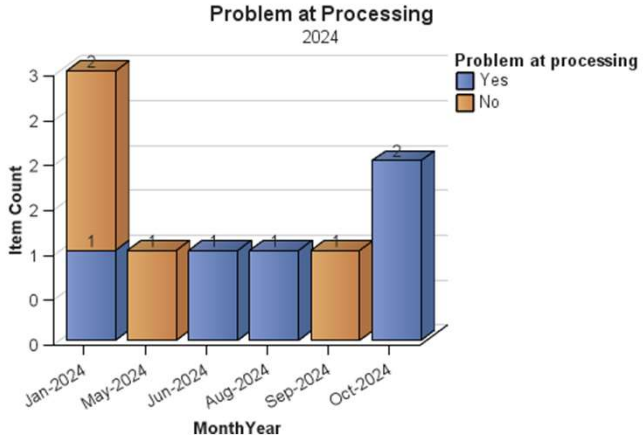
	Jan-2024	Feb-2024	Mar-2024	May-2024	Aug-2024	Sep-2024	Oct-2024	Total
No		1	7	1	1			10
Unknown	1			1		1		3
Yes	1						1	2
Total	**2**	**1**	**7**	**2**	**1**	**1**	**1**	**15**

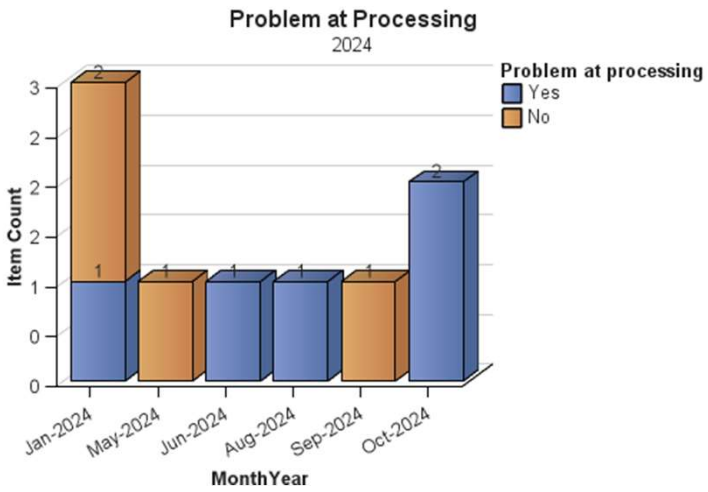
	Jan-2024	Feb-2024	Apr-2024	May-2024	Aug-2024	Sep-2024	Total
Yes			2				2
No		1			1		2
Unknown	1			2		1	4
Total	**1**	**1**	**2**	**2**	**1**	**1**	**8**

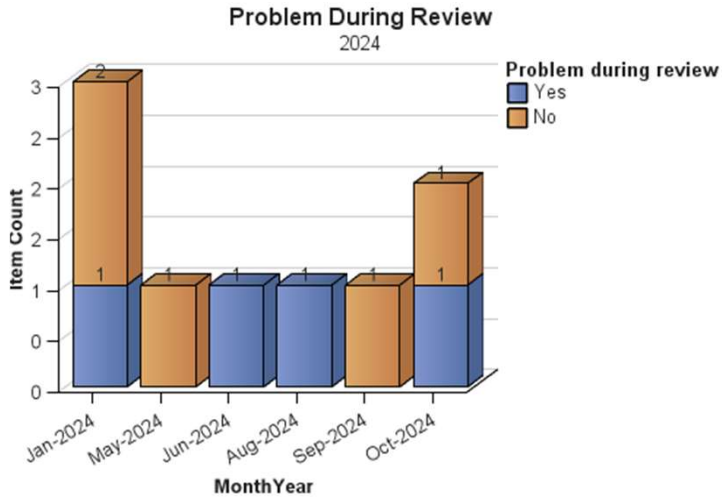

Number of Specimen Problems
2024
Procedure/Test Problems
Specimen Problems** LAB .
Item Count
MonthYear
Jan-2024
Feb-2024
Mar-2024
Apr-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024

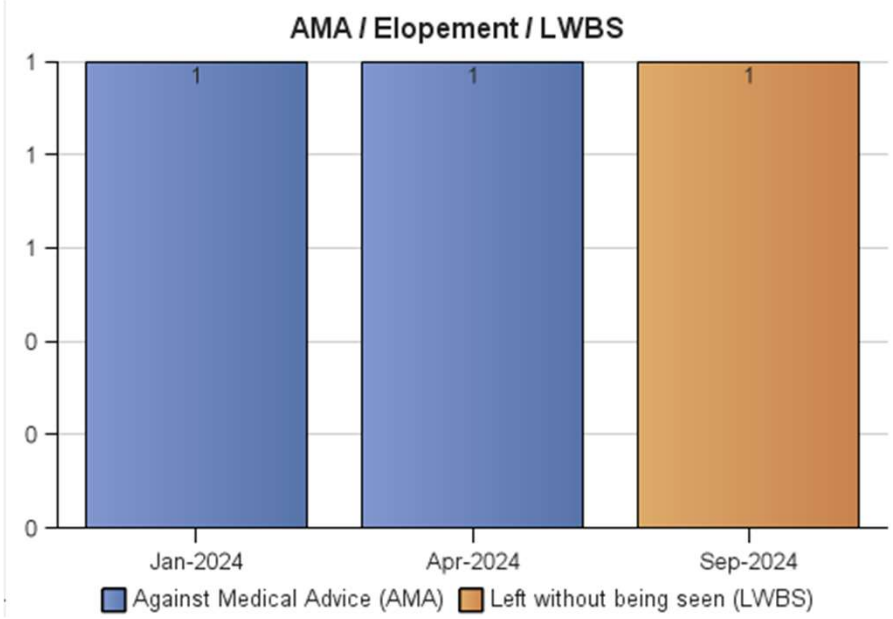

Problem at Order Entry
2024
Problem at Order Entry
Yes
No
Item Count
MonthYear
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024


Problem at Collection
2024
Problem at Collection
Yes
No
Item Count
MonthYear
Jan-2024
Feb-2024
Apr-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024


Problem at Processing
2024
Problem at processing
Yes
No
Item Count
MonthYear
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024


Problem at Processing
2024
Problem at processing
Yes
No
Item Count
MonthYear
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024

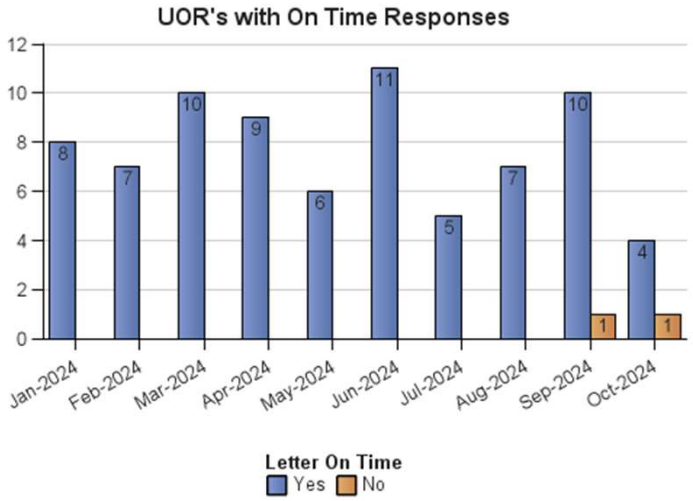

Problem During Review
2024
Problem during review
Yes
No
Item Count
MonthYear
Jan-2024
May-2024
Jun-2024
Aug-2024
Sep-2024
Oct-2024



	Jan-2024	Apr-2024	Sep-2024	Total
Against Medical Advice (AMA)	1	1		**2**
Left without being seen (LWBS)			1	**1**
Total	**1**	**1**	**1**	3

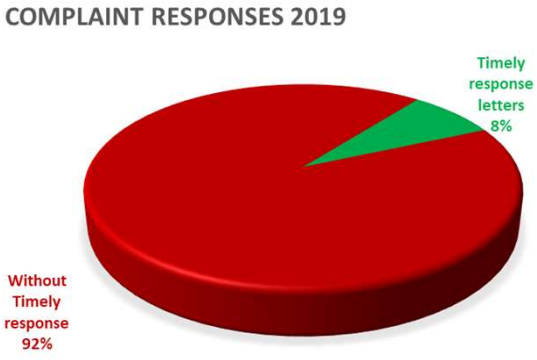
AMA – Against Medical Advice
LWBS – Left Without Being Seen

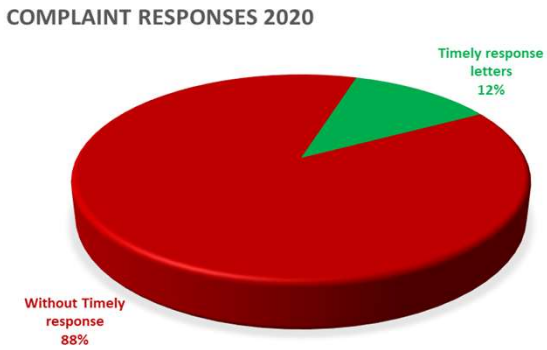
Jan-2024	8
Feb-2024	7
Mar-2024	10
Apr-2024	9
May-2024	6
Jun-2024	11
Jul-2024	5
Aug-2024	7
Sep-2024	11
Oct-2024	5
Total	**79**

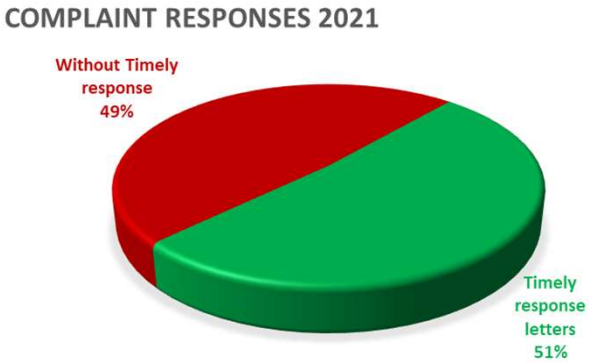


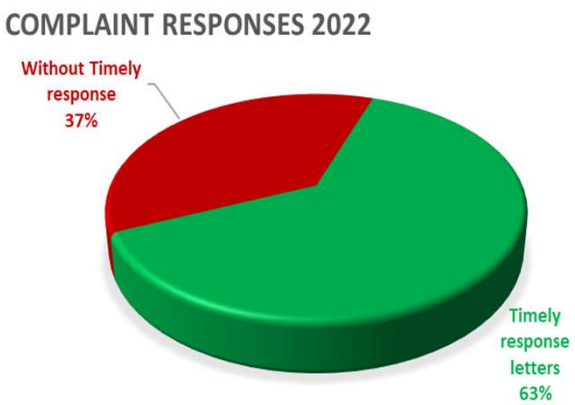
	Yes	No	Total
Jan-2024	8		**8**
Feb-2024	7		**7**
Mar-2024	10		**10**
Apr-2024	9		**9**
May-2024	6		**6**
Jun-2024	11		**11**
Jul-2024	5		**5**
Aug-2024	7		**7**
Sep-2024	10	1	**11**
Oct-2024	4	1	**5**
Total	**77**	**2**	**79**

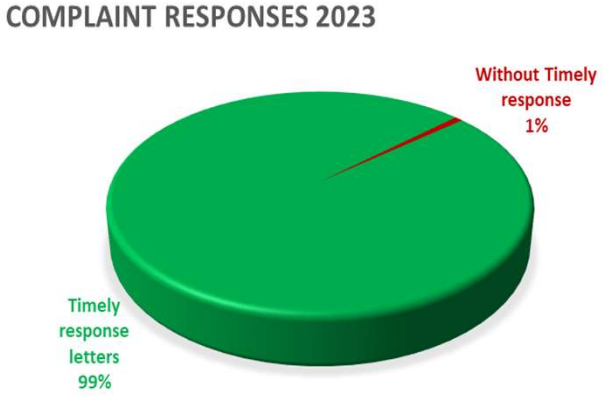
*April 2024 – One letter had previously been marked untimely; however, it was a date calculation error.







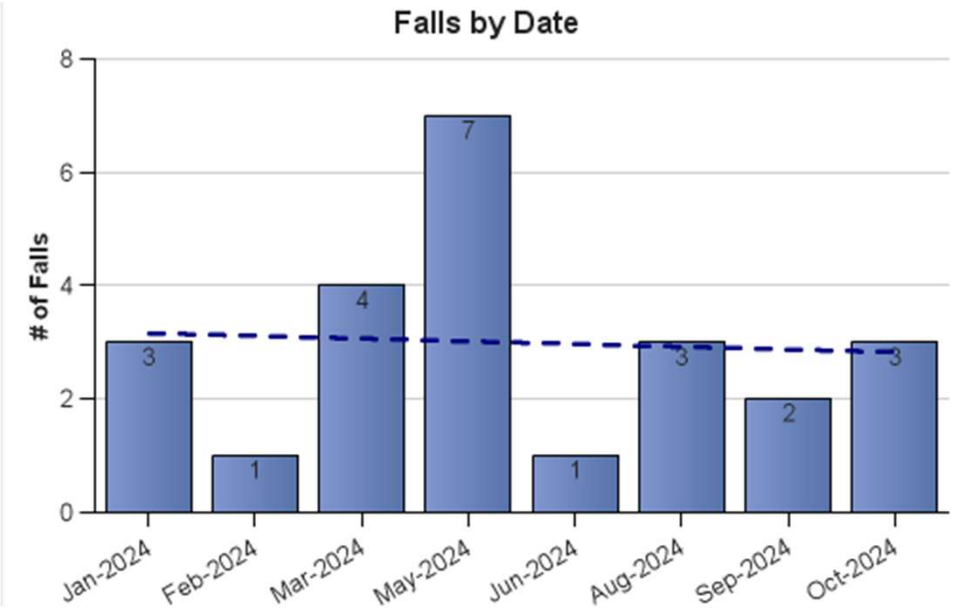




2024
10 months

Goal is 100% Green (timely responses)

On average, a time frame of seven (7) business days for the provision of the response is the NIHD standard. (Requirement from NIHD POLICY)



# of Falls	Was there any injury?			
	Not Identified	Unknown	No	Total
Not Identified	7			7
ED	1		1	2
Inpatient		2	5	7
Outpatient	8			8
Total	**16**	**2**	**6**	**24**

# of Falls	Falls/Slip Problem(s)								Total
	Not Identified	Ambulating	Bathroom	Bed/Crib	Chair	Grounds/floor issues	Other	Other Person	
Not Identified	1	3		1	1	6	3	1	16
Confused		2	1						3
Oriented		2	3	1					6
Total	**1**	**7**	**4**	**2**	**1**	**6**	**3**	**1**	**25**

# of Falls	Falls/Slips	Total
Dietary	1	1
ED	2	2
EVS	1	1
Imaging	1	1
Medical Surgical Unit	7	7
OB	1	1
Other	3	3
Rehab Services - PT/OT/ST	6	6
Specialty Clinic	1	1
Surgery	1	1
Total	**24**	**24**

# of Falls	Was the Patient Assessed for Fall Risk		
	Not assessed	Yes	Total
Workforce	7		7
Outpatient	8		8
Inpatient		7	7
ED	1	1	2
Total	**16**	**8**	**24**

# of Falls	Was the Patient Assessed for Falls Protocol		
	Not assessed	Yes	Total
Workforce	7		7
Outpatient	8		8
Inpatient		7	7
ED	1	1	2
Total	**16**	**8**	**24**

# of Falls	Received a Sedative w/in the Last 4 Hours			
	Not assessed	Yes	No	Total
Workforce	7			7
Outpatient	8			8
Inpatient		1	6	7
ED	1	1		2
Total	**16**	**2**	**6**	**24**

# of Falls	The Patient Is			
	Not assessed	Oriented	Confused	Total
Workforce	7			7
Outpatient	8			8
ED	1	1		2
Inpatient		5	2	7
Total	**16**	**6**	**2**	**24**

# of Falls	Activity Privileges		
	Not assessed	Ambulatory	Total
Workforce	7		7
ED	1	1	2
Inpatient		7	7
Outpatient	8		8
Total	**16**	**8**	**24**

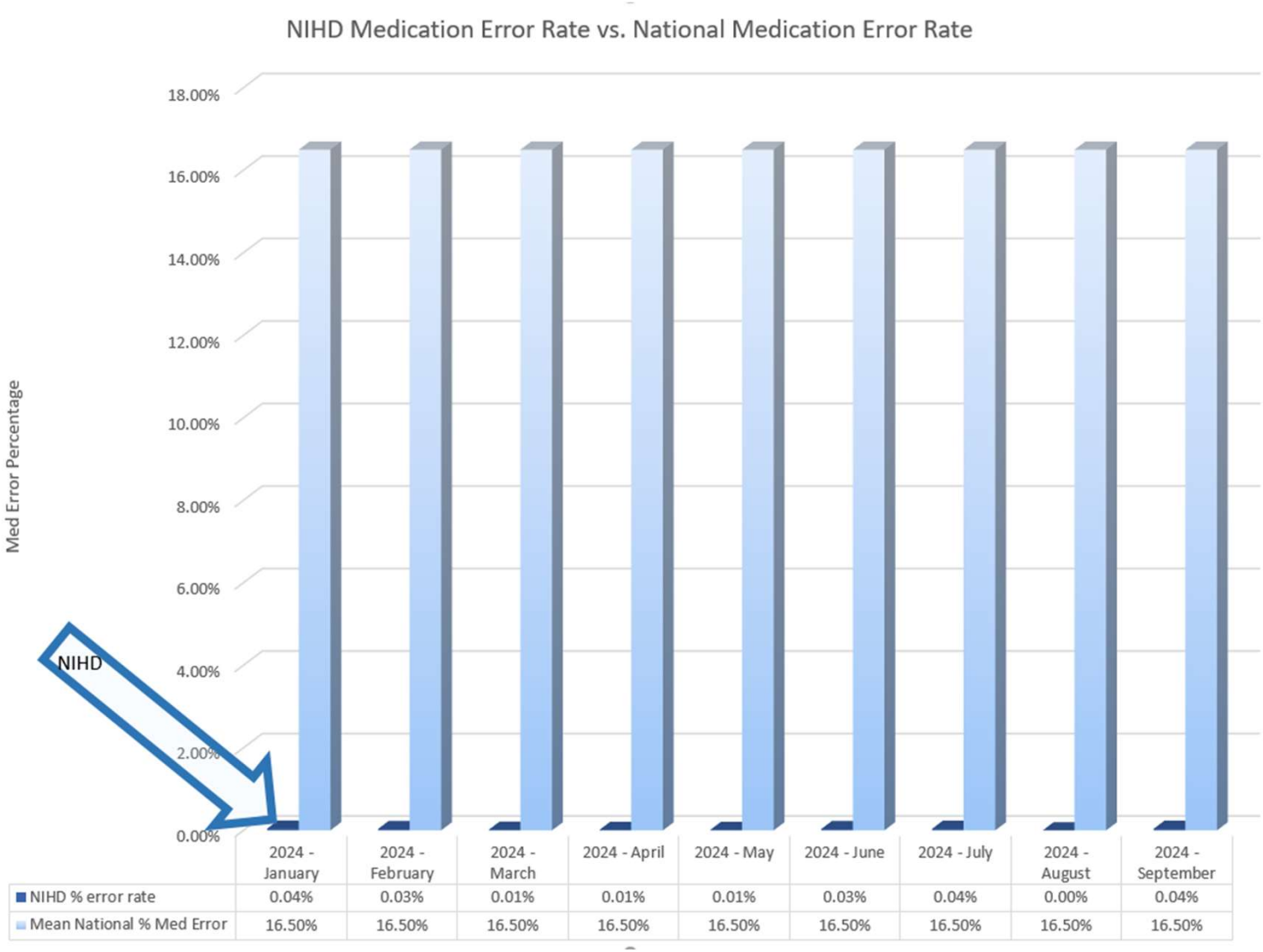
# of Falls	Siderails			
	Not assessed	Siderails down	Siderails up	Total
Workforce	7			7
Outpatient	8			8
ED	1	1		2
Inpatient		1	6	7
Total	**16**	**2**	**6**	**24**

# of Falls	Restraints		
	Not assessed	None	Total
Workforce	7		7
Outpatient	8		8
Inpatient		7	7
ED	1	1	2
Total	**16**	**8**	**24**

# of Falls	Patient Attendent			
	Not assessed	Yes	No	Total
Workforce	7			7
Outpatient	8			8
Inpatient		3	4	7
ED	1	1		2
Total	**16**	**4**	**4**	**24**

# of Falls	Environment			
	Not assessed	No environmental concerns	Other	Total
Workforce	7			7
Outpatient	8			8
Inpatient		5	2	7
ED	1	1		2
Total	**16**	**6**	**2**	**24**

# of Falls	Fall Witnessed				Fall Alleged				Assisted to Floor				Found on Floor			
	Not Identified	No	Yes	Total	Not Identified	No	Yes	Total	Not Identified	No	Yes	Total	Not Identified	No	Yes	Total
Not Identified	7			7	7			7	7			7	7			7
ED	1		1	2	1	1		2	1	1		2	1		1	2
Inpatient	1	4	2	7	5		2	7	3	3	1	7	3	1	3	7
Outpatient	8			8	8			8	8			8	8			8
Total	**17**	**4**	**3**	**24**	**21**	**1**	**2**	**24**	**19**	**4**	**1**	**24**	**19**	**1**	**4**	**24**

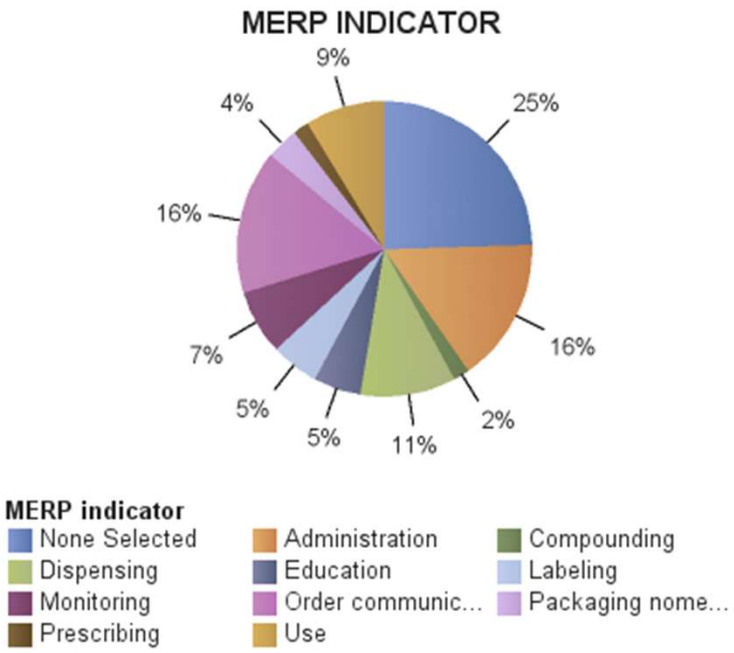


	2024 - January	2024 - February	2024 - March	2024 - April	2024 - May	2024 - June	2024 - July	2024 - August	2024 - September
NIHD % error rate	0.04%	0.03%	0.01%	0.01%	0.01%	0.03%	0.04%	0.00%	0.04%
Mean National % Med Error	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%

Data for previous slide

Month/Year	Total number of Medications administered	NIHD Total number of errors	NIHD % error rate	National % Medication Error	Mean National % Med Error	NIHD % Medication Administration accuracy	References
2024 - January	16,772	7	0.04%	8%-25%	16.50%	99.96%	In a review of 91 direct observation studies of medication errors in hospitals and long-term care facilities, investigators estimated median error rates of 8%–25% during medication administration.
2024 - February	12,671	4	0.03%	8%-25%	16.50%	99.97%	
2024 - March	13,815	2	0.01%	8%-25%	16.50%	99.99%	
2024 - April	14,886	2	0.01%	8%-25%	16.50%	99.99%	reference for above: https://psnet.ahrq.gov/primer/medication-administration-errors#:~:text=In%20a%20review%20of%2091,%E2%80%932
2024 - May	15,273	2	0.01%	8%-25%	16.50%	99.99%	Occurrences not included, as they are not errors that are administered to a patient.
2024 - June	12,566	4	0.03%	8%-25%	16.50%	99.97%	
2024 - July	16,173	6	0.04%	8%-25%	16.50%	99.96%	
2024 - August	15,416	0	0.00%	8%-25%	16.50%	100.00%	None reported. Will review.
2024 - September	16,221	6	0.04%	8%-25%	16.50%	99.96%	

Medication Error Reduction Plan (MERP)

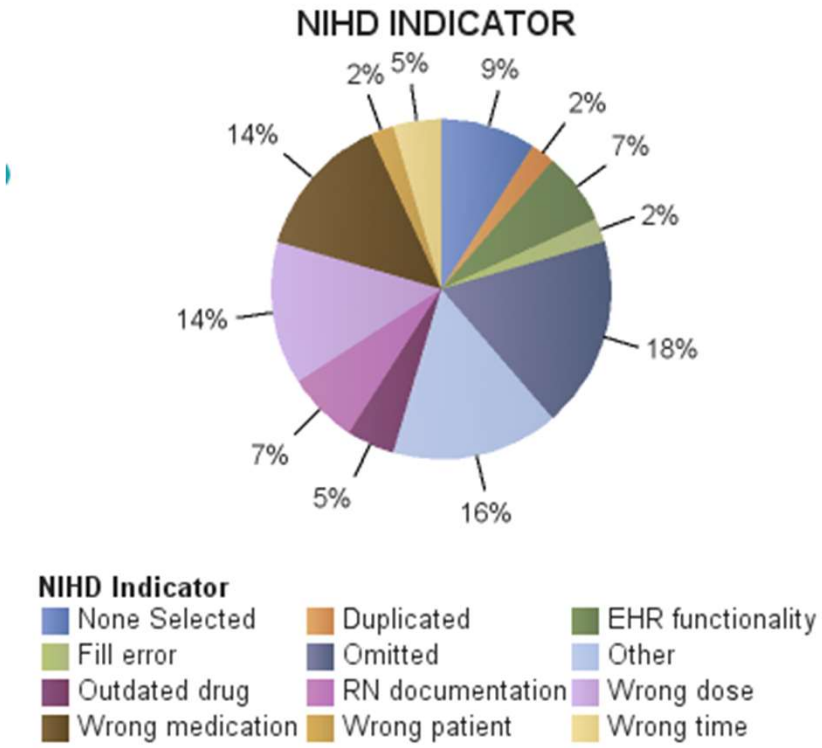


None Selected	14
Administration	9
Compounding	1
Dispensing	6
Education	3
Labeling	3
Monitoring	4
Order communication	9
Packaging nomenclature	2
Prescribing	1
Use	5
Total	**57**

	# of Errors	# of Occurrences	Total
Jan-2024	7	3	**10**
Feb-2024	4		**4**
Mar-2024	2	1	**3**
Apr-2024	2	1	**3**
May-2024	2	3	**5**
Jun-2024	4	3	**7**
Jul-2024	6	1	**7**
Sep-2024	6		**6**
Oct-2024	3	1	**4**
Total	**36**	**13**	**49**

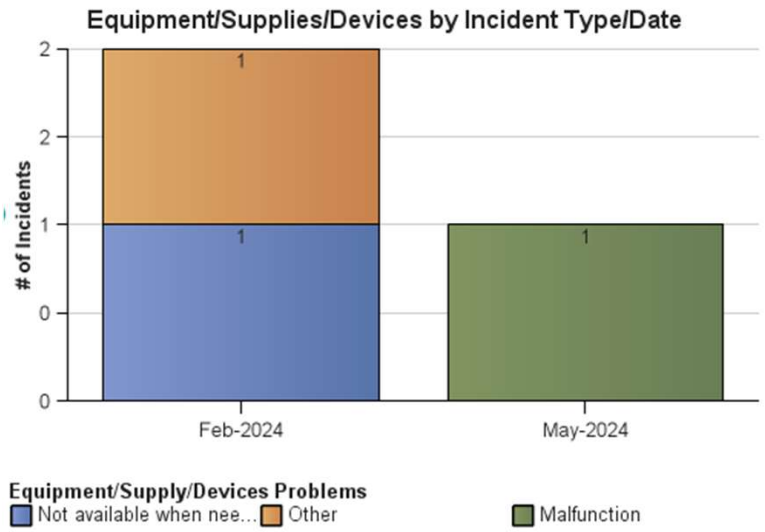
All medication errors and occurrences are reviewed by the Medication Administration Improvement Committee. The MERP and NIHD Indicators (following page) allow NIHD to categorize errors in order to focus on high frequency error reasons to create a plan for reduction.

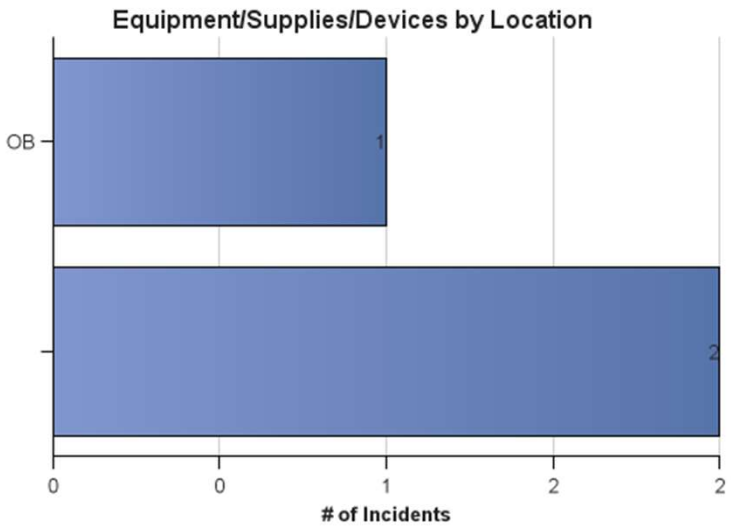
Medication errors are errors that reach the patient. Medication occurrences are errors that are caught before they reach the patient.



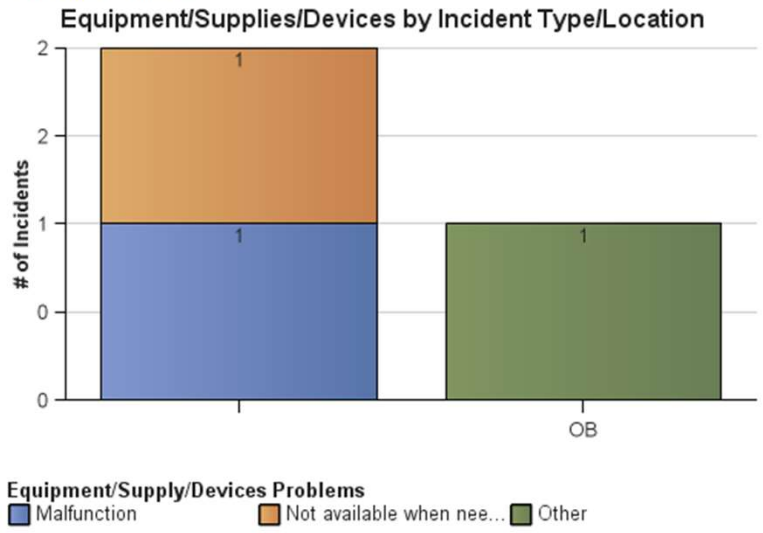
None Selected	4
Duplicated	1
EHR functionality	3
Fill error	1
Omitted	8
Other	7
Outdated drug	2
RN documentation	3
Wrong dose	6
Wrong medication	6
Wrong patient	1
Wrong time	2
Total	**44**

Total numbers of errors and occurrences are not equal to the indicators since some error/occurrences have more than one indicator.





No Data Available



Robbin Cromer-Tyler, MD FACS

152 Pioneer Lane, STE G

Bishop, CA 93514

October 27, 2024

To the members of the Board of Directors of Northern Inyo Hospital District

In 2017, I expanded my corporation, Robbin Cromer-Tyler, MD Inc to enable physicians here to receive benefits such as health insurance, a 401K, disability insurance and some support for CME (Continued Medical Education). It was time consuming and stressful. As I am to be 65 next year, I have looked to find someone within the employed physicians to assume the fiduciary and business responsibilities. Dr Bo Loy, MD has sought out this challenge. He will be assuming ownership and be the CEO as of Nov 15, 2024. This will continue the work of the corporation and allow me to reduce my stress. I will not be retiring next year.

Thank You,

Robbin Cromer-Tyler, MD

CEO

Robbin Cromer-Tyler, MD Inc

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

Date: June 7, 2024

Title: **Regulatory "Hot Topics" and Regulatory Changes for 2025**

Synopsis: The information on the following pages will provide valuable insight to the Board for regulations that are high focus areas for regulatory agencies. It will also provide insight into some of the regulatory changes that will affect NIHD in 2025.

Prepared by: Patty Dickson
Compliance Officer

Reviewed by: _____
Name
Title of Chief who reviewed

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: _____ Submitted by: _____
Chief Officer

Compliance – Areas of focus for regulatory agencies

Gathered from multiple resources – available upon request

False Claims Act - providers can be liable even if they did not knowingly commit misconduct but rather acted with deliberate ignorance or reckless disregard

No Surprises Act - Among various areas of concern, the requirement to provide good-faith estimates to uninsured and self-pay patients leaves hospitals vulnerable to a dispute resolution process. Patients can pursue that option when the cost of the care episode exceeds the estimate by at least $400. $10,000 Potential penalty per case for noncompliance with provisions pertaining to good-faith estimates in the No Surprises Act. The requirement will become more burdensome whenever HHS implements the provision for convening providers to incorporate projected costs from co-providers on an estimate for a care episode. A potentially overlooked challenge is the gray area between the No Surprises Act and the Emergency Medical Treatment and Labor Act (EMTALA). Under EMTALA], somebody comes in on an emergency basis, and providers are not even allowed to ask, 'Do you have insurance?' until the patient is stabilized.

HIPAA impacts from the Dobbs decision - HIPAA's core privacy regulations were updated in a proposed rule drafted by the Trump administration and released in early 2021, but implementation has been delayed ever since. There's still an expectation that the new rules will take effect, quite possibly this year. In April 2023, HHS released a proposed rule "to prevent an individual's information from being disclosed to investigate, sue or prosecute an individual, a healthcare provider or a loved one simply because that person sought, obtained, provided or facilitated legal reproductive healthcare, including abortion."

Artificial Intelligence and Machine Learning - Artificial intelligence and machine learning have the potential to revolutionize the healthcare industry by improving patient outcomes and reducing costs. Compliance professionals must ensure that their organizations use AI and machine learning in a way that is ethical and transparent. They must also be aware of any regulatory guidelines related to these technologies. These include the FDA's recent guidance on AI in healthcare. Another challenge is the sheer volume of data that healthcare organizations are generating. Compliance professionals must be able to collect, analyze, and report on this data in a way that is efficient and effective. This requires access to sophisticated data analytics tools and a deep understanding of how to use them.

Hospital Price Transparency - CMS is working to ensure that all hospitals comply with hospital price transparency requirements. In November 2023, CMS finalized changes to the hospital price transparency regulations, which will take effect on January 1, 2024. The changes include improved accessibility, standardization of files and data elements, and strengthened enforcement capabilities. There are additional changes for pharmaceutical pricing effective January 1, 2025.

Online Tracking Technologies - Tracking technologies are used to collect and analyze information about how users interact with regulated entities' websites or mobile applications ("apps"). Regulated entities are not permitted to use tracking technologies in a manner that would result in impermissible disclosures of PHI to tracking technology vendors or any other violations of the HIPAA Rules.

Regulatory Changes and Hot Topics

Additional information available upon requestc

2025 California Legislative Updates

Summaries of individual bills may not include all aspects of their provisions; therefore, for a full understanding of the legislation, the bill itself should be reviewed in its entirety. This is a summary of information provided by NIHD's General Liability Provider.

AB 3030 Patient Communication

This bill requires healthcare entities that use generative artificial intelligence (AI) to generate written or verbal patient communications about clinical information to ensure those communications include a disclaimer that AI is used and clear instructions on how the patient may contact a human healthcare provider or employee. All communication read and reviewed by a human licensed or certified healthcare provider is exempt.

Health Care Minimum Wage Provisions – SB 159

This omnibus bill further delays the healthcare minimum wage increases and amends various terms related to healthcare minimum wage provisions.

Syndromic Surveillance

This bill authorizes the California Department of Public Health (CDPH) to develop and administer a syndromic surveillance system to collect public health and medical data in near real-time, detect and investigate changes in disease occurrences, and support responses to emerging public health threats.

Medi-Cal Program

The bill establishes the Medi-Cal Provider Payment Increases and Investments (PPI) Act to, among other things, improve access to high-quality care for Medi-Cal members and promote provider participation in the Medi-Cal program. The bill contains numerous other provisions related to various state agencies, including those related to the Department of Industrial Relations, Health Care Information and Access (HCAI), the California Department of Health Care Services, the California Health Benefit Exchange (Covered California), the Department of Justice, the Department of Managed Health Care, and the State Department of State Hospitals, among others.

AB 177

The bill, upon appropriation or availability of funds, authorizes the Department of Health Care Services (DHCS) and the California Department of Public Health (CDPH) to develop and implement a Hospital, Emergency Medical Services, and Behavioral Health Facilities Bed Capacity Data Solution to monitor bed capacity in near real-time in specified entities, with the goal of facilitating patient transfers and placement to reduce morbidity and mortality. To that end, the bill requires general acute care hospitals, emergency departments, and behavioral health facilities to submit information on the availability of beds for inclusion in the data solution.

Chemical Dependency Recovery Services – AB 2376

This bill expands access to chemical dependency recovery services by broadening the definition of such services, and expanding the locations in which the services may be offered. The bill expands the meaning of "chemical dependency recovery services" to include medications for addiction treatment and medically supervised voluntary inpatient detoxification. The bill expands locations by deleting an existing law requirement for chemical dependency recovery as a supplemental service to be provided in a distinct part of a general acute care hospital or acute psychiatric hospital. The bill also authorizes chemical dependency recovery services to be provided in a general acute care hospital or acute psychiatric hospital without a distinct part, or outside the hospital's distinct part, in beds that are licensed for a service other than chemical dependency recovery if certain staffing competencies and ratios are satisfied.

Prehospital Emergency Medical Care – AB 2225

This bill adds "prehospital emergency medical care person or personnel" to the list of health care professionals whose organized peer review committee proceedings and records are exempt from discovery in a civil action, and states that a person in attendance at a meeting of such a committee shall not be required to testify in a civil action as to what transpired at the meeting. The bill specifies that this amendment does not exclude the discovery or use of relevant evidence in a criminal action.

Hospital and Emergency Physician Fair Pricing Policies – AB 2297

This bill amends existing law which requires a general acute care hospital, acute psychiatric hospital, or special hospital (collectively hospital) to maintain a written "charity care" policy and a "discount payment" policy for uninsured patients or patients with high medical costs whose family income does not exceed 400 percent of the federal poverty level. The bill also amends provisions related to a requirement for an emergency physician who provides emergency medical services in a general acute care hospital to provide discounts to uninsured patients or patients with high medical costs who are at or below 350 percent of the federal poverty level. The bill defines "charity care" to mean free care, and "discounted payment" or "discount payment" to mean any charge for care that is reduced but not free. The bill prohibits a hospital from considering the monetary assets of the patient in determining eligibility for both the charity care and the discount payment policies but authorizes the hospital to consider the availability of a health savings account held by the patient or the patient's family.

The bill specifies that for purposes of determining eligibility for charity care or discounted payment, documentation of income must be limited to recent pay stubs or income tax returns, and permits a hospital to accept other forms of documentation, but must not require those other forms. The bill requires a hospital to determine eligibility for charity care or discounted payments at any time the hospital is in receipt of recent pay stubs, income tax returns, or other forms of documentation. The bill prohibits a hospital from imposing time limits for applying for charity care or discounted payments and prohibits a hospital from denying eligibility based on the timing of a patient's application.

Medical Debt - SB1061

This bill prohibits a consumer credit reporting agency or an investigative consumer reporting agency from making a consumer credit report or an investigative consumer report containing information of "medical debt," defined in the bill as a debt owed by a consumer to a person whose primary business is providing medical services, products, or devices for the provision of such medical services, products, or devices, as specified. The bill requires a hospital to maintain all records relating to money owed to the hospital by a patient or a patient's guarantor for five years, including documents related to litigation filed by the hospital, or a contract and significant related records by which the hospital assigns or sells medical

debt to a third party. The bill further requires any contract entered into by a hospital related to the assignment or sale of medical debt to require the assignee or buyer and any subsequent assignee or buyer to maintain records related to litigation for five years.

Controlled Substances Patient Education – SB 607

This bill expands an existing requirement for prescribers to discuss specified information about the risks associated with opioid use and addiction when issuing or dispensing opioids to a minor patient to require that discussion to occur regardless of the patient's age. The bill exempts patients currently receiving hospice care from the discussion requirement. The bill removes an exemption from the discussion requirement for patients who are being treated for a diagnosis of chronic intractable pain.

Prescribing and Dispensing – AB2115

This bill, effective September 27, 2024, authorizes a practitioner, including, in part, a physician, pharmacist, nurse practitioner, or physician assistant, to dispense no more than a 3-day supply of a Schedule II controlled substance, which may be from a hospital pharmacy inventory, directly to an ultimate user for the purpose of initiating maintenance treatment or detoxification treatment for a person with an opioid use disorder. The bill specifies that the controlled substance must be dispensed at one time while arrangements are being made for referral for treatment, and prohibits such emergency treatment from being renewed or extended.

The bill requires the California State Board of Pharmacy (BOP) to amend specified state regulations regarding narcotic treatment programs to comply with federal regulations pertaining to dispensing of narcotic drugs for maintenance treatment or detoxification treatment, and requires the BOP to adopt these regulations by April 30, 2029. The bill removes a requirement that take-home doses of narcotic replacement therapy medications be provided only when daily attendance at a narcotic treatment program clinic would be incompatible with gainful employment, education, responsible homemaking, retirement, or medical disability.

Disclosure of Patient Information, Sexual Orientation, Gender Identity, Intersex Status – SB 957

This bill amends state law that requires health care providers and other specified entities to disclose certain immunization information from a patient's or client's medical record to local health departments and the California Department of Public Health (CDPH). The bill adds an adult patient's or client's sexual orientation, gender identity, and variations in sex characteristics/intersex status (SOGISC), and sex assigned at birth to the list of information subject to disclosure. The bill specifies that a health care provider is only required to disclose SOGISC information that is voluntarily provided by the patient or client. The bill expressly prohibits a health care provider from disclosing any SOGISC information related to a patient or client who is under 18 years of age.

Paid Family Leave Program – AB 2123

This bill relates to the California Paid Family Leave Program, which allows for wage replacement benefits to workers who take time off work to care for certain seriously ill family members, to bond with a minor child within one year of birth or placement, or to participate in a qualifying exigency related to the covered active duty or call to covered active duty of certain family members. The bill removes an existing authorization for an employer to require an employee to take up to two weeks of earned but unused

vacation before accessing their benefits under the Paid Family Leave Program by specifying that it shall not apply to any period of disability commencing on or after January 1, 2025.

Religious or Political Matters- SB 399

This bill enacts the California Worker Freedom from Employer Intimidation Act, to prohibit an employer from subjecting, or threatening to subject, an employee to discharge, discrimination, retaliation, or any other adverse action because the employee declines to attend an employer-sponsored meeting or

affirmatively declines to participate in, receive, or listen to any communications with the employer or its agents or representatives, the purpose of which is to communicate the employer's opinion about religious or political matters. The bill provides that an employee who is working at the time of such a meeting and elects not to attend must continue to be paid while the meeting is held.

Healing Arts Professions – Continuing Medical Education AB 3119

This bill requires the Medical Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, and the Physician Assistant Board to consider including in their continuing medical education requirements for physicians and surgeons, osteopathic physicians and surgeons, nurse practitioners, and physician assistants, as applicable, a course in infection-associated chronic conditions, including, but not limited to, long COVID, myalgic encephalomyelitis, and dysautonomia.

Medical Professionals: Course Requirements - Senate Bill 639

This bill requires all general internists and family physicians, nurse practitioners, and physician assistants with a patient population where 25 percent of their patients are 65 years or older to complete at least 20 percent of their continuing medical education (CME) or continuing education (CE) requirements in the field of gerontology, the special care needs of patients with dementia, or the care of older patients.

National Provider Identifier - Assembly Bill 1991

This bill requires healing arts boards to require a licensee or registrant who electronically renews their license or registration to provide to that board the licensee's or registrant's individual National Provider Identifier, if they have one.

Professional Licensing Boards -Senate Bill 1451

As to licensees of the Medical Board of California, the bill requires an initial physician's and surgeon's license issued on or after January 1, 2025, to be for a period of 26 months, rather than 24 months. The bill also authorizes a physician's and surgeon's certificate issued on or after January 1, 2022, to be renewed for the first time if the Medical Board of California (MBC) receives evidence that the licensee is enrolled in a California MBC-approved postgraduate training program at the time the license expires. The bill requires the relevant postgraduate training program director to report to the MBC within 30 days if a licensee who renews their license for the first time pursuant to these provisions is disenrolled from their training program, as specified. The bill contains other related provisions.

The bill adds "D.O" to the list of prohibited terms for which it is a misdemeanor for a person to use to imply that they are authorized to practice medicine. The bill, except as specified, also prohibits a person from using the words "doctor" or "physician," the letters or prefix "Dr.," the initials "M.D." or "D.O.," or any other terms or letters indicating or implying that the person is a physician and surgeon, physician,

surgeon, or practitioner in a health care setting that would lead a reasonable patient to determine that the person is a licensed "M.D." or "D.O."

The bill contains other provisions related to licensees of the Dental Board of California, the Board of Registered Nursing, the California State Board of Pharmacy, and the Respiratory Care Board, along with other non-health professional licensing boards such as the State Board of Barbering and Cosmetology and the Structural Pest Control Board.

"**Three-Day Rule" - Senate Bill 1468**

This bill relates to the federal Drug Enforcement Administration's "Three Day Rule" (21 CFR 1306.07(b)), which authorizes a practitioner who is not specifically registered to conduct a narcotic treatment program to dispense not more than a three-day supply of narcotic drugs, in accordance with applicable federal, state, and local laws, to one person or for one person's use at one time for the purpose of initiating maintenance treatment or detoxification treatment while arrangements are being made for referral for treatment, as specified.

Claim Reimbursement - Assembly Bill 3275

The bill, beginning January 1, 2026, requires a health care service plan, including a Medi-Cal managed care plan, or health insurer to reimburse a complete claim or a portion thereof within 30 calendar days after receipt of the claim, or, if a claim or portion thereof does not meet the criteria for a complete claim or portion thereof, to notify the claimant as soon as practicable, but no later than 30 calendar days that the claim or portion thereof is contested or denied.

Coverage for PANDAS and PANS - Assembly Bill 2105

This bill requires a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2025, to provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon and is medically necessary, as specified.

Immediate Postpartum Contraception - Assembly Bill 2129

This bill requires a contract between a health care service plan or health insurer and a health care provider issued, amended, or renewed on or after January 1, 2025, to authorize a provider to separately bill for devices, implants, or professional services, or a combination thereof, associated with "immediate postpartum contraception" if the birth takes place in a general acute care hospital or licensed birth center.

Infertility and Fertility Services - Senate Bill 729

This bill requires large group health care service plan contracts and large group disability insurance policies issued, amended, or renewed on or after July 1, 2025, to provide coverage for the diagnosis and treatment of infertility and fertility services, including a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with specified guidelines, using single embryo transfer when recommended and medically appropriate.

The bill requires small group health care service plan contracts and small group disability insurance policies, except as specified, issued, amended, or renewed on or after July 1, 2025, to offer coverage for

the diagnosis and treatment of infertility and fertility services. The bill explicitly states that this provision is not to be construed to require such plans or policies to provide coverage for infertility services.

Medication-Assisted Treatment - Assembly Bill 1842

This bill requires a group or individual health care service plan or health insurer offering an outpatient prescription drug benefit to provide coverage without prior authorization, step therapy, or utilization review for at least one medication approved by the United States Food and Drug Administration in each of the following categories: (1) medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist; (2) medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product; (3) a long-acting buprenorphine product; and (4) a long-acting injectable naltrexone product.

Rape and Sexual Assault - Assembly Bill 2843

This bill requires a health care service plan or health insurance policy that is issued, amended, renewed, or delivered on or after July 1, 2025, to provide coverage for emergency room medical care and follow-up health care treatment for an enrollee or insured who is treated following a rape or sexual assault, without imposing cost sharing, including copayments, coinsurance, or deductibles, for the first nine months after the enrollee initiates treatment.

The bill prohibits a health care service plan or health insurer from requiring, as a condition of providing coverage: (1) an enrollee or insured to file a police report; (2) charges to be brought against an assailant; or (3) an assailant to be convicted of rape or sexual assault.

Closure: Psychiatric and Perinatal Services - Senate Bill 1300

This bill requires a general acute care hospital or acute psychiatric hospital (collectively hospital) to provide public notice 120 days, rather than 90 days, prior to eliminating a supplemental service of an inpatient psychiatric unit or perinatal unit. The bill requires the hospital to provide public notice of the proposed elimination of the supplement service, including a notice posted at the entrance of all affected facilities, a notice to all contracted Medi-Cal managed care plans, and a notice to the California Department of Public Health and the board of supervisors of the county in which the hospital is located. The bill requires the public notice to contain specified information, including, in part, statistically deidentified and aggregated data about the hospital's patients who received either inpatient psychiatric services or perinatal services, as applicable, within the past five years, including, among other things, the conditions treated and a justification for the hospital's decision to eliminate the services.

The bill also requires the hospital to conduct at least one noticed public hearing within 60 days of providing public notice of the proposed elimination of the inpatient psychiatric unit or perinatal unit and requires the hospital to accept public comment. The bill directs the hospital to post a public hearing notice and the public hearing agenda alongside its public notice for the elimination of the inpatient psychiatric unit or perinatal unit.

Emergency Departments - Assembly Bill 977

This bill makes an assault or battery committed against a physician, nurse, or other health care worker of a licensed hospital engaged in providing services within an emergency department, when the person

committing the offense knows or reasonably should know that the victim is a physician, nurse, or other health care worker of a hospital providing services within the emergency department, punishable by imprisonment in a county jail not exceeding one year, by a fine not exceeding $2,000, or by both that fine and imprisonment.

The bill permits a licensed hospital, as provided, that maintains and operates an emergency department to post a notice in a conspicuous place in the emergency department stating: "WE WILL NOT TOLERATE any form of threatening or aggressive behavior toward our staff. Assaults and batteries against our staff are crimes and may result in a criminal conviction."

Health Omnibus - Senate Bill 1511

This bill is an omnibus measure meant to implement non-controversial, non-substantive changes to a number of statutes in the Health and Safety Code and the Welfare and Institutions Code. Among other things, the bill amends the Compassionate Access to Medical Cannabis Act (Act), also known as Ryan's Law, to clarify that a general acute care hospital is required to permit patients who have a chronic condition to use medicinal cannabis when they are also terminally ill.

The bill contains other amendments to fix various technical errors in numbering of the Health and Safety Code, add clarifying language to slightly ambiguous phrases, allot appropriate periods for agencies to access administrative funding for the Distressed Hospital Program, specify funding for the LEA (local educational agency) Medi-Cal Billing Option program, update the definition of "gravely disabled," in the Lanterman-Petris-Short Act, implement accountability measures in the fetal death registration process, and align state law with federal law regarding third party liability.

Patient Safety and Antidiscrimination - Assembly Bill 3161

This bill amends existing law that requires a general acute care hospital, acute psychiatric hospital, skilled nursing facility, and special hospital (collectively, health facility) to implement a patient safety plan, including a patient safety event reporting system. Among other things, the bill requires a health facility to include in its patient safety event reporting system an option by which a person may anonymously report a patient safety event.

The bill also requires a health facility to analyze patient safety events by specified sociodemographic factors to identify disparities in these events. The bill states the intent of the Legislature that a health facility use prescribed stratification categories for this requirement and that a health facility, for certain sociodemographic factors, only be required to disclose information that is voluntarily provided by the patient or client.

The bill further requires a health facility patient safety plan to include a process for addressing racism and discrimination and its impacts on patient health and safety, including monitoring sociodemographic disparities in patient safety events and developing interventions to remedy known disparities, and encouraging facility staff to report suspected instances of racism and discrimination.

The bill, beginning January 1, 2026, and biannually thereafter, requires a health facility to submit its patient safety plans to the California Department of Public Health's (CDPH) licensing and certification division. The bill authorizes the CDPH to impose a fine not to exceed $5,000 on a health facility for failure to adopt, update, or submit patient safety plans, and permits the CDPH to grant an automatic 60-day

extension to submit biannual patient safety plans. The bill requires the CDPH to make all patient safety plans submitted by health facilities available to the public on its internet website.

Terminal Illness Diagnosis - Assembly Bill 1005

This bill requires a general acute care hospital's designated case manager or discharge planner prior to the discharge from the hospital of a Medi-Cal beneficiary diagnosed with a terminal illness, to evaluate the patient's likely need for posthospital services and their ability to access those services.

Human Immunodeficiency Virus - Preexposure and Postexposure Prophylaxis - Senate Bill 339

This bill, effective February 6, 2024, authorizes a pharmacist to furnish up to a 90-day course of preexposure prophylaxis (PrEP), or PrEP beyond a 90-day course, if specified conditions are met. The bill would require the California State Board of Pharmacy to adopt emergency regulations to implement these provisions by October 31, 2024.

The bill requires a health care service plan and health insurer to cover PrEP and postexposure prophylaxis (PEP) furnished by a pharmacist, including costs for the pharmacist’s services and related testing ordered by a pharmacist at an in-network pharmacy or a pharmacist at an out-of-network pharmacy if the health care service plan has an out-of-network pharmacy benefit.

Human Milk, Requirements: Hospitals - Assembly Bill 3059

This bill provides that a general acute care hospital is not required to have a license to operate a tissue bank to store or distribute pasteurized donor human milk that was obtained from a tissue bank licensed by the California Department of Public Health (CDPH).

The bill also provides that a hospital storing or distributing human milk obtained from a licensed tissue bank is exempt from tissue bank licensing requirements, but requires such hospitals to comply with the most current standards established for the collection, processing, storage, or distribution of human milk by the Human Milk Banking Association of North America, or other standards approved by the CDPH. The bill states that hospitals that collect, process, store, or distribute human milk in any other circumstance must obtain a tissue bank license.

Human Trafficking or Domestic Violence, Requirements: Emergency Departments - Senate Bill 963

This bill requires all general acute care hospitals with an emergency department to adopt and implement policies and procedures to facilitate the self-identification of an emergency department patient as a victim of human trafficking or domestic violence to hospital personnel. The bill requires the policies and procedures to meet specified minimum requirements, including providing the patient with a safe and discreet means of informing hospital personnel that they are a victim of human trafficking or domestic violence, and providing patients who self-identify with information to local resources and services for victims of human trafficking or domestic violence.

Intravenous Solution Containers and Tubing - Assembly Bill 2300

This bill, commencing January 1, 2030, prohibits a person or entity from manufacturing, selling, or distributing into commerce in California certain intravenous solution containers made with intentionally

added Di-(2-ethylhexyl) phthalate (DEHP). The bill extends the deadline to January 1, 2032, for a person or entity who has a pending United States Food and Drug Administration approval for the DEHP-free intravenous solution container or who does not have adequate equipment to manufacture a DEHP-free intravenous solution container, if other specified requirements are met, including providing notice of the delay to customers.

Medical Evidentiary Examinations, Sexual Assault - Assembly Bill 2730

This bill amends current law which requires a "qualified health care professional" to conduct an examination for evidence of a sexual assault or an attempted sexual assault. The bill revises the meaning of "qualified health care professional" to include a certified nurse-midwife working in consultation with a licensed physician and surgeon. The bill also updates the meaning of "qualified health care professional" as it pertains to a nurse, nurse practitioner, or physician assistant by deleting the requirement that the licensed physician and surgeon with whom they consult conduct examinations or provide treatment in a general acute care hospital or a physician and surgeon's office.

Community Health Workers: Supervising Providers - Senate Bill 1385

This bill requires a Medi-Cal managed care plan, no later than July 1, 2025, to adopt policies and procedures to effectuate a billing pathway for "supervising providers," including contracted hospitals, to claim for the provision of community health worker services to enrollees during an emergency department visit and an outpatient follow-up to an emergency department visit. The bill requires that the policies and procedures be consistent with guidance developed by the California Department of Health Care Services (DHCS). The bill requires the DHCS, not later than July 1, 2025, to develop guidance on policies and procedures to be used by supervising providers, including contracted hospitals, to claim for community health worker services to Medi-Cal members under the fee-for-service delivery system during an emergency department visit and as an outpatient follow-up to an emergency department visit.

Mental Health, Involuntary Treatment: Patient's Rights - Assembly Bill 2154

This bill requires a facility in which a person is involuntarily detained for assessment, evaluation, or treatment to offer and provide a copy of the California Department of Health Care Services' prepared patient's rights handbook to the detained person's family member if: (1) the detained person authorizes the disclosure of their detainment information; (2) the family member is physically present at the facility and has knowledge that the individual is involuntarily detained there; (3) the family member has been notified of the person's presence in the facility, as specified; or (4) the detained person has consented to the family member being provided the handbook.

Overdose Fatality Review Teams, Establishment - Assembly Bill 2871

This bill authorizes a county or regional group of counties to establish an interagency overdose fatality review team (review team) to assist local agencies in identifying and reviewing overdose fatalities, facilitate communication among the various persons and agencies involved in overdose fatalities, and integrate local overdose prevention efforts through strategic planning, data dissemination, and community collaboration.

The bill requires a provider of health care or a covered entity, as defined, to provide a county review team with any information, including protected health information and mental health records, excluding psychotherapy notes, in its possession that is directly related to the review about the individual involved

in the case. The bill states that the provision of information under this section is a disclosure required by law, and must be made only to the extent permitted under federal regulations, as specified. The bill also states that the information shall include substance use disorder patient records only to the extent permitted by specified federal law.

Pharmacy, Prescription Drug Labels - Assembly Bill 1902

This bill requires pharmacies to, upon being informed that a patient identifies as being blind, having low-vision, or being otherwise print-disabled, provide the person, at no additional cost, an accessible prescription label affixed to the container that meets specified requirements, including, in part, is appropriate to the disability and language of the requesting person by use of audible, large print, Braille, or translated directions as required by state law. The bill also requires a dispenser to ensure that the prescription label is compatible with the prescription reader if a reader is provided.

Licensure Requirements: Disclosure - Assembly Bill 2164

This bill prohibits the Medical Board of California (MBC) from requiring an applicant for a physician's and surgeon's license or a physician's and surgeon's postgraduate training license to disclose a condition or disorder: (1) that does not impair the applicant's ability to practice medicine safely; or (2) for which the applicant is receiving appropriate treatment and which, as a result of treatment, does not impair the applicant's ability to practice medicine safely.

Psychiatric Emergency Medical Conditions, Emergency Services -Assembly Bill 1316

This bill revises the definition of "psychiatric emergency medical condition" to make the definition applicable regardless of whether the patient is voluntary or involuntarily detained, defining the term to mean: a mental health disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following, regardless of whether the patient is voluntarily or involuntarily detained for assessment, evaluation, and crisis intervention, or placement for evaluation and treatment pursuant to the Lanterman-Petris-Short (LPS) Act: (a) an immediate danger to themselves or others; or (b) immediately unable to provide for, or utilize, food, shelter, or clothing due to the mental health disorder. The bill specifies that its provisions do not require a transfer or admission that conflicts with the requirements of the LPS Act or the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

Reproductive Health Services. Crimes Assembly Bill 2099

This bill increases penalties for violations of the California Freedom of Access to Clinics and Church Entrances (FACCE) Act and other crimes against reproductive health care services patients, providers, or others. As to the FACCE, existing law prohibits specified actions that, by force, threat of force, or physical obstruction, impede access to reproductive health services facilities, and specifies the penalties for a violation, including imprisonment as a misdemeanor and specified fines. This bill increases the penalties for FACCE violations, including making specified violations punishable as either a misdemeanor or as a felony, with potential imprisonment of up to 16 months, or two or three years.

The bill also increases the penalty for the offense of posting on the internet or social media the personal information or image of a reproductive health care services patient, provider, or assistant, or other individuals residing at the same home address, with the intent that another person imminently use that information to commit a crime involving violence or a threat of violence against the reproductive health

care services patient, provider, or assistant, or other individuals residing at the same home address. The bill increases this crime from a misdemeanor to an alternate misdemeanor-felony punishable by up to one year in the county jail, or 16 months, or two or three years, and continues to allow a fine of up to $10,000 per violation, or both the fine and imprisonment. The bill makes the violation a felony, rather than a misdemeanor, if bodily injury occurs, punishable by imprisonment for 16 months, or two or three years, rather than one year, or a fine of up to $50,000, or both the fine and imprisonment.

Compliance Deadline - Assembly Bill 869

This bill authorizes a Distressed Hospital Loan Program recipient, a small hospital, a rural hospital, a critical access hospital, or a health care district hospital, except as specified, to seek approval from the Department of Health Care Access and Information (HCAI) for a delay of up to three years from the January 1, 2030, deadline for compliance with seismic safety building standards for all acute care inpatient hospitals.

Tuberculosis, Screening - Assembly Bill 2132

This bill requires a patient who is 18 years of age or older receiving health care services in a facility, clinic, center, office, or other setting, where primary care services are provided, to be offered tuberculosis screening if tuberculosis risk factors are identified, to the extent these services are covered under the patient's health care coverage. The bill specifies exceptions to this requirement, including, in part, the patient is being treated for a life-threatening emergency, or the patient lacks the capacity to consent, and consent cannot be obtained from a person legally authorized to make medical decisions on the patient's behalf.

Workplace Violence Prevention Plan, Weapons Detection - Assembly Bill 2975

This bill requires the California Occupational Safety and Health Standards Board, by March 1, 2027, to amend the workplace violence prevention in health care standards (standards) to require certain licensed hospitals to implement a weapons detection screening policy that requires the use of weapons detection devices that automatically screen a person's body at the hospital's main public entrance, at the emergency department entrance, and at the labor and delivery department entrance, if separately accessible to the public. The bill specifies that this requirement does not apply to the hospital's ambulance entrance.

The bill requires a hospital's weapons detection screening policy to include security mechanisms, devices, or technology designed to screen and identify instruments capable of inflicting death or serious bodily injury. The bill specifies that while handheld metal detector wands may be used in connection with other weapons detection devices, they may not be the sole equipment used, except as provided.

The bill mandates that the standards include a requirement that a hospital assign appropriate personnel, other than a health care provider, who meet specified training standards to implement the weapons detection screening policy, including the monitoring and operation of the weapons detection devices.

The bill directs that the standards must also require hospital weapons detection screening policies to include certain elements, including, in part, reasonable protocols addressing how the hospital will respond if a dangerous weapon is detected, and alternative search and screening for patients, family, or visitors who refuse to undergo weapons detection device screening.

The bill further requires the standards to include a requirement for hospitals to post, in a conspicuous

location, within reasonable proximity of any public entrances where weapons detection devices are utilized, a notice advising the public that the hospital conducts screenings for weapons upon entry but that no person shall be refused medical care, pursuant to the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

2025 Federal Legislative Updates

CMS published its FY 2025 Medicare Hospital Inpatient Prospective Payment System (IPPS) final rule on August 1, 2024.

CMS has finalized new health and safety requirements for hospitals and CAHs providing obstetrical services, which set baseline standards for the organization, staffing, and delivery of care within obstetrical units, update the quality assessment and performance improvement (QAPI) program, and require staff training on evidence-based maternal health practices. Hospitals and CAHs that provide OB services must use their QAPI programs to improve health outcomes and disparities

Hospitals and CAHs with emergency services must have protocols and provisions to meet patient needs. This includes having equipment, supplies, and medication for emergency cases. Staff must also be trained on these protocols annually.

HIPAA and 42 CFR Part 2 (Confidentiality of Substance Use Disorder Patient Records) changes

https://www.hipaajournal.com/hipaa-updates-hipaa-changes/

On February 8, 2024, a Final Rule was published by the HHS which took effect on April 16, 2024. All persons subject to the regulation must ensure full compliance by February 16, 2025.

- Single patient consent for all future uses and disclosures of SUD records for treatment, payment, and healthcare operations.
- Segregation of Part 2 records is not required
- HIPAA-regulated entities are permitted to re-disclose SUD records received under that consent in accordance with the HIPAA Privacy Rule
- Disclosure of patient records to public health authorities is permitted, if they have been unidentified in accordance with HIPAA standards
- Patients will be able to obtain an accounting of disclosures of their SUD records and request restrictions on certain disclosures
- Part 2 programs must establish a complaints process about Part 2 violations and must not require patients to waive the right to file a complaint as a condition of providing treatment, enrollment, payment, or eligibility for services
- The HIPAA Breach Notification Rule requirements will also apply to Part 2 records
- The Part 2 Patient Notice requirements now align with the HIPAA Privacy Rule Notice of Privacy Practices requirements
- The HHS will be able to impose civil money penalties for violations of Part 2, in line with HIPAA and the HITECH Act
- Restriction of the use of records and testimony in civil, criminal, administrative, and legislative proceedings against patients, absent patient consent or a court order
- A safe harbor requires investigative agencies to take steps in the event that they discover they have received Part 2 records without having first obtained the required court order.

Section §164.512(e) of the HIPAA Privacy Rule permits but does not require disclosures of PHI in extraterritorial civil, criminal, or administrative investigations or proceedings. In April 2023, OCR published an NPRM to strengthen reproductive health information privacy, and a final rule was issued in April 2024, which took effect on June 25, 2024, and will be enforced from December 23, 2024.

The final rule "prohibits a regulated entity from using or disclosing an individual's PHI for the purpose of conducting a criminal, civil, or administrative investigation into or imposing criminal, civil, or administrative liability on any person for the mere act of seeking, obtaining, providing, or facilitating reproductive health care that is lawful under the circumstances in which it is provided," and prohibits the identification of any person for the purpose of conducting such an investigation or imposing such liability. These prohibitions apply to all HIPAA-regulated entities where reproductive health care is lawful in the state it is provided or reproductive health care is protected, required, or authorized by federal law, regardless of the state in which it is provided.

The final rule includes a new category of uses and disclosures – "Attested uses and disclosures." Under the new category, recipients of PHI will have to attest that it will not be further used or disclosed for prohibited purposes – i.e., in the case of reproductive health care, to support a civil, criminal, or administrative investigation or proceeding. HIPAA-regulated entities will be required to obtain a signed attestation from the requester of the PHI that it will not be used for a prohibited purpose, which will apply to health oversight activities, judicial and administrative proceedings, law enforcement purposes, and disclosures to coroners and medical examiners. HIPAA-regulated entities will be required to update their Notice of Privacy Practices to reflect the changes. The Notice of Privacy Practices requirement has a different compliance date, matching the compliance deadline for the Part 2 update – February 16, 2025.

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

DATE: November 2024

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Andrea Mossman, Chief Financial Officer

RE: Financial Summary and Operation Insights as of September 2024

Financial Summary

1. Net Income: September's net income was $533k higher than budget due to lower than budgeted expenses primarily in wages, benefits, and contract labor. For the year, net income was $1.44M higher than prior year-to-date due to lower expenses.
2. Operating Income: September's operating income was $484k higher than budget due to lower than budgeted expenses primarily in wages, benefits, and contract labor. For the year, operating income was $1.04M higher than prior year-to-date due to lower expenses.
3. Earnings Before Interest, Depreciation, and Amortization (EBIDA): September's EBIDA was $610k higher than budget due to lower than budgeted expenses primarily in wages, benefits, and contract labor. For the year, EBIDA was $1.79M higher than prior year-to-date.
4. Revenue Breakdown: September's gross revenue was $1.9M higher than budget. For the year, gross revenue was $5.7M higher than prior year-to-date. September's net revenue was $(648k) lower than budget. For the year, net revenue was $(6.55M) lower than prior year-to-date. Rates updated since it was the end of the quarter causing a decline in net patient revenue. Overall, net revenue percentage of gross revenue is in line with trend at 47%.

Deductions Summary

1. Contractual Adjustments: Contractual discounts were higher due to increased gross revenue but were in line with trend when reviewed as a percentage of gross revenue.
2. Bad Debt: For September, bad debt was higher due to Account Receivable (AR) cleanup. However, for the year, bad debt was in line with budget.
3. Write-offs: Other write-offs were lower than budget and prior year.

Salaries

1. Per Adjusted Patient Day / Adjusted Employee per Occupied Bed (Adjusted EPOB): Wages and full-time equivalents remained relatively consistent with prior year while volume increased which caused wages per patient to be lower. This indicated we operated more efficiently compared to last year.
2. Total Salaries: Wages were flat to budget and were lower than last September. For the year, wages were lower than prior year-to-date.
3. Average Hourly Rate: Average hourly rate was lower than budget and consistent with prior year-to-date.

Benefits

1. Total Benefits: For September, total benefits were lower than budget due to less paid time off and payroll taxes. For the year, benefits were lower than budget due to lower medical, dental, and vision expenses.
2. Benefits % of Wages: For September, we were at 48% of wages. For the year, we were at 46% of wages, which was lower than prior year by (13%).

Total Salaries, Wages and Benefits (SWB)

1. Salaries, Wages and Benefits (SWB) / Adjusted Patient Day: For September, we were (9%) under budget and (10%) under last September. For the year, we were (13%) under budget and (3%) under prior year-to-date. This was due to higher volume meaning we were more productive.
2. Salaries, Wages and Benefits (SWB) % of Total Expenses: For September, we were consistent with budget. For the year, we were lower than budget but higher than prior year. This was due to overall expenses being lower this year with declines in areas such as supplies. For the year, we were at 53% and our goal was 50%.

Contract Labor

1. Contract Labor Expense: For September, we had a credit of $(113k) in expense due to over-accruals in August reversing out. This caused us to be under budget and prior year. For the year, contract labor expense is over budget due to staffing challenges and increased volume but we were under prior year-to-date by $(404k).
2. Contract Labor Rates: For the year, contract labor rates are higher than budget but they were (27%) lower than prior year-to-date. We will continue to evaluation and negotiate rates based on market.
3. Contract Labor Full-Time Equivalents (FTEs): For the year, contract labor is consistent with prior year-to-date.

Other Expenses

1. Physician Expense / Adjusted Patient Day: For the year, physician expenses per patient were (23%) under budget and prior year-to-date.
2. Supplies: For the year, supplies were lower than prior year-to-date due to lower pharmacy costs.
3. Total Expenses: For September, total expenses were (11%) lower than budget and (16%) compared to last September. For the year, total expenses were (6%) under prior year-to-date.

Stats Summary

1. Admits (excluding Nursery): For September, admits were up 24% from last September. For the year, admits were up 21% compared to prior year-to-date. This was due to higher deliveries and more emergency department admissions.
2. Inpatient Days (excluding Nursery): For September, inpatient days were up 44% from last September. For the year, inpatient days were up 41% compared to prior year-to-date.
3. Average Daily Census: Average census increased 39% compared to last year.
4. Average Length of Stay (ALOS): Average length of stay increased 15% compared to last year but was still below the maximum for a critical access hospital.
5. Deliveries: For the year, Deliveries were 20% higher than last year-to-date.
6. Surgical Procedures: For September, total surgical procedures were 17% higher than last September. For the year, total surgical procedures were 10% higher than last year-to-date. This was due to higher general surgeries.
7. Emergency Department (ED) Visits: Emergency visits were up 7% compared to last September and were up 5% compared to last year-to-date. This increased our admissions.
8. Diagnostic Imaging (DI) Exams: For September, DI was up 12% compared to last September. For the year, DI was up 2% compared to last year-to-date.
9. Rehab Visits: Rehab visits were up 46% compared to last year-to-date due to better staffing.
10. Outpatient Infusion / Injections / Wound Care Visits: These visits were up 34% compared to last year-to-date.
11. Observation Hours: Observations hours were up 5% compared to last year-to-date.
12. Rural Health Clinic (RHC) Visits: For September, RHC visits were up 2% compared to last September due to women's and behavioral. For the year, RHC visits remained flat compared to last year-to-date.
13. Other Clinics: For the year, all clinics increased 14% due to new providers in surgery and specialty.

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

DATE: November 2024

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Gloria Sacco, Revenue Cycle Consultant

RE: Quarterly Revenue Cycle Updates

Revenue Cycle Director

1. We hired Janai Lind to become our permanent revenue cycle director. She started November 11. She is local to the community and will be onsite full-time. With 25 years in revenue cycle experience, most of which was at Mammoth Hospital, she brings a strong expertise in revenue cycle and Cerner Community Works with her.

Projects

1. Medicare Bad Debt: We hired a consultant to revise our Medicare bad debt listings after our cost report preparer recommend we do this. We will revise several years since they are still open with Medicare. This will bring us additional reimbursement.
2. Underpayment audit: conduct a look back on all accounts underpaid based on our contracts and State Regulation required payments (i.e. workers compensation). The kickoff was in June. However, there were delays in claim data files that slowed down the audit.
3. Charge Capture Audit: Our auditing and cost report firm (CLA) conducted a charge capture audit resulting in opportunities to increase billing in chargeable supplies, contrast, and labor & delivery hours. We are working internally to assess these opportunities.
4. Charge Master Pricing Analysis: NIHD has opportunities to review current prices and compare with market prices including pharmacy prices. We are working internally as a team to work on this project and plan to hire a consultant to assist with market data.
5. Daily Charge Recon: This project went live for the hospital departments in January 2024 and is now institutionalized. We still need to set up a process for the clinics to reconcile their charges daily.

Business Office

1. Overall, AR days reduced from 86 in September 2024 to 73 in October 2024. We decreased AR by $(6.4M) due to writing off aged balances and ensuring self-pay was sent to our vendors to be collected. We will still pursue all avenues of recoupment (denial appeals, collection agencies, etc.)
2. AR over 90 days old decreased by $(3.4M) due to better collection efforts.
3. Discharges not final billed (DNFB) increased due to a Cerner technical issue that is in process of being resolved. Even though claims had been billed, the billing notes did not transfer to Cerner and kept the accounts listed an unbilled when they truly had been billed.
4. Vendor Management:
    a. Novus / Medicaid vendor increased 3% in AR greater than 90 days.
    b. OS Healthcare / all other payors increased 2% in AR greater than 90 days.
    c. MedPlan / Hauge / Self-Pay & Bad debt: Self-pay AR has reduced $(2.4M). We are offering a discount for aged claims if paid by the end of the year to incentivize payment by year end.
    d. Clearinghouse – we changed our clearinghouse from efficientC to CMP (Inovalon). This went live in June. Since then, our clean claim rate is at 50%. The transition caused some delays which we are addressing. Once resolved, claims will be submitted electronically without human intervention.

Patient Access

1. Patient Messaging System (Artera): The new patient messaging system was successful launched and is going well. Patients are text reminders for their upcoming appointments. They can confirm or cancel via text. Patient access will then reschedule any requests.
2. Training: We are continuing to work on cross-training staff to float and cover various areas. Additionally, we are developing a customer service-training plan designed to improve our patient experience scores in patient access.

HIM / Coding

1. No updates from this area at this time

Denials

1. Overall denials reduced from 25% in September 2024 to 17% in October 2024. Our goal is 10%.
2. Clinical denials / medical necessity: We are working through disputing and appealing these as quickly as possible. We will be starting up a denials management workgroup to ensure all denials are assigned and being appealed timely.

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

DATE: November 2024

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Neil Lynch, Purchasing Director

RE: Quarterly Purchasing Department Updates

IV Solutions

1. Purchasing has been working with incident command and vendors to procure IV solutions during the recent shortage.

Longshore man strike

1. East Coast Longshore man strike has had a small impact in supply chain. Workers returned to work under a temporary agreement and shippers continue to send ships to west coast in anticipation of failed negotiations scheduled to end in January.

Capital

1. Purchasing has procured the GE HealthCare Senographe Pristina Mammography system for the Diagnostic Imaging Department.

Northern Inyo Healthcare District

September 2024 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	**Budget**	**Variance**	**Variance %**	**Actual**	**Change**	**Change %**	**Actual**	**Budget**	**Variance**	**Variance %**	**Actual**	**Change**	**Change %**
Net Income (Loss)	19,121	(514,353)	533,475	(104%)	1,355,571	(1,336,450)	99%	2,306,242	(2,405,486)	4,711,728	196%	864,526	1,441,716	167%
Operating Income (Loss)	(302,930)	(786,508)	483,579	(61%)	1,170,684	(1,473,614)	126%	1,076,861	(3,257,069)	4,333,930	133%	36,047	1,040,814	2,887%
EBIDA (Loss)	459,316	(150,775)	610,092	(405%)	1,682,046	(1,222,730)	73%	3,628,879	(1,314,752)	4,943,631	376%	1,840,131	1,788,748	97%
IP Gross Revenue	4,039,585	3,572,453	467,133	13%	3,530,592	508,993	14%	11,742,446	10,817,403	925,042	9%	10,565,433	1,177,013	11%
OP Gross Revenue	15,293,444	13,971,656	1,321,788	9%	12,209,645	3,083,799	25%	44,550,962	43,478,701	1,072,261	2%	40,703,211	3,847,751	9%
Clinic Gross Revenue	1,756,606	1,613,717	142,889	9%	1,455,030	301,577	21%	5,118,307	4,846,379	271,928	6%	4,450,698	667,609	15%
Total Gross Revenue	**21,089,635**	**19,157,826**	**1,931,810**	**10%**	**17,195,267**	**3,894,368**	**23%**	**61,411,715**	**59,142,484**	**2,269,231**	**4%**	**55,719,343**	**5,692,373**	**10%**
Net Patient Revenue	**8,574,140**	**9,221,990**	**(647,850)**	**(7%)**	**11,716,740**	**(3,142,600)**	**(27%)**	**28,830,062**	**27,009,199**	**1,820,863**	**7%**	**29,685,079**	**(855,017)**	**(3%)**
Cash Net Revenue % of Gross	*41%*	*48%*	*(7%)*	*(16%)*	*68%*	*(27%)*	*(40%)*	*47%*	*46%*	*1%*	*3%*	*53%*	*(6%)*	*(12%)*
Admits (excl. Nursery)	83	67	16	24%	67	16	24%	227	188	39	21%	188	39	21%
IP Days	294	204	90	44%	204	90	44%	832	590	242	41%	590	242	41%
IP Days (excl. Nursery)	251	177	74	42%	177	74	42%	727	523	204	39%	523	204	39%
Average Daily Census	8.4	5.9	2.5	42%	5.9	2.5	42%	7.9	5.7	2.2	39%	5.7	2.2	39%
ALOS	3.0	2.6	0.4	15%	2.6	0.4	15%	3.2	2.8	0.4	15%	2.8	0.4	15%
Deliveries	17	17	-	-%	17	-	-%	54	45	9	20%	45	9	20%
OP Visits	3,792	3,028	764	25%	3,028	764	25%	11,070	10,051	1,019	10%	10,051	1,019	10%
Rural Health Clinic Visits	2,314	2,345	(31)	(1%)	2,345	(31)	(1%)	6,671	6,895	(224)	(3%)	6,895	(224)	(3%)
Rural Health Women Visits	497	445	52	12%	445	52	12%	1,520	1,374	146	11%	1,374	146	11%
Rural Health Behavioral Visits	202	160	42	26%	160	42	26%	579	464	115	25%	464	115	25%
Total RHC Visits	**3,013**	**2,950**	**63**	**2%**	**2,950**	**63**	**2%**	**8,770**	**8,733**	**37**	**0%**	**8,733**	**37**	**0%**
Bronco Clinic Visits	46	35	11	31%	35	11	31%	65	49	16	33%	49	16	33%
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	201	(201)	(100%)	201	(201)	(100%)
Orthopedic Clinic Visits	391	291	100	34%	291	100	34%	1,141	1,071	70	7%	1,071	70	7%
Pediatric Clinic Visits	527	564	(37)	(7%)	564	(37)	(7%)	1,715	1,748	(33)	(2%)	1,748	(33)	(2%)
Specialty Clinic Visits	603	332	271	82%	332	271	82%	1,655	1,026	629	61%	1,026	629	61%
Surgery Clinic Visits	175	106	69	65%	106	69	65%	466	317	149	47%	317	149	47%
Virtual Care Clinic Visits	53	36	17	47%	36	17	47%	173	143	30	21%	143	30	21%
Total NIA Clinic Visits	**1,795**	**1,364**	**431**	**32%**	**1,364**	**431**	**32%**	**5,215**	**4,555**	**660**	**14%**	**4,555**	**660**	**14%**
IP Surgeries	19	25	(6)	(24%)	25	(6)	(24%)	43	66	(23)	(35%)	66	(23)	(35%)
OP Surgeries	114	89	25	28%	89	25	28%	392	330	62	19%	330	62	19%
Total Surgeries	**133**	**114**	**19**	**17%**	**114**	**19**	**17%**	**435**	**396**	**39**	**10%**	**396**	**39**	**10%**
Cardiology	1	-	1	-%	-	1	100%	3	-	3	-%	-	3	-%
General	66	55	11	20%	55	11	20%	210	170	40	24%	170	40	24%
Gynecology & Obstetrics	7	16	(9)	(56%)	16	(9)	(56%)	35	33	2	6%	33	2	6%
Ophthalmology	-	15	(15)	(100%)	15	(15)	(100%)	57	71	(14)	(20%)	71	(14)	(20%)
Orthopedic	38	16	22	138%	16	22	138%	90	95	(5)	(5%)	95	(5)	(5%)
Pediatric	-	-	-	-%	-	-	-%	-	-	-	-%	-	-	-%
Plastics	-	-	-	-%	-	-	-%	1	-	1	-%	-	1	-%
Podiatry	1	-	1	-%	-	1	-%	2	1	1	100%	1	1	100%
Urology	20	12	8	67%	12	8	67%	37	26	11	42%	26	11	42%
Diagnostic Image Exams	2,194	1,955	239	12%	1,955	239	12%	6,353	6,237	116	2%	6,237	116	2%
Emergency Visits	947	885	62	7%	885	62	7%	2,755	2,616	139	5%	2,616	139	5%
ED Admits	47	25	22	88%	25	22	88%	130	77	53	69%	77	53	69%
ED Admits % of ED Visits	5%	3%	2%	76%	3%	2%	76%	5%	3%	2%	60%	3%	2%	60%
Rehab Visits	887	329	558	170%	329	558	170%	2,414	1,652	762	46%	1,652	762	46%
OP Infusion/Wound Care Visits	329	247	82	33%	247	82	33%	1,060	789	271	34%	789	271	34%
Observation Hours	1,770	1,463	307	21%	1,463	307	21%	5,548	5,275	273	5%	5,275	273	5%

Provided by: Chief Financial Officer
Report Name: September 2024 Financial Summary

Northern Inyo Healthcare District

September 2024 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
PAYOR MIX														
Blue Cross	22.2%	12.3%	9.9%	81.2%	12.3%	9.9%	81.2%	23.0%	16.7%	6.3%	37.7%	16.7%	6.3%	37.7%
Commercial	5.2%	3.4%	1.8%	52.5%	3.4%	1.8%	52.5%	4.7%	2.9%	1.8%	62.4%	2.9%	1.8%	62.4%
Medicaid	22.9%	30.9%	(8.0%)	(25.9%)	30.9%	(8.0%)	(25.9%)	28.4%	20.7%	7.7%	37.3%	20.7%	7.7%	37.3%
Medicare	44.5%	50.0%	(5.5%)	(11.0%)	50.0%	(5.5%)	(11.0%)	39.7%	53.7%	(14.0%)	(26.1%)	53.7%	(14.0%)	(26.1%)
Self-pay	5.2%	2.9%	2.2%	76.1%	2.9%	2.2%	76.1%	3.1%	5.0%	(1.8%)	(36.9%)	5.0%	(1.8%)	(36.9%)
Worker's Comp	-%	-%	-%	-%	-%	-%	-%	1.1%	0.9%	0.2%	28.0%	0.9%	0.2%	28.0%
Other	-%	0.5%	(0.5%)	(100.0%)	0.5%	(0.5%)	(100.0%)	-%	0.2%	(0.2%)	(100.0%)	0.2%	(0.2%)	(100.0%)
DEDUCTIONS														
Contract Adjust	(10,744,619)	(8,696,277)	(2,048,342)	24%	(4,068,387)	(6,676,232)	164%	(28,641,113)	(28,241,028)	(400,085)	1%	(21,618,401)	(7,022,712)	32%
Bad Debt	(1,378,285)	(703,108)	(675,177)	96%	(625,969)	(752,316)	120%	(2,656,072)	(2,150,144)	(505,928)	24%	(2,583,532)	(72,540)	3%
Write-off	(394,591)	(536,450)	141,859	(26%)	(784,171)	389,580	(50%)	(1,136,285)	(1,742,113)	605,828	(35%)	(1,833,717)	697,433	(38%)
CENSUS														
Patient Days	251	177	74	42%	177	74	42%	727	523	204	39%	523	204	39%
Adjusted ADC	44	29	15	52%	29	15	52%	42	30	12	39%	30	12	39%
Adjusted Days	1,312	862	450	52%	862	450	52%	3,802	2,758	1,044	38%	2,758	1,044	38%
Employed FTE	358.8	351.6	7.2	2%	351.6	7.2	2%	361.7	358.2	3.5	1%	358.2	3.5	1%
Contract Labor FTE	24.8	21.8	3.1	14%	21.8	3.1	14%	25.7	25.0	0.6	3%	25.0	0.6	3%
Total Paid FTE	383.7	373.4	10.3	3%	373.4	10.3	3%	387.4	383.2	4.1	1%	383.2	4.1	1%
EPOB (Employee per Occupied Bed)	1.5	2.1	(0.6)	(28%)	2.1	(0.6)	(28%)	1.6	2.2	(0.6)	(27%)	2.2	(0.6)	(27%)
EPOC (Employee per Occupied Case)	0.3	0.4	(0.1)	(32%)	0.4	(0.1)	(32%)	0.1	0.1	(0.0)	(27%)	0.1	(0.0)	(27%)
Adjusted EPOB	8.0	10.3	(2.3)	(22%)	10.3	(2.3)	(22%)	8.5	11.9	(3.3)	(28%)	11.9	(3.3)	(28%)
Adjusted EPOC	1.5	2.1	(0.6)	(28%)	2.1	(0.6)	(28%)	0.5	0.7	(0.2)	(28%)	0.7	(0.2)	(28%)
SALARIES														
Per Adjust Bed Day	2,571	4,008	(1,437)	(36%)	4,701	(2,130)	(45%)	2,623	3,820	(1,197)	(31%)	3,604	(981)	(27%)
Total Salaries	3,372,236	3,455,540	(83,303)	(2%)	4,052,687	(680,451)	(17%)	9,972,418	10,536,228	(563,809)	(5%)	9,941,666	30,752	0%
Average Hourly Rate	54.82	57.33	(2.51)	(4%)	67.24	(12.42)	(18%)	52.45	55.95	(3.51)	(6%)	52.80	(0.35)	(1%)
Employed Paid FTEs	358.8	351.6	7.2	344.3	351.6	7.2	2%	361.7	358.2	3.5	1%	358.2	3.5	1%
BENEFITS														
Per Adjust Bed Day	1,246	2,397	(1,151)	(48%)	1,752	(506)	(29%)	1,216	2,252	(1,037)	(46%)	1,824	(608)	(33%)
Total Benefits	1,634,036	2,066,015	(431,979)	(21%)	1,510,474	123,562	8%	4,621,688	6,212,267	(1,590,579)	(26%)	5,030,475	(408,787)	(8%)
Benefits % of Wages	48%	60%	(11%)	(19%)	37%	11%	30%	46%	59%	(13%)	(21%)	51%	(4%)	(8%)
Pension Expense	375,012	497,683	(122,671)	(25%)	391,794	(16,782)	(4%)	1,292,353	1,493,984	(201,632)	(13%)	1,395,520	(103,168)	(7%)
MDV Expense	1,002,562	748,612	253,950	34%	1,665,275	(662,713)	(40%)	2,225,996	2,245,836	(19,840)	(1%)	2,748,178	(522,182)	(19%)
Taxes, PTO accrued, Other	256,463	819,720	(563,258)	(69%)	(546,594)	803,057	(147%)	1,103,340	2,472,447	(1,369,107)	(55%)	886,776	216,563	24%
Salaries, Wages & Benefits	5,006,273	5,521,554	(515,282)	(9%)	5,563,162	(556,889)	(10%)	14,594,106	16,748,495	(2,154,388)	(13%)	14,972,141	(378,035)	(3%)
SWB/APD	3,817	6,405	(2,588)	(40%)	6,453	(2,636)	(41%)	3,839	6,072	(2,234)	(37%)	5,428	(1,590)	(29%)
SWB % of Total Expenses	56%	55%	1%	2%	53%	4%	7%	53%	55%	(3%)	(5%)	50%	2%	4%

Provided by: Chief Financial Officer
Report Name: September 2024 Financial Summary

Northern Inyo Healthcare District

September 2024 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
PROFESSIONAL FEES														
Per Adjust Bed Day	1,509	2,591	(1,082)	(42%)	3,705	(2,196)	(59%)	1,853	2,423	(570)	(24%)	2,998	(1,146)	(38%)
Total Physician Fee	1,621,308	1,463,822	157,486	11%	1,424,804	196,505	14%	4,573,689	4,389,867	183,822	4%	4,330,657	243,031	6%
Total Contract Labor	(112,642)	343,860	(456,502)	(133%)	700,581	(813,223)	(116%)	1,224,621	1,042,527	182,094	17%	1,628,742	(404,121)	(25%)
Total Other Pro-Fees	470,487	425,539	44,948	11%	1,068,357	(597,870)	(56%)	1,245,352	1,250,222	(4,870)	(0%)	2,310,816	(1,065,463)	(46%)
Total Professional Fees	1,979,154	2,233,222	(254,068)	(11%)	3,193,742	(1,214,588)	(38%)	7,043,662	6,682,615	361,046	5%	8,270,215	(1,226,553)	(15%)
Contract AHR	118.60	92.14	26.46	29%	187.73	(69.13)	(37%)	90.69	79.20	11.49	15%	123.74	(33.05)	(27%)
Contract Paid FTEs	24.8	21.8	3.1	14%	21.8	3.1	14%	25.7	25.0	0.6	3%	25.0	0.6	3%
Physician Fee per Adjust Bed Day	1,236	1,698	(462)	(27%)	1,653	(417)	(25%)	1,203	1,592	(389)	(24%)	1,570	(367)	(23%)
PHARMACY														
Per Adjust Bed Day	330	535	(206)	(38%)	440	(111)	(25%)	178	502	(324)	(65%)	518	(340)	(66%)
Total Rx Expense	432,361	461,460	(29,099)	(6%)	379,562	52,799	14%	676,357	1,384,379	(708,022)	(51%)	1,428,201	(751,844)	(53%)
MEDICAL SUPPLIES														
Per Adjust Bed Day	270	496	(227)	(46%)	436	(166)	(38%)	414	467	(52)	(11%)	499	(85)	(17%)
Total Medical Supplies	353,623	427,743	(74,120)	(17%)	375,431	(21,809)	(6%)	1,575,313	1,286,974	288,338	22%	1,377,049	198,264	14%
EHR SYSTEM														
Per Adjust Bed Day	20	157	(137)	(87%)	10	10	93%	30	147	(117)	(79%)	100	(70)	(70%)
Total EHR Expense	26,143	135,000	(108,857)	(81%)	8,890	17,254	194%	114,533	405,000	(290,467)	(72%)	275,086	(160,554)	(58%)
OTHER EXPENSE														
Per Adjust Bed Day	487	1,005	(517)	(51%)	811	(323)	(40%)	638	967	(329)	(34%)	852	(214)	(25%)
Total Other	639,321	865,941	(226,620)	(26%)	698,794	(59,472)	(9%)	2,426,594	2,668,071	(241,477)	(9%)	2,350,734	75,860	3%
DEPRECIATION AND AMORTIZATION														
Per Adjust Bed Day	336	422	(86)	(20%)	379	(43)	(11%)	348	395	(48)	(12%)	354	(6)	(2%)
Total Depreciation and Amortization	440,195	363,578	76,617	21%	326,475	113,720	35%	1,322,637	1,090,734	231,903	21%	975,605	347,032	36%
TOTAL EXPENSES	8,877,070	10,008,498	(1,131,429)	(11%)	10,546,056	(1,668,986)	(16%)	27,753,201	30,266,269	(2,513,067)	(8%)	29,649,032	(1,895,830)	(6%)
Per Adjust Bed Day	6,768	11,610	(4,842)	(42%)	12,234	(5,466)	(45%)	7,300	10,973	(3,673)	(33%)	10,750	(3,450)	(32%)
Per Calendar Day	295,902	333,617	(37,714)	(11%)	351,535	(55,633)	(16%)	301,665	328,981	(27,316)	(8%)	322,272	(20,607)	(6%)

Provided by: Chief Financial Officer
Report Name: September 2024 Financial Summary

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2025

	9/30/2024	Sept Budget	9/30/2023	2025 YTD	2024 YTD	Budget Variance	PYM Change	PYTD Change
Gross Patient Service Revenue								
Inpatient Patient Revenue	4,039,585	3,572,453	3,530,592	11,742,446	10,565,433	467,133	508,993	1,177,013
Outpatient Revenue	15,293,444	13,971,656	12,209,645	44,550,962	40,703,211	1,321,788	3,083,799	3,847,751
Clinic Revenue	1,756,606	1,613,717	1,455,030	5,118,307	4,450,698	142,889	301,577	667,609
Gross Patient Service Revenue	21,089,635	19,157,826	17,195,267	61,411,715	55,719,343	1,931,810	3,894,368	5,692,373
Deductions from Revenue								-
Contractual Adjustments	(10,744,619)	(8,696,277)	(4,068,387)	(28,641,113)	(21,618,401)	(2,048,342)	(6,676,232)	(7,022,712)
Bad Debt	(1,378,285)	(703,108)	(625,969)	(2,656,072)	(2,583,532)	(675,177)	(752,316)	(72,540)
A/R Writeoffs	(394,591)	(536,450)	(784,171)	(1,136,285)	(1,833,717)	141,859	389,580	697,433
Other Deductions from Revenue	-	-	-	(152,618)	-	-	-	(152,618)
Deductions from Revenue	(12,517,495)	(9,935,835)	(5,478,527)	(32,586,087)	(26,035,651)	(2,581,660)	(7,038,968)	(6,550,437)
Other Patient Revenue								-
Incentive Income	2,000	-	-	2,000	-	2,000	2,000	2,000
Other Oper Rev - Rehab Thera Serv	-	-	-	2,435	1,387	-	-	1,048
Medical Office Net Revenue	-	-	-	-	-	-	-	-
Other Patient Revenue	2,000	-	-	4,435	1,387	2,000	2,000	3,048
Net Patient Service Revenue	**8,574,140**	**9,221,990**	**11,716,740**	**28,830,062**	**29,685,079**	**(647,850)**	**(3,142,600)**	**(855,017)**
CNR%	**40.7%**	**48.1%**	**68.1%**	**46.9%**	**53.3%**	**-7.5%**	**-27.5%**	**-6.3%**
Cost of Services - Direct								-
Salaries and Wages	2,855,425	2,925,962	3,511,439	8,408,854	8,538,922	(70,537)	(656,013)	(130,068)
Benefits	1,387,677	1,754,527	1,284,353	3,966,226	4,305,241	(366,850)	103,324	(339,015)
Professional Fees	1,865,737	1,685,180	1,825,852	5,235,712	5,496,811	180,557	39,885	(261,099)
Contract Labor	(172,022)	525,131	657,327	1,069,784	1,455,752	(697,153)	(829,349)	(385,968)
Pharmacy	432,361	461,460	379,562	676,357	1,428,201	(29,099)	52,799	(751,844)
Medical Supplies	353,623	427,743	375,431	1,575,313	1,377,049	(74,120)	(21,809)	198,264
Hospice Operations	-	-	-	-	-	-	-	-
EHR System Expense	26,143	135,000	8,890	114,533	275,086	(108,857)	17,254	(160,554)
Other Direct Expenses	452,410	612,775	569,841	1,877,581	1,850,285	(160,365)	(117,431)	27,296
Total Cost of Services - Direct	7,201,353	8,527,778	8,612,694	22,924,359	24,727,347	(1,326,425)	(1,411,340)	(1,802,988)
								-
General and Administrative Overhead								-
Salaries and Wages	516,811	529,578	541,249	1,563,565	1,402,744	(12,767)	(24,437)	160,820
Benefits	246,360	311,488	226,122	655,462	725,234	(65,128)	20,238	(69,771)
Professional Fees	226,058	204,181	667,309	583,329	1,144,662	21,877	(441,250)	(561,333)
Contract Labor	59,381	(181,271)	43,254	154,837	172,990	240,651	16,126	(18,153)
Depreciation and Amortization	440,195	363,578	326,475	1,322,637	975,605	76,617	113,720	347,032
Other Administative Expenses	186,912	253,166	128,953	549,013	500,449	(66,255)	57,958	48,563
Total General and Administrative Overhead	1,675,716	1,480,720	1,933,362	4,828,842	4,921,684	194,996	(257,646)	(92,842)
Total Expenses	**8,877,070**	**10,008,498**	**10,546,056**	**27,753,201**	**29,649,032**	**(1,131,429)**	**(1,668,986)**	**(1,895,830)**
						-	-	-
Financing Expense	192,696	185,154	177,359	579,830	536,322	7,542	15,337	43,508
Financing Income	286,867	238,960	228,125	860,600	684,374	47,906	58,742	176,226
Investment Income	50,746	46,181	61,899	142,473	175,157	4,565	(11,153)	(32,684)
Miscellaneous Income	177,134	172,167	72,221	806,139	505,270	4,967	104,913	300,869
Net Income (Change in Financial Position)	**19,121**	**(514,353)**	**1,355,571**	**2,306,242**	**864,526**	**533,475**	**(1,336,450)**	**1,441,716**
Operating Income	(302,930)	(786,508)	1,170,684	1,076,861	36,047	483,579	(1,473,614)	1,040,814
EBIDA	459,316	(150,775)	1,682,046	3,628,879	1,840,131	610,092	(1,222,730)	1,788,748
Net Profit Margin	0.2%	-5.6%	11.6%	8.0%	2.9%	5.8%	-11.3%	-168.6%
Operating Margin	-3.5%	-8.5%	10.0%	3.7%	0.1%	5.0%	-13.5%	-121.7%
EBIDA Margin	5.4%	-1.6%	14.4%	12.6%	6.2%	7.0%	-9.0%	-209.2%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2025

	PY Balances	7/31/2024	7/31/2023	8/31/2024	8/31/2023	9/30/2024	9/30/2023	PM Change	PY Year
Assets									
Current Assets									
Cash and Liquid Capital	18,718,414	20,537,230	15,220,072	17,874,637	18,008,863	17,374,679	18,771,541	(499,958)	(1,396,862)
Short Term Investments	6,418,451	7,565,620	10,513,789	7,570,368	10,555,533	7,574,716	10,555,533	4,348	(2,980,817)
PMA Partnership	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	17,924,674	18,219,994	16,283,014	20,277,373	13,668,526	19,842,483	15,119,591	(434,890)	4,722,892
Other Receivables	4,754,052	4,293,186	3,071,746	4,361,004	321,629	4,823,782	794,581	462,778	4,029,201
Inventory	5,193,281	5,176,986	5,120,179	5,173,320	5,099,597	5,202,337	5,155,489	29,017	46,849
Prepaid Expenses	1,119,559	1,463,004	2,154,415	1,782,536	2,821,462	1,933,935	2,326,052	151,399	(392,117)
Total Current Assets	**54,128,430**	**57,256,020**	**52,363,215**	**57,039,238**	**50,475,610**	**56,751,933**	**52,722,787**	**(287,305)**	**4,029,146**
Assets Limited as to Use									
Internally Designated for Capital Acquisition	-	-	-	-	-	-	-	-	-
Short Term - Restricted	1,467,786	1,467,914	1,466,418	1,468,042	1,466,541	1,468,166	1,466,663	124	1,503
Limited Use Assets								-	-
LAIF - DC Pension Board Restricted	-	-	870,163	-	828,419	-	828,419	-	(828,419)
LAIF - DB Pension Board Restricted	10,346,490	10,346,490	15,684,846	10,346,490	13,076,830	10,346,490	13,076,830	-	(2,730,340)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-	-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	573,097	573,097	-	573,097	573,097	-	-
Total Limited Use Assets	10,919,587	10,919,587	17,128,106	10,919,587	13,905,249	10,919,587	14,478,346	-	(3,558,759)
Revenue Bonds Held by a Trustee	376,411	370,707	1,072,480	365,005	912,490	359,303	752,501	(5,702)	(393,198)
Total Assets Limited as to Use	**12,763,784**	**12,758,208**	**19,667,005**	**12,752,634**	**16,284,281**	**12,747,056**	**16,697,511**	**(5,578)**	**(3,950,455)**
Long Term Assets									
Long Term Investment	1,846,138	751,539	2,776,508	754,812	2,783,284	755,869	2,790,423	1,058	(2,034,554)
Fixed Assets, Net of Depreciation	84,799,308	84,516,197	84,781,121	84,190,423	77,751,338	84,391,564	76,854,908	201,140	7,536,655
Total Long Term Assets	**86,645,446**	**85,267,736**	**87,557,629**	**84,945,235**	**80,534,623**	**85,147,433**	**79,645,331**	**202,198**	**5,502,102**
Total Assets	**153,537,660**	**155,281,965**	**159,587,849**	**154,737,107**	**147,294,513**	**154,646,421**	**149,065,629**	**(90,686)**	**5,580,793**
Liabilities									
Current Liabilities									
Current Maturities of Long-Term Debt	4,146,183	4,217,792	4,936,019	4,204,640	798,370	4,771,637	190,197	566,997	4,581,440
Accounts Payable	5,010,089	4,451,768	4,929,766	5,232,265	6,750,705	4,443,274	6,935,344	(788,991)	(2,492,071)
Accrued Payroll and Related	6,224,657	6,279,496	7,600,696	4,607,440	11,656,151	4,915,339	12,664,513	307,898	(7,749,175)
Accrued Interest and Sales Tax	109,159	192,510	169,971	261,700	244,123	78,276	96,606	(183,424)	(18,330)
Notes Payable	446,860	446,860	1,532,689	446,860	1,633,708	446,860	1,633,708	-	(1,186,847)
Unearned Revenue	(4,542)	(4,542)	(4,542)	(3,242)	(4,542)	(4,542)	(4,542)	(1,300)	-
Due to 3rd Party Payors	693,247	693,247	693,247	693,247	693,247	693,247	693,247	-	-
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	12,599,823	12,597,753	1,942,292	12,595,684	1,873,995	12,593,614	1,873,995	(2,070)	10,719,619
Total Current Liabilities	**29,225,475**	**28,874,885**	**21,800,138**	**28,038,593**	**23,645,757**	**27,937,705**	**24,083,068**	**(100,889)**	**3,854,636**
Long Term Liabilities									
Long Term Debt	36,301,355	36,202,581	37,511,965	36,103,552	33,455,530	36,004,290	33,341,647	(99,262)	2,662,643
Bond Premium	165,618	162,481	200,126	159,344	196,989	156,207	193,852	(3,137)	(37,645)
Accreted Interest	16,991,065	17,084,422	16,635,302	17,177,780	17,314,009	17,271,137	17,409,141	93,358	(138,003)
Other Non-Current Liability - Pension	32,946,355	32,946,355	47,257,663	32,946,355	47,257,663	32,946,355	47,257,663	-	(14,311,308)
Total Long Term Liabilities	**86,404,394**	**86,395,839**	**101,605,056**	**86,387,031**	**98,224,191**	**86,377,989**	**98,202,303**	**(9,042)**	**(11,824,314)**
Suspense Liabilities	-	-	-	-		-	-		
Uncategorized Liabilities (grants)	31,506	94,166	44,693	147,821	36,944	147,821	36,944	0	110,877
Total Liabilities	**115,661,375**	**115,364,890**	**123,449,887**	**114,573,445**	**121,906,892**	**114,463,515**	**122,322,315**	**(109,931)**	**(7,858,800)**
Fund Balance									
Fund Balance	31,992,031	36,408,499	31,992,032	36,408,499	23,268,194	36,408,499	23,268,194	-	13,140,305
Temporarily Restricted	1,467,786	1,467,914	1,466,417	1,468,042	2,610,472	1,468,166	2,610,594	124	(1,142,428)
Net Income	4,416,468	2,040,662	2,679,513	2,287,121	(491,045)	2,306,242	864,526	19,121	1,441,716
Total Fund Balance	**37,876,285**	**39,917,075**	**36,137,962**	**40,163,662**	**25,387,621**	**40,182,906**	**26,743,313**	**19,245**	**13,439,593**
Liabilities + Fund Balance	**153,537,660**	**155,281,965**	**159,587,849**	**154,737,107**	**147,294,513**	**154,646,421**	**149,065,629**	**(90,686)**	**5,580,793**
(Decline)/Gain		1,744,305	(1,044,798)	(544,858)	(415,868)	(90,686)	1,771,115	454,172	(1,861,801)

Northern Inyo Healthcare District
Long-Term Debt Service Coverage Ratio
FYE 2025

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	FS	$ 2,306,242	3 months
+ Depreciation Expense	FS	1,322,637	
+ Interest Expense	FS	579,830	
Less GO Property Tax revenue		562,547	
Less GO Interest Expense		125,908	
"Income available for debt service"		**$ 3,520,254**	
Denominator:			
Maximum "Annual Debt Service"			
2021A Revenue Bonds		$ 112,700	
2021B Revenue Bonds		894,160	
2009 GO Bonds (Fully Accreted Value)			
2016 GO Bonds			
Financed purchases and other loans		1,546,875	
Total **Maximum Annual Debt Service**		**$ 2,553,735**	total annu
		638,434	3 months
Ratio: (numerator / denominator)	Rx	**5.51**	YTD debt
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	FS	$ 24,949,395	
Cash and Investments-non current	FS	755,869	
Sub-total		25,705,264	
Less - Restricted:			
PRF and grants (Unearned Revenue)	FS	-	
Held with bond fiscal agent	FS	(359,303)	
Building and Nursing Fund	FS	(1,468,166)	
Total Unrestricted Funds		**$ 23,877,795**	
Total Operating Expenses	FS	$ 27,753,201	
Less Depreciation	FS	1,322,637	
Net Expenses		26,430,565	
Average Daily Operating Expense	Rx	$ 287,289	days that have elapsed
Days Cash on Hand	Rx	**83**	

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2025

CASH FLOWS FROM OPERATING ACTIVITIES	
Receipts from and on Behalf of Patients	29,209,747
Payments to Suppliers and Contractors	(11,944,842)
Payments to and on Behalf of Employees	(15,818,727)
Other Receipts and Payments, Net	31,600
Net Cash Provided (Used) by Operating Activities	1,477,778
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES	
Noncapital Contributions and Grants	225,526
Property Taxes Received	298,053
Other	
Net Cash Provided (Used) by Noncapital Financing Activities	523,579
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES	
Principal Payments on Long-Term Debt	-
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defease Revenue Bonds	-
Interest Paid	(579,830)
Purchase and Construction of Capital Assets	(914,892)
Payments on Lease Liability	20,920
Payments on Subscription Liability	(377,279)
Property Taxes Received	-
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	(1,851,082)
CASH FLOWS FROM INVESTING ACTIVITIES	
Investment Income	142,473
Rental Income	15,392
Net Cash Provided (Used) by Investing Activities	157,865
NET CHANGE IN CASH AND CASH EQUIVALENTS	308,140
Cash and Cash Equivalents - Beginning of Year	25,136,864
CASH AND CASH EQUIVALENTS - END OF YEAR	25,445,005

Key Financial Performance Indicators	Industry Benchmark	Sep-22	Sep-23	FYE 2024 Average	Jul-24	Aug-24	Sep-24	Variance to Prior Month	Variance to FYE 2024 Average	Variance to Prior Year Month
Volume										
Admits	41	56	67	71	75	75	83	8	12	16
Deliveries	n/a	8	17	17	18	19	17	(2)	0	-
Adjusted Patient Days	n/a	998	862	1,035	1,164	1,362	1,312	(50)	277	450
Total Surgeries	153	80	114	146	134	168	133	(35)	(13)	19
ER Visits	659	772	885	840	903	905	947	42	107	62
RHC and Clinic Visits	n/a	4,054	4,314	4,607	4,252	4,921	4,808	(113)	201	494
Diagnostic Imaging Services	n/a	2,045	1,955	2,069	2,274	2,221	2,194	(27)	125	239
Rehab Services	n/a	712	329	662	719	808	887	79	225	558
AR & Income										
Gross AR (Cerner only)	n/a	$ 52,630,796	$ 51,259,303	$ 52,823,707	$ 56,859,164	$ 57,648,281	$ 58,109,192	$ 460,911	$ 5,285,484	$ 6,849,889
AR > 90 Days	$ 7,688,895.45	$ 22,918,050	$ 23,867,624	$ 24,488,432	$ 24,988,857	$ 32,958,845	$ 34,041,771	$ 1,082,926	$ 9,553,339	$ 10,174,147
AR % > 90 Days	15%	43.5%	46.19%	46.7%	44.5%	57.2%	58.6%	1.4%	11.9%	12.4%
AR Days	43.00		84.50	85.52	89.02	92.17	85.85	(6.32)	0.33	1.35
Net AR	n/a	$ 22,244,291	$ 15,119,591	$ 16,938,200	$ 18,260,024	$ 21,183,785	$ 21,089,635	$ (94,150)	$ 4,151,435	$ 5,970,044
Net AR % of Gross	n/a	42.3%	29.5%	31.9%	32.1%	36.7%	36.3%	-0.5%	4.3%	6.8%
Gross Patient Revenue/Calendar Day	n/a	$ 495,991	$ 573,176	$ 619,457	$ 617,364	$ 683,348	$ 702,988	$ 19,640	$ 83,531	$ 129,812
Net Patient Revenue/Calendar Day	n/a	$ 226,427	$ 390,558	$ 292,759	$ 337,843	$ 315,574	$ 285,805	$ (29,769)	$ (6,954)	$ (104,753)
Net Patient Revenue/APD	n/a	$ 6,806	$ 13,593	$ 8,757	$ 8,998	$ 7,183	$ 6,537	$ (646)	$ (2,220)	$ (7,055)
Wages										
Wages	n/a	$ 2,885,806	$ 4,052,687	$ 3,285,431	$ 3,359,076	$ 3,241,107	$ 3,372,236	$ 131,130	$ 86,806	$ (680,451)
Employed paid FTEs	n/a	387.83	351.58	353.69	366.38	366.24	358.83	(7.41)	5.14	7.25
Employed Average Hourly Rate	$ 38.00	$ 43.41	$ 67.24	$ 53.32	$ 51.76	$ 49.96	$ 54.82	$ 4.86	$ 1.50	$ (12.42)
Benefits	n/a	$ 1,797,715	$ 1,510,474	$ 1,640,216	$ 1,509,407	$ 1,478,605	$ 1,634,036	$ 155,431	$ (6,180)	$ 123,562
Benefits % of Wages	30%	62.3%	37.3%	50.3%	44.9%	45.6%	48.5%	2.8%	-1.9%	11.2%
Contract Labor	n/a	$ 1,544,426	$ 700,581	$ 518,351	$ 507,387	$ 829,876	$ (112,642)	$ (942,517)	$ (630,993)	$ (813,223)
Contract Labor Paid FTEs	n/a	44.19	18.33	23.49	29.45	32.19	24.84	(7.34)	1.35	6.51
Total Paid FTEs	n/a	432.02	369.91	377.18	395.83	398.43	383.67	(14.75)	6.50	13.76
Contract Labor Average Hourly Rate	$ 81.04	$ 203.87	$ 222.95	$ 126.74	$ 97.26	$ 145.55	$ 118.60	$ (26.95)	$ (8.14)	$ (104.35)
Total Salaries, Wages, & Benefits	n/a	$ 6,227,947	$ 6,263,742	$ 5,443,998	$ 5,375,870	$ 5,549,587	$ 4,893,631	$ (655,956)	$ (550,367)	$ (1,370,111)
SWB% of NR	50%	91.7%	53.5%	63.2%	51.3%	56.7%	57.1%	0.3%	-6.1%	3.6%
SWB/APD	2,607	$ 6,240	$ 7,267	$ 5,346	$ 4,618	$ 4,075	$ 3,731	$ (344)	$ (1,615)	$ (3,536)
SWB % of total expenses	50%	68.6%	59.4%	56.7%	59.6%	56.3%	55.1%	-1.2%	-1.6%	-4.3%

					FYE 2024 Average	Jul-24	Aug-24	Sep-24	Variance to Prior Month	Variance to FYE 2024 Average	Variance to Prior Year Month
Physician Spend											
Physician Expenses	n/a		$ 1,282,945	$ 1,424,804	$ 1,507,510	$ 1,553,004	$ 1,399,376	$ 1,621,308	$ 221,932	$ 113,798	$ 196,505
Physician expenses/APD	n/a		$ 1,286	$ 1,653	$ 1,478	$ 1,334	$ 1,028	$ 1,236	$ 209	$ (242)	$ (417)
									$ -	$ -	$ -
Supplies											
Supply Expenses	n/a		$ 632,198	$ 754,993	$ 776,504	$ 387,610	$ 904,005	$ 353,623	$ (550,382)	$ (422,881)	$ (401,370)
Supply expenses/APD			$ 633	$ 876	$ 780	$ 333	$ 664	$ 270	$ (394)	$ (511)	$ (606)
Other Expenses											
Other Expenses	n/a		$ 937,355	$ 2,102,517	$ 1,891,477	$ 1,696,938	$ 2,007,341	$ 2,008,508	$ 1,166	$ 117,031	$ (94,010)
Other Expenses/APD	n/a		$ 939	$ 2,439	$ 1,878	$ 1,458	$ 1,474	$ 1,531	$ 57	$ (347)	$ (908)
Margin											
Net Income	n/a		$ (3,404,427)	$ 1,355,571	$ 383,763	$ 2,041,456	$ 248,064	$ 19,121	$ (228,943)	$ (364,642)	$ (1,336,450)
Net Profit Margin	n/a		-50.1%	11.6%	3.0%	19.5%	2.5%	0.2%	-2.3%	-2.8%	-11.4%
Operating Income	n/a		$ (3,599,679)	$ 1,170,684	$ (686,403)	$ 1,459,716	$ (77,526)	$ (302,930)	$ (225,404)	$ 383,474	$ (1,473,614)
Operating Margin		2.9%	-53.0%	10.0%	-10.9%	13.9%	-0.8%	-3.1%	-2.3%	7.8%	-13.1%
EBITDA	n/a		$ (3,739,255)	$ 1,682,046	$ 841,932	$ 2,482,790	$ 689,172	$ 459,316	$ (229,856)	$ (382,616)	$ (1,222,730)
EBITDA Margin		12.7%	-55.0%	14.4%	8.7%	23.7%	7.0%	4.7%	-2.3%	-4.0%	-9.7%
Debt Service Coverage Ratio		3.70		3.7	3.3	0.8	7.3	5.5	(1.8)	2.2	1.8
Cash											
Avg Daily Disbursements (excl. IGT)	n/a		$ 294,051	$ 321,703	$ 355,328	$ 367,107	$ 398,922	$ 315,796	$ (83,126)	$ (39,532)	$ (5,907)
Average Daily Cash Collections (excl. IGT)	n/a		$ 202,191	$ 255,132	$ 299,110	$ 349,783	$ 262,199	$ 302,042	$ 39,843	$ 2,931	$ 46,910
Average Daily Net Cash			$ (91,861)	$ (66,571)	$ (56,218)	$ (17,324)	$ (136,723)	$ (13,754)	$ 122,969	$ 42,464	$ 52,817
Unrestricted Funds	n/a		$ 24,595,951	$ 32,193,415	$ 23,536,438	$ 27,015,779	$ 24,366,780	$ 24,708,310	$ 341,530	$ 1,171,872	$ (7,485,105)
Change of cash per balance sheet	n/a		$ (3,925,898)	$ 929,805	$ (541,459)	$ 1,876,964	$ (2,648,999)	$ 341,530	$ 2,990,529	$ 882,989	$ (588,275)
Days Cash on Hand (assume no more cash is collected)		196	81	100	72	98	84	58	(26)	(14)	(42)
Estimated Days Until Depleted			268	422	406	506	413	440	27	34	18
Years Until Cash Depletion			0.73	1.16	1.11	1.39	1.13	1.21	0.07	0.09	0.05

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

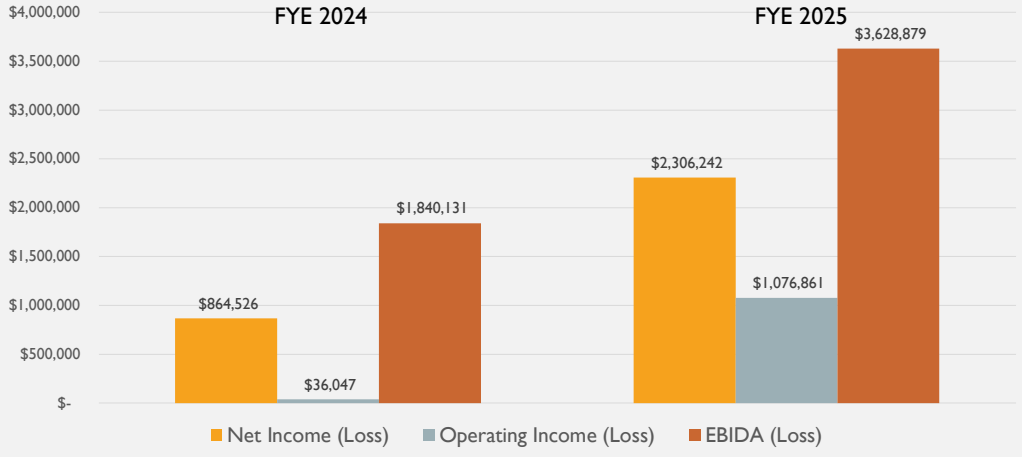
NIHD FINANCIAL UPDATE

September 2024

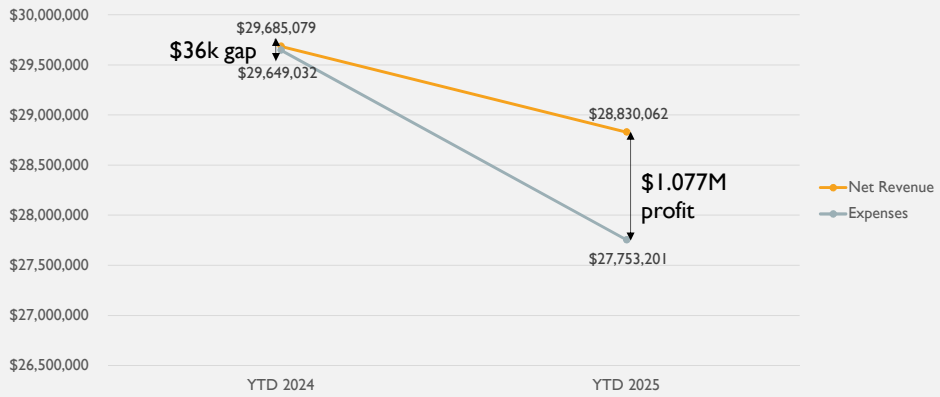
INCOME

SEPTEMBER 2024 FINANCIAL PERFORMANCE

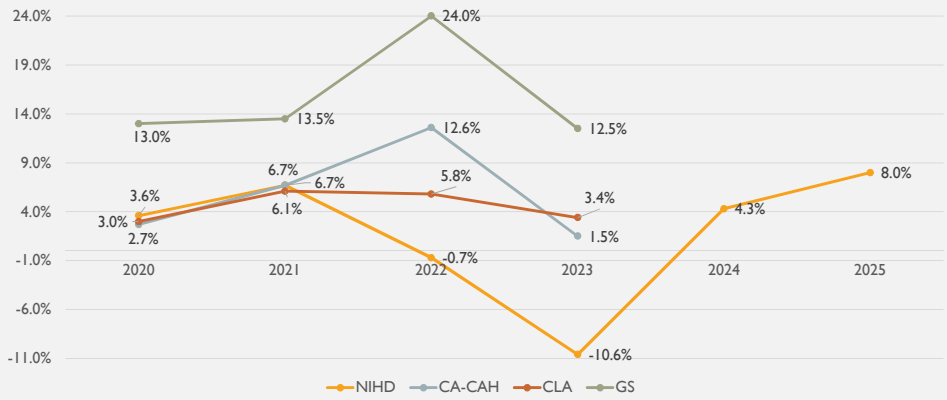
FYE 2025 FINANCIAL PERFORMANCE



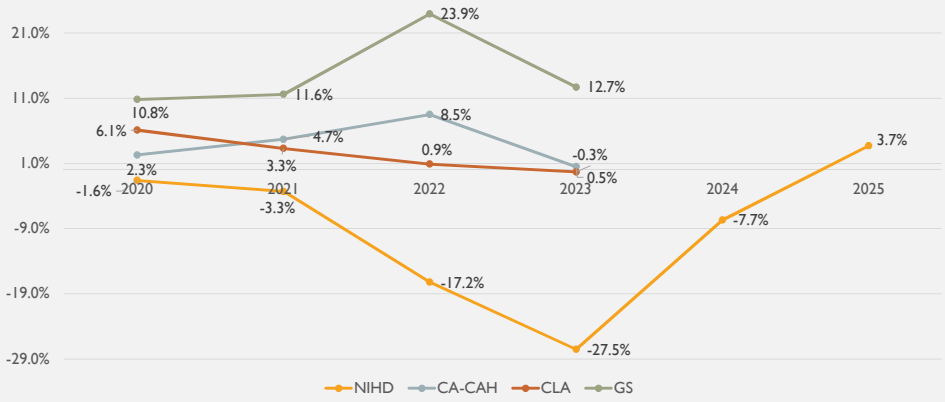
YTD OPERATING INCOME (LOSS) PERFORMANCE



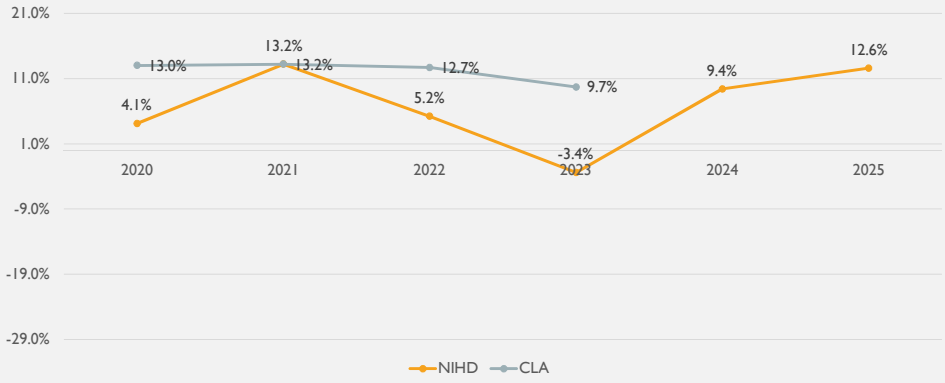
NET PROFIT MARGIN



OPERATING MARGIN

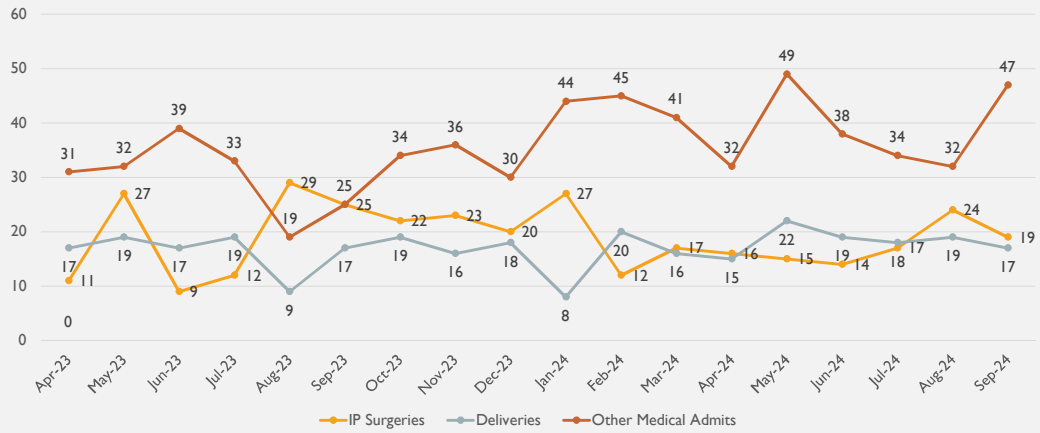


EBIDA MARGIN

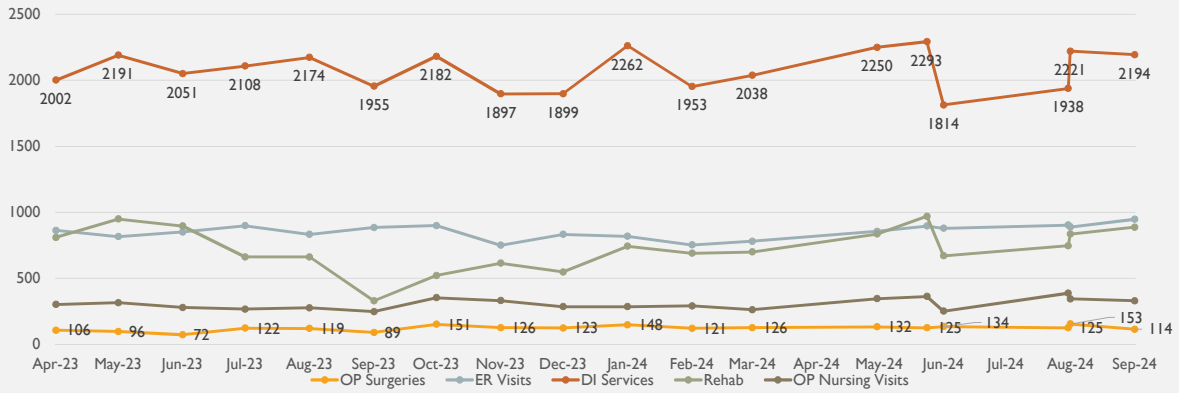


VOLUMES

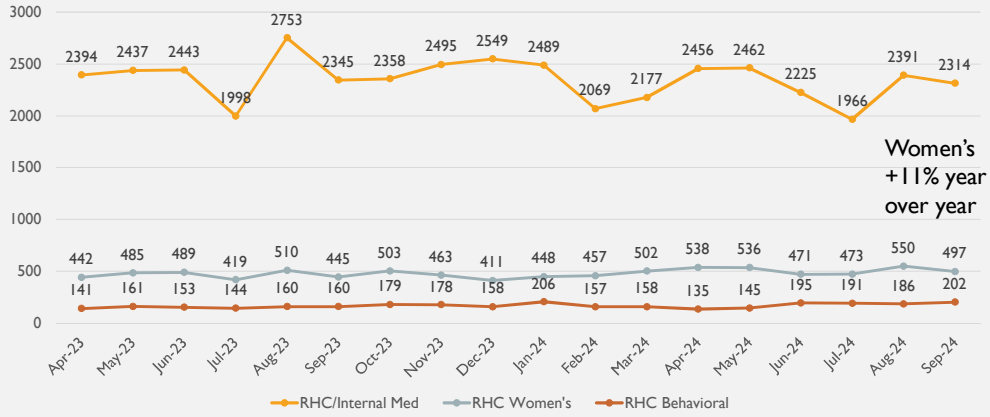
INPATIENT VOLUME PERFORMANCE



OUTPATIENT VOLUME PERFORMANCE

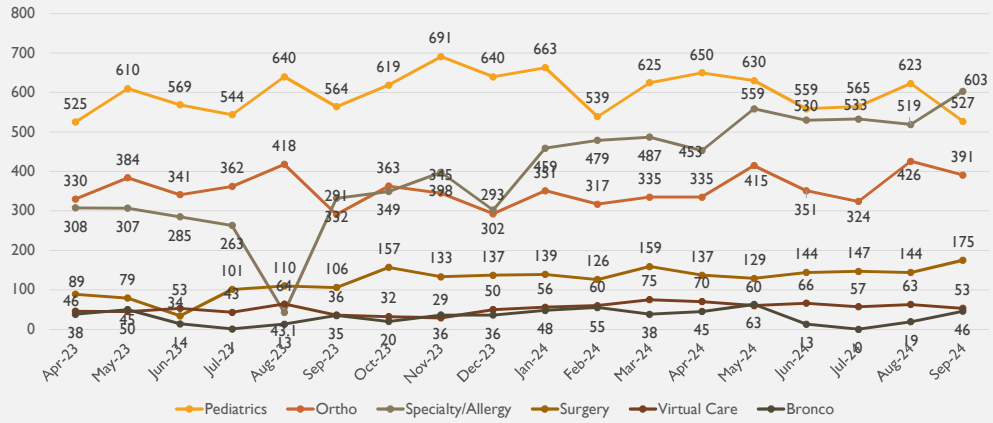


RHC VOLUME PERFORMANCE



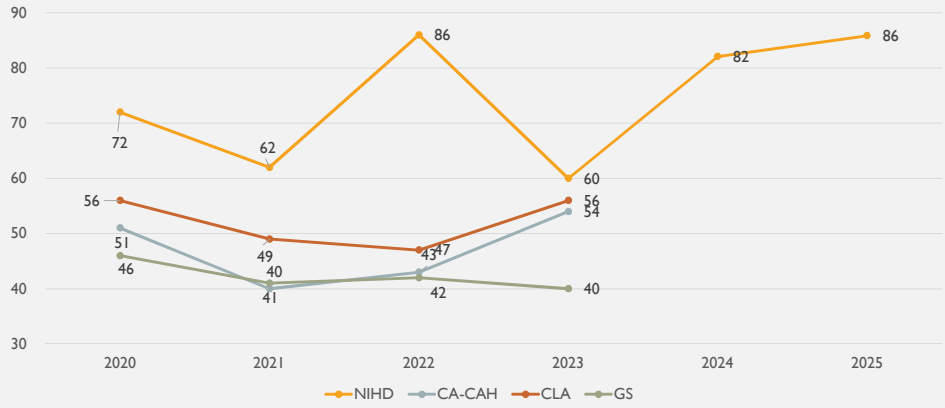
Women's +11% year over year

CLINIC VOLUME PERFORMANCE

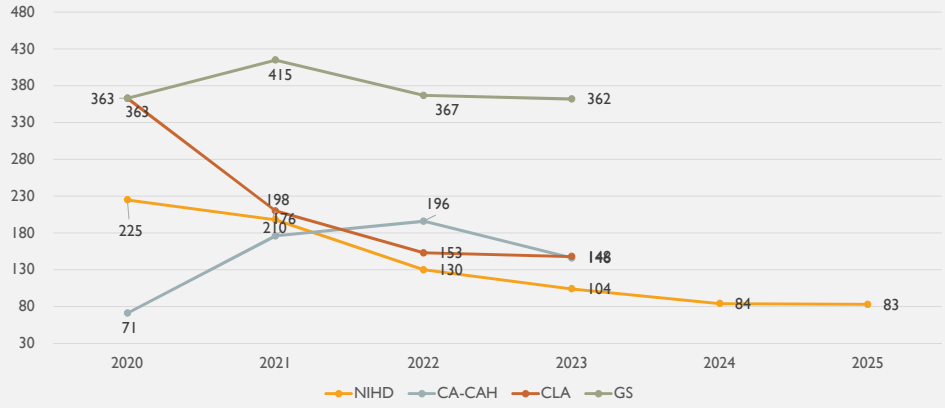


KEY PERFORMANCE INDICATORS

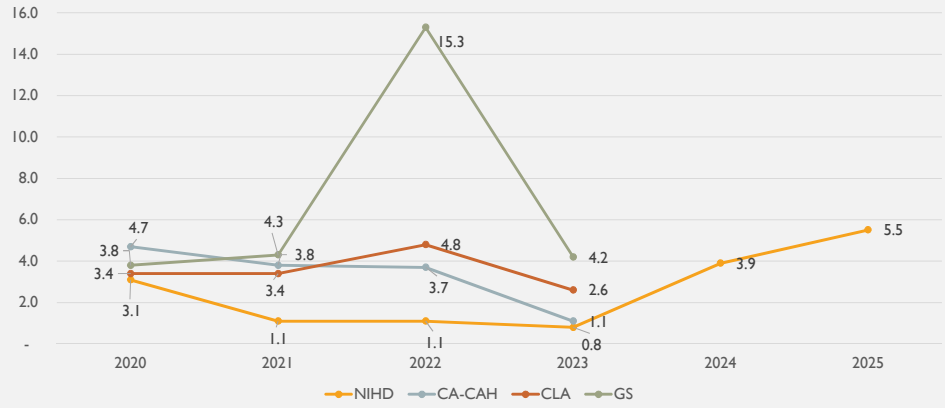
AR DAYS



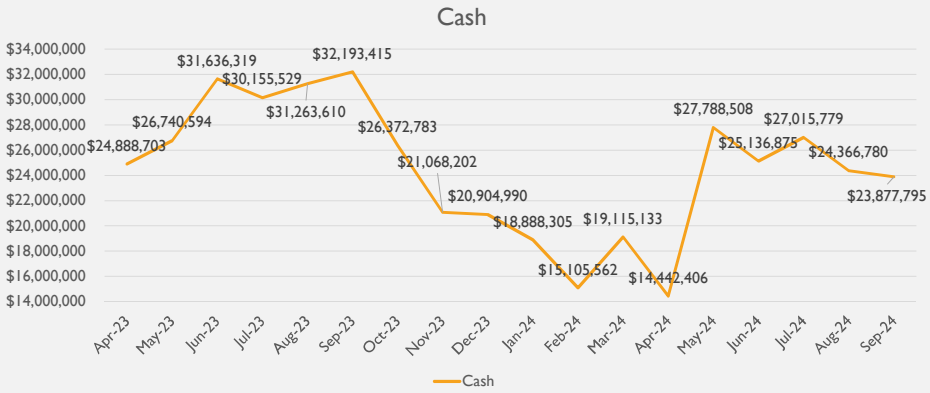
DAYS CASH ON HAND



DEBT SERVICE COVERAGE RATIO



UNRESTRICTED FUNDS



WAGE COSTS

	Sept 2022	Sept 2023	Sept 2024
Total Paid FTEs	432	370	416
Salaries, Wages, Benefits (SWB) Expense (incl. contract labor)	$6,227,947	$6,263,742	$4,893,631
SWB % of total expenses (including contract labor)	68.6%	59.4%	55.1%
Employed Average Hourly Rate	$43.41	$67.24	$50.26
Benefits % of Wages	55.7%	30.4%	46.6%

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

DATE: November 2024

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Alison Murray – CBDO/CHRO

RE: District Updates

REPORT DETAIL

The Department Leaders have contributed to this report with an overview of the ongoing work in their areas of oversight.

Marketing

1. Hosted a plaque unveiling to honor the legacy of former CEO/CFO John Halfen and Dr. John Ungersma, the hospital's first orthopedic surgeon, celebrating their lasting contributions to the healthcare district and community.
2. Contributed collateral to successful recruitment campaigns for Rehabilitation and Pediatrics in San Francisco and Orlando.
3. Completed the 2024 Breast Cancer Awareness effort, including:
    a. Displaying pink ribbons across Inyo County Main Streets with the support of the Northern Inyo Hospital Foundation and Eastern Sierra Cancer Alliance to raise awareness for early detection.
    b. Hosting the ninth annual Moonlight Mammograms event with extended screening hours and distributing 180+ goodie bags featuring donations from local businesses and healthcare partners including Tahoe Carson Radiology, Toiyabe, Valley Health, SIHD, Carson Tahoe Cancer Center, and City of Hope.
    c. A Healthy Lifestyle Talk by Drs. Cheryl Olson and Eva Wasef on the stages of breast cancer.
    d. Producing four breast cancer podcasts with NIHD experts including Breast Cancer Surgeon Dr. Cheryl Olson, Dietitian Denice Hynd, Lymphedema therapist Dana Georgeson, and then spotlighting the services provided by our partners at the Eastern Sierra Cancer Alliance.
    e. Organizing special screening days for NIHD employees and patients of Toiyabe and SIHD.

   f. Held on-campus pre-registration for participants for the Eastern Sierra Cancer Alliance's 24th Annual 5K Walk/Run as well as hosting an educational table at the event.
   g. NIHD employees raised more than $1,000 for the Eastern Sierra Cancer Alliance through t-shirt sales and showed support for early detection by wearing the pink shirts on Wednesdays and Fridays, but also frequently throughout the month.
4. Social media channels experienced solid post reach and engagement and garnered new likes across the board. Our most wide-reaching posts this quarter: Moonlight Mammograms, Employee Halloween Costume Contest, October Employee of the Month announcement (Alicia Jarvis), Halfen-Ungersma Honor video, Medicare Education Event with Stephen DelRossi, and our Healthy Lifestyle Talks with Drs. Brown, Olson and Wasef.
5. Hosted two in-person Healthy Lifestyle Talks with Dr. Stacey Brown on skin cancer.
6. Launched a new round of radio ads to increase brand awareness, including a Medical Minute on KSRW.
7. Supported the NIH Foundation’s drawing to fund a CARE shuttle AED. NIHD employee Cinthya Salazar won the watercolor painting by the late artist Jeffrey Scott.
8. Announced promotions of Chief Financial Officer and Chief Business Development Officer.
9. Completed a targeted mobile ad campaign on shopping carts to boost visibility of NIHD services.
10. Completed monthly distribution of electronic NIHD newsletter.
11. Showed solidarity for local veterans as part of Operation Green Light.
12. Preparing for participation in Bishop’s Holiday Parade and other holiday events to further enhance brand awareness.

Business Development

1. Attended Inyo Associates Dinner
2. Met with Tawni Thomson, Executive Director of Bishop Chamber of Commerce to discuss future partnerships on community events
   a. Re-established NIHD membership
3. Attended the Auxiliary craft fair fundraising event along with a number of other community fairs
4. Named a Business Development Analyst (Brittney Watson)

Foundation

1. Met with the Foundation Board x 2.
2. Named Foundation Board Clerk (Ashley Reed)
3. Ended most recent fundraiser for the CARE Shuttle AED unit earning $2891.
4. Asked NIHD staff to make recommendations for fundraising ideas and shared them with the Foundation Board to make recommendation for future fundraising plans

Grant Writing

1. Found a local Grant Writer (Carol Newark) who will be a contracted employee in charge of grant writing
    a. Carol is an experienced grant writer who has worked in public agency for many years. We are both very excited about this opportunity and she is committed to finding many opportunities for grant funding for NIHD.
2. Applied for two $1500 CARES Grants to assist with quality and finance initiatives
3. Reviewed current grants, timelines, and administration of grants to ensure compliance

Human Resources

1. Return of in person benefits fair for employees to ask vendors specific questions about their benefit options to prepare for open enrollment
    a. Improved Long Term Disability buy-up amounts while still achieving a 21% savings
2. Open enrollment from 10/21/2024 to 11/8/2024
3. Hosted Annual Halloween Costume Contest – Winners
    a. Individual winner Abel Jones from the Emergency Department as Australian Break-dancer Raygun
    b. Group winner – Authorization and Referral team as the struggle bus
    c. Team winner Rural Health Clinic as Alicia in Wonderland (inspired by the classic Alice in Wonderland).
4. Prepared for holiday festivities –
    a. Brewed Awakening Coffee cart on 11/6/2024
    b. Employee Holiday Food Drive
    c. Holiday Party 12/13/2024

5. Second Annual Point in-Time Performance Evaluation cycle completed, support for both leadership and employees
6. Comprehensive job description project is underway with full review of every current job description and minimum qualifications for the job
7. Policy review and updates, workplace violence domain is starting to wrap up
    a. Workplace Violence Domain is a partnership with our liability insurance. This partnership provided a 2% savings on our insurance premiums.
8. Created a new career ladder for the Maintenance Department that allows for growth and development opportunities within the department improving morale and job satisfaction
9. Attended annual HR and labor relations training at CALPELRA conference
10. Ongoing Management training and development including:
    a. Becoming an Emotionally Intelligent Leader
    b. Being a Fair and Caring Manager
    c. Building Up Your Emotional Intelligence
    d. Making Difficult Conversations Meaningful
    e. Fundamentals of Management: Winning at Work
    f. Fundamentals of Management: Setting the Stage for Success
    g. Fundamentals of Management vs. Leadership
    h. Fundamentals of Management: The Emerging Leader
    i. Human Resources for the Leadership Team
    j. New Employee Onboarding and Organizational Culture
    k. Promoting a Positive Work Environment
    l. Staff Retention Part 1: Current Employment Market Trends and Future Projections
    m. Staff Retention Part 2: The Generational Story You've Never Heard
    n. Staff Retention Part 3: Building An Organization That Attracts and Keeps Talent
    o. Staff Retention Part 4: Management Strategies For Improving Staff Loyalty and Longevity
    p. Staff Retention Part 5: Communicating More Effectively With Your Team
    q. Communicating Effectively
    r. Working with Difficult Individuals
    s. Effective Teamwork
    t. Handling Team Conflict
    u. FMLA: What Supervisors Need to Know

v. Key Accounting Concepts and Principles
w. Financial Management: An Introduction
x. Administrative Support: Interacting Effectively with Colleagues
y. Forging Relationships with External Stakeholders
z. Change Management: Navigating Change
aa. Change Management: Leading Change
bb. How to Improve Employee Engagement
cc. Effectively Directing and Delegating as a Manager
dd. Taking Your Team to the Next Level with Delegation

NIHD Strategic Plan

Mission Statement: Our purpose is your health; our passion is your well-being.

Values: Respect, Compassion, Stewardship, Excellence, Accountability

Respect: Unwavering support for employees and providers. **Purpose:** Fostering an environment of trust and engagement. **Definition:** Respect entails treating everyone – staff, patients, and their families – with courtesy, professionalism and empathy. To show respect to all people, beliefs, and cultures, acknowledging the inherent value of every person and their role, is of paramount importance.	**Compassion**: Leading with empathy to preserve dignity. **Purpose:** Prioritize patient experience. **Definition:** Compassion means temporarily suspending judgment so that you can appreciate others perspectives or situations when they are different from your own. To be compassionate you need to be genuinely concerned about the other person or people's needs. You need to think about and feel it from their perspective.	**Stewardship:** Mindful use of resources. **Purpose:** Efficient, innovative, and sustainable. **Definition:** Stewardship is the responsible planning, management and use of resources with the aim of ensuring their sustainability. This includes taking into account environmental, social, and economic factors to ensure that future generations can also benefit from these resources.	**Excellence:** Pursuit of excellence in quality and safety. **Purpose:** Zero harm **Definition:** An organizational recognition that achieving excellence requires a daily commitment in order to provide our patients with the highest quality care to achieve the best possible outcome.	**Accountability:** Reliable access to exceptional care. **Purpose:** Responsibly serving the community with integrity. **Definition:** Accountability is the responsibility of the organization to respond to the health priorities of the community while upholding our commitment to our patients and employees. We will be proactive in understanding healthcare related inequities that exists and implementing processes to minimize their negative impact on our patients and community.

Strategic Initiatives (Tactics):				
Workforce	**Patient experience**	**Sustainability**	**No harm**	**Access to care**
Engagement survey: Goal: Increase scores for engagement and job satisfaction every year for the next three years: • Analyze survey results to identify key areas for improvement. • Implement initiatives like regular recognition programs, team-building activities, and feedback mechanisms. • Conduct quarterly check-ins with employees to monitor progress. • Create a communication plan to share improvements and next steps with employees. Goal: Increase participation rates every year for the next three years:	Improve Patient Experience: Goal: Increase HCAHPS: • Assess baseline HCAHPS scores and identify areas for improvement, focusing on empathy, communication, and responsiveness to patient needs. • Launch staff education on empathy and compassionate communication, incorporating HCAHPS-focused training. • Implement a hospital-wide initiative to improve key touchpoints (e.g., pain management, nurse communication) based on HCAHPS results. • Review data and adjust strategies based on survey results, aiming for the 75% target.	Financial Stewardship: Goal: Maintain Financial Health Through Cash Management and Debt Service • Regularly review cash flow projections, identify trends, and implement strategies to ensure that cash on hand remains at or above the required threshold. Goal: Reduce Accounts Receivable (AR) Days to Industry Standard • Implement more efficient billing practices, streamline the claims process, and enhance the	Highest Quality Care: Goal: Continuously deliver the highest quality clinical care by achieving excellence in clinical performance, regulatory compliance, and patient-centered outcomes, with a focus on health equity. • Reimagine the Northern Inyo Healthcare District Quality Assurance and Performance Improvement (QAPI) Plan to align with the District's Strategic Plan. • Achieve the maximum allowable metrics for the Quality Incentive Pool (QIP) annually, with a focus on cancer screenings	Community Needs: Goal: Decrease the amount of time new-to-provider patients have to wait for an appointment. • Measure next third available appointment per provider. • Establish processes that maximize the workflows for patient access, clinical efficiency, and provider productivity. • Monitor on a monthly basis; discuss daily at morning huddle of clinic and patient access leadership; discuss monthly with providers lagging for expected daily appointment.

• Promote the importance of surveys through internal communications and leadership messaging. • Offer incentives such as prize drawings for survey completion. • Simplify survey process to make participation easier. • Share results transparently to encourage future participation.		revenue cycle management system. • Regular audits and training for billing staff will be implemented to minimize delays. Goal: Reduce First Pass Denials • Conduct regular training sessions for the billing and coding teams. • Streamline the claims submission process • Implement a robust audit process to ensure claims are correctly coded and documented before submission.	and mental health services. • Improve the completion rates of cancer screenings (Breast, Colon, and Cervical).	• Continuous monitoring by management and training provided to staff.

Turnover: Goal: Reduce overall turnover rate: • Conduct exit interviews to identify common reasons for turnover. • Develop targeted retention strategies, such as improving work-life balance and offering professional development opportunities. • Work closely with leadership to address high-turnover departments. • Monitor turnover rates quarterly and adjust strategies as needed.	Press Ganey Survey: Goal: Improve Press Ganey Patient Experience Survey Scores • Analyze existing Press Ganey survey data to identify key pain points in patient care and interaction. • Develop an action plan for each department based on survey feedback, including specific training for staff. • Launch initiatives to improve areas such as wait times, patient-doctor communication, and staff responsiveness. • Monitor results and make final adjustments to achieve increase in "very good" ratings.	Budget and Expense Management Goal: Meet or Exceed Budgeted Net Income • Review and adjust operational budgets as needed • Monitor departmental performance against budget expectations • Ensure appropriate cost containment strategies are in place. Goal: Maintain Capital Spending Discipline • Develop a comprehensive capital expenditure plan and establish approval processes to ensure spending is controlled and justified.	Infection Prevention / Control: Goal: Maintain infection rates for healthcare-associated infections (HAIs) and reduce surgical site infections (SSIs). • Zero infections for Central Line-Associated Bloodstream Infection (CLABSI), Catheter-Associated Urinary Tract Infections (CAUTI), Ventilator-Associated Pneumonia (VAP), and Hospital-Onset C. difficile infections. • Reduce Surgical Site Infections for key procedures year-over-year.	Continuous Review of Service Lines: Goal: Meet needs of community in a sustainable manner. • Conduct referral patterns analysis to determine the highest number of outside referrals. • Work with outside stakeholders to develop strategies to address community health needs. • Work with community leaders, governmental agencies, not-for-profit organizations, social clubs, and other third party stakeholders to develop comprehensive plan.

		• Review project costs regularly to identify opportunities for cost savings.		
Retention Rate: Goal: Increase retention rate: • Partner with locals who offer housing options for staff. • Improve internal communication and listen to employee feedback. • Implement career development programs to support career growth. • Conduct regular stay interviews to understand and address employees' needs.	Patient rounding: Goal: Implement Leader Patient Rounding in Patient Care Areas • Establish clear goals for rounding, including frequency, responsibilities, and expected outcomes. • Develop and deploy training for leaders, ensuring they understand the importance of compassionate, empathetic interactions with patients during rounds. • Implement rounds across the hospital, ensuring leaders are present and actively engaging with patients. • Review the effectiveness of rounding through patient feedback, and make adjustments to	Productivity and Staffing: Goal: Establish Staffing Benchmarks and Control Labor Costs • Collect and analyze data on staffing needs and productivity, adjusting hiring, retention, and training strategies accordingly. Goal: Migrate Provider Compensation Models to Include Productivity or Quality Components • Work with providers and legal teams to revise compensation contracts and ensure alignment	Culture of Safety: Goal: Foster a culture of safety through leadership development, employee engagement, and a systematic approach to reducing harm. • Implement BETA HEART Program • Safety Education and Training for Leaders	Community Relations Goal: Promote the District with local, state, and national audiences; develop good-will with the public; communicate the services offered by NIHD. • CEO, executives, management, leaders, and other staff attend and participate in community events. • Develop a robust marketing plan using internal and external strategies to promote the District. • Work with State and Federal Representatives to effectively communicate the needs and challenges of the District.

	improve rounding quality and outcomes.	with performance goals.		
Diversity, Equity, and Inclusion (DEI) Management Plan: Goal: Create an inclusive, equitable, and sustainable culture and work environment: • Conduct DEI training for all employees, ensuring 100% participation. • Establish a DEI advisory committee to monitor progress and suggest improvements. • Create a DEI dashboard to track diversity metrics and share progress with staff. • Implement policies to ensure equitable access to career advancement opportunities.	Leadership Training: Goal: Executive Leadership Training on Quality Customer Experience and Employee Engagement • Identify key training opportunities and providers for leadership, with a focus on customer experience and employee engagement. • Schedule and conduct training for all executive leadership. • Apply learned concepts to leadership practices, including regular monitoring and feedback to staff. • Evaluate the impact of leadership training on patient experience and employee morale.	Service Line Management: Goal: Conduct Annual Service Line Analysis and Ensure ROI for New Services • Collaborate with clinical leadership to assess existing services and determine opportunities for optimization. • For new services, conduct thorough financial assessments before contract initiation.	Prioritizing Health Equity to Reduce Health Disparities: Goal: Prioritize health equity to reduce health disparities by focusing on vulnerable populations and addressing social determinants of health. • Identify priority populations experiencing health equity disparities and implement action plans. • Stratify key clinical KPIs by demographic variables and include findings in the hospital's performance dashboards. • Deepen community relationships to mitigate health disparities and to provide equitable	

			access to high quality services.	
Leadership rounding: Goal: Conduct regular rounding with teams to address issues in real-time. • Develop a rounding schedule and assign responsibilities to leadership. • Log rounding sessions in a centralized system. • Review feedback gathered during rounding sessions and create action items. • Report weekly rounding activity to the Executive Team for accountability.	District-wide education: Goal: Establish and Implement a District-Wide Patient Experience Education Plan • Assess current patient experience standards and create a curriculum tailored to each department and role. • Launch district-wide training, ensuring all employees have access to the materials and sessions. • Complete training for all staff and gather feedback for continuous improvement. • Integrate patient experience education into the onboarding process for new employees.	Cash and Investment Management: Goal: Review Investments Annually for Maximum ROI • Conduct an annual review of all investments, working with financial advisors to adjust strategies for optimal returns.		

Union Negotiations: Goal: Successfully negotiate successor contracts by October 31, 2025. • Form a negotiation team and partner with representatives from key departments. • Develop a negotiation timeline and communication plan. • Meet regularly with union representatives to discuss priorities and address concerns. • Review financial models to ensure proposed contracts align with the District's goals.	Control and Monitoring: Goal: Ensure that patient experience improvements are sustained by instituting a formal observation and feedback process. • Define the control plan, including observation tools, protocols, and a feedback loop for staff. • Conduct initial observations and provide feedback to department leaders. • Expand the control plan to all relevant areas, including regular monitoring and continuous improvement. • Analyze data to ensure that patient care continues to meet established compassion-based standards.	Seismic Compliance: Goal: Achieve Seismic 2030 NPC5 Compliance • Ensure that necessary resources, project teams, and timelines are in place to meet seismic compliance requirements		
Leadership training: Goal: Provide monthly leadership training for all leaders.				

• Identify monthly training topics aligned with organizational goals. • Assign training modules through the Relias Learning Management System. • Monitor and report training completion rates to the Executive Team. • Gather feedback on training sessions to improve future content.				

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Melissa Best-Baker called the meeting to order at 5:30 pm.
PRESENT	Melissa Best-Baker, Chair Jean Turner, Vice Chair Ted Gardner, Secretary David McCoy Barrett, Treasurer Mary Mae Kilpatrick, Member at Large Stephen DelRossi, Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Adam Hawkins, DO, Chief Medical Officer Alison Murray, Chief Human Resources Officer, Chief Business Development Officer Andrea Mossman, Chief Financial Officer Sierra Bourne, MD, Chief of Staff
TELECONFERENCING	Notice has been posted and a quorum participated from locations within the jurisdiction.
PUBLIC COMMENT	Chair Best-Baker reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board. There were no comments from the public.
NEW BUSINESS	Chair Best-Baker called attention to new business.
COO/CNO REPORT	COO/CNO Partridge provided an update on the national IV fluid shortage. Partridge provided an update on the pharmacy project and receipt of the hood vents. Partridge highlighted the district-wide flooring and parking projects. Discussion ensued regarding the report.
CHIEF EXECUTIVE OFFICER REPORT	Chair Best-Baker called attention to the CEO report. Strategic Plan 1. CEO DelRossi said the executive team will present the strategic plan at the November 2024 board meeting. CHRO and CFO Updates 1. Andrea Mossman has accepted the CFO position. 2. Alison Murray has accepted the Chief of Business Development and Strategic Planning Officer position. Updates on conference and public appearances

1. CEO DelRossi, CBDO Murray, and Marketing Manager Barb Laughon will continue engaging the public and building relationships within the community.
2. CEO DelRossi emphasized the importance of continuing education and employee growth.

Lunch and learn training

1. An executive officer trains managers on a specific topic, such as assets, revenue, expenditures, and cost expenses.

CHIEF FINANCIAL OFFICER REPORT

Chair Best-Baker introduced the CFO Report.

Financial and Statistical Report
Discussion ensued.

Motion to accept Financial and Statistical Report: Turner
Seconded: Gardner
Roll call vote
Turner: Aye
Gardner: Aye
Kilpatrick: Aye
Barrett: Aye
Best-Baker: Aye
Passed: 5-0

Recruitment for Revenue Cycle Director

1. This position has been filled and the employee will begin in November 2024.

Preparation for audit and cost update

1. The accounting team is automating different processes and working to complete the audit.
2. We hope to present financials to the board in December 2024.

CHIEF OF STAFF REPORT

Chair Best-Baker introduced the Chief of Staff Report.

Medical Staff Appointments 2024-2025

Motion to approved medical staff appointments: Gardner
Seconded: Kilpatrick
Roll call vote
Turner: Aye
Gardner: Aye
Kilpatrick: Aye
Barrett: Aye
Best-Baker: Aye
Passed: 5-0

Medical Staff Appointments 2024-2025 – Proxy credentialing

Motion to approve medical staff appointments: Kilpatrick
Seconded: Gardner

Roll call vote
Turner: Aye
Gardner: Aye
Kilpatrick: Aye
Barrett: Aye
Best-Baker: Aye
Passed: 5-0

Medical Executive Committee Meeting Report

1. ER Doctor, Megan Young, is a local physician joining November 2024.
2. Medical Executive Committee Addition
   a. Bo Loy – Member at large
   b. Connor Wiles – Member at large

CONSENT AGENDA

Chair Best-Baker introduced the consent agenda

Motion to approve consent agenda: Gardner
Seconded: Turner
Roll call vote
Turner: Aye
Gardner: Aye
Kilpatrick: Aye
Barrett: Aye
Best-Baker: Aye
Passed: 5-0

GENERAL INFORMATION FROM BOARD MEMBERS

Chair Best-Baker introduced the general information.

Vice Chair Turner

1. Vice Chair Turner commended CEO DelRossi's presentation at the annual ACHD 2024 conference in September 2024.
2. Vice Chair Turner stated she sits on the education committee for ACHD and requested feedback to improve the education from the ACHD conference.
3. Writer Lauren Miller of the Sheet, wrote an article on the importance of health care districts in the community in October 2024.

PUBLIC COMMENT ON CLOSED SESSION ITEMS

There were no comments from the public.

ADJOURNMENT TO CLOSED SESSION

Adjournment to closed session at 06:42 pm

RETURN TO OPEN SESSION

Called back to order at 8:12 pm

Chair Best-Baker stated NIHD Board of Directors rejected the claim, John Brown v. Dr. Thomas Reid and Northern Inyo Healthcare District by a vote of 5 ayes and 0 nays.

ADJOURNMENT

Adjournment at 8:12 pm.

_____
Melissa Best-Baker
Northern Inyo Healthcare District
Chair

Attest: _____
Ted Gardner
Northern Inyo Healthcare District Chair
Secretary

November 2024 Statement

[redacted]
Open Date: 10/05/2024 Closing Date: 11/05/2024

U.S. Bank Business Platinum Card
NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

[redacted]

New Balance	**$11,232.68**
Minimum Payment Due	**$113.00**
Payment Due Date	**12/01/2024**

Activity Summary

Previous Balance	+	$6,436.88
Payments	-	$6,436.88CR
Other Credits		$0.00
Purchases	+	$11,232.68
Balance Transfers		$0.00
Advances		$0.00
Other Debits		$0.00
Fees Charged		$0.00
Interest Charged		$0.00
New Balance	**=**	**$11,232.68**
Past Due		**$0.00**
Minimum Payment Due		**$113.00**
Credit Line		$37,500.00
Available Credit		$26,267.32
Days in Billing Period		32

[redacted]

[redacted]

24-Hour Cardmember Service: [redacted]

. to pay by phone
. to change your address

[redacted]

Account Number	[redacted]
Payment Due Date	12/01/2024
New Balance	$11,232.68
Minimum Payment Due	$113.00

Amount Enclosed $_____

[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: Cardmember Service, [redacted]

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, [redacted]

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 U.S. Bank National Association, [redacted] 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
10/25	10/25	0000	INTERNET PAYMENT THANK YOU	$6,436.88CR	
			TOTAL THIS PERIOD	**$6,436.88CR**	

Purchases and Other Debits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
10/08	10/07	[redacted]	USPS PO [redacted] BISHOP CA	$209.99	Mail
10/15	10/13		FACEBK [redacted] CA	$400.00	Marketing
10/15	10/12		WOLTERS KLUWER/CCH/ [redacted] IL	$70.00	Education
10/15	10/12		WOLTERS KLUWER/CCH/ [redacted] IL	$70.00	Education
10/17	10/16		TST*GREAT BASIN BAKERY Bishop CA	$178.52	Recruiting
10/18	10/16		CIELO HOTEL BISHOP CA [redacted]	$462.52	Recruiting
10/18	10/17		AVENU HRS PRO [redacted] NH	$419.00	Licensing
10/24	10/23		USPS PO [redacted] BISHOP CA	$9.68	Mail
10/25	10/25		NATIONALPUMPSUPPLY [redacted] WA	$7,743.69	Facilities
10/25	10/24		AMAZON MKTPL* [redacted]	$21.01	Office Supplies
10/28	10/24		MARRIOTT MISSION VALLE SAN DIEGO CA [redacted]	$691.69	Board Clerk Conf
10/28	10/25		AMAZON MKTPL* [redacted]	$19.01	Office Supplies
10/30	10/29		ACADEMY CDR ACEND PAC [redacted]	$604.00	Manuals
11/01	10/31		FACEBK *7PYBWDYKU2 [redacted]	$333.57	Marketing
			TOTAL THIS PERIOD	**$11,232.68**	

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)*

Continued on Next Page

NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

[redacted]

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	23.74%	
**PURCHASES	$11,232.68	$0.00	YES	$0.00	23.74%	
**ADVANCES	$0.00	$0.00	YES	$0.00	29.99%	

Contact Us

[redacted]

NORTHERN INYO HOSPITA

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Anesthesia Clinical Standards and Professional Conduct		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Privileged Practitioners in Anesthesia		
Date Last Modified: 09/07/2022	Last Review Date: 11/06/2024	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/01/2001	

PURPOSE:

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

POLICY:

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

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

REFERENCES:

1. The Joint Commission. CAMCAH (2022). PC.03.01.01. PC. 03.01.03. PC.03.01.07
2. CMS Conditions of Participation: Operative and Invasive Procedures.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. *Anesthesia in Ancillary Departments*
2. *Medical Staff Department Policy – Anesthesia*
3. *Pre and Post Operative Anesthesia Visits*
4. *Scope of Anesthesia Practice*
5. *NPO Guidelines*

Supersedes: v.3 Anesthesia Clinical Standards and Professional Conduct

NORTHERN INYO HEALTHCARE DISTRICT
COMMITTEE CHARTER

Title: Billing and Coding Compliance Committee Charter		
Owner: HIM Manager	Department: Medical Records	
Scope: Committee Membership		
Date Last Modified: 11/01/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: Executive Committee	Original Approval Date:	

COMMITTEE PURPOSE

The Billing and Coding Compliance Committee (BCCC) reports to the Compliance and Business Ethics Committee (CBEC). The BCCC reviews Revenue Cycle questions, chargemaster updates and changes, and provides informative, collaborative advisory oversight, and approval to charging, billing, and coding related items and policies for Northern Inyo Healthcare District's (NIHDs) hospital and clinic services. BCCC ensures that all facility validation and recertification requirements are met based on federal, state, and local laws and regulations. This committee contributes to the compliant and successful implementation of new services lines in accordance to the New Line of Service Implementation policy.

COMMITTEE MEMBERSHIP

- Chief Financial Officer
- Compliance Officer
- Director of Revenue or designee
- Defense Auditor
- Manager of Project Management
- Director of Medical Staff Support or representative
- Director of Patient Access
- Billing Office Manager (Billing Office Manager and HIMS Manager will be Co-Chairs)
- Charge Capture
- Health Information Management Services (HIMS) Manager
- Member from the following teams:
    - Billing and Coding including 3rd Party Vendors
    - Information Technology Services
    - Clinic Leadership
    - Clinical Informatics representative
    - Pharmacy
- Ad Hoc
    - Chief Executive Officer
    - Chief Nursing Officer
    - Chief Operating Officer
    - Director of Diagnostic Services or a representative

- Finance Budget Analyst
- Additional staff as needed

FREQUENCY OF MEETINGS

Convenes every other week or as needed

COMMITTEE GOALS

1. Ensure all charge master changes are reviewed and recommendations sent to CEO or CFO prior to being implemented across the District.
2. Approve processes related to charging, billing, and coding compliance of hospital and clinical services.
3. Complete coding review, which will include the discussion of denials in order to identify ways of reducing denials in the future, if there is not a Denials Review group in the Revenue Cycle.
4. Review and discuss coding audits. Identify action items and process, as needed.
5. Ensure that all new service lines move through the appropriate channels, in accordance with the New Service Line Implementation Policy.
6. Keep all members of the committee, and appropriate NIHD team members, aware of onboarding physicians or specialists.
7. Ensure that NIHD is in compliance with facility validation requirements and recertification.
8. Other items related to billing and coding compliance, as needed.

COMMITTEE RESPONSIBILITIES

- Members will add ~~any~~ agenda items to the tracking system prior to the scheduled meeting for discussion.
- Members will review the agenda on the tracking system and be prepared to provide input or discuss impact in regards to their unit or department.
- Members should have an update for their action items prior to each meeting to ensure that the meeting runs smoothly and there is no time wasted.

RETENTION AND DESTRUCTION OF RECORDS

Minutes are to be maintained for a minimum of six (6) years.

Supersedes: v.1 Billing and Coding Compliance Committee Charter

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Coroner's Cases		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: District Wide		
Date Last Modified: 10/28/2024	Last Review Date: 02/18/2020	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/01/86	

PURPOSE: To provide a procedure for establishing, reporting and preparing coroner's cases.

POLICY: All deaths in the hospital are reported to the House Supervisor (HS). The HS will call the coroner regarding deaths that falls under the classification of reportable cases. In no instance should a body under the jurisdiction of the Coroner be released to a funeral establishment, or removed from surgery or emergency room except by explicit instructions from the Coroner's office. Permission from the deceased's family for autopsy is desirable but not mandatory. The Coroner is entitled to the custody of the remains until the conclusion of his autopsy or medical investigation.

TYPE OF CORONER'S CASES:

1. No physician in attendance at the time of death.
   a. If the physician has not seen the patient during the 20 days before death.
   b. If the physician has been in attendance less than 24 hours, or when attending physician is unable to make the diagnosis.
2. Known or suspected homicide.
3. Known or suspected suicide.
4. Involving any criminal action or suspicion of a criminal act, such as criminal abortion or euthanasia.
5. Related or following known or suspected self-induced criminal abortion.
6. Associated with a known or alleged rape or abnormal sex act.
7. Following an accident or injury (primary or contributory) occurring recently or at some remote time.
8. Drowning, fire, hanging, gunshot, stabbing, cutting, starvation, exposure, acute alcoholism, drug addiction, strangulation or aspiration.
9. Accidental poisoning (food, chemical, drug, therapeutic agent).
10. Occupational diseases or occupational hazards.
11. Known or suspected contagious disease constituting a public hazard.
12. All deaths in an operating room.
13. All deaths where a patient has not recovered from an anesthetic, whether in surgery, recovery room or elsewhere.
14. All deaths in which the patient is comatose throughout the period of physician's attendance, whether at home or in the hospital.
15. Deaths of patients in state mental hospitals serving the mentally disabled and developmentally disabled operated by state agencies.
16. Deaths wherein suspected cause is Sudden Infant Death Syndrome.
17. In prison or while under sentence.

18. All solitary death unattended by physician or other person in period preceding death.
19. All deaths of unidentified persons.
20. Deaths under such circumstances as to afford a reasonable ground to suspect that the death was caused by a criminal act.

PROCEDURE:

1. Notify the House Supervisor of all patient deaths. The HS can call the coroner at (760) 873-4266 to notify of death. If you have doubt, or not sure if the cause should be a coroner's case, call the coroner and ask.
2. Do not remove any tubes (example: ET, IV, Foley, Chest Tubes, etc.). Simply clamp off the ones that may drain.
3. Do not clean the body (example: it could remove powder burns or other forms of evidence).
4. Wait for the coroner to pick up the body.
5. The coroner will complete the "Authorization for Release of Body to Mortuary" form. This completed form is then part of the medical record.
6. The patient's belongings are given to the coroner. Do not release any evidence or personal property to law enforcement or family without the knowledge and consent of coroner.

DOCUMENTATION:

1. Document in the medical record:
   a. All documentation regarding the patient's death.
   b. Time of death according to physician pronouncement.
   c. Family members notified.
   d. Time coroner picked up the body.
   e. Tubes left in place.
   f. Any belongings sent with the body or home with the family. The clothing may be given to the family only with the permission and in the presence of the coroner

REFERENCES:

1. California Public Law. Health and Safety Code (2010). Article 3. *Responsibility of Coroner.* Section 102850-10286
2. Center for Disease Control and Prevention. Coroner/Medical Examiner Laws. Retrieved from https://www.cdc.gov/phlp/publications/coroner/california.html
3. California Code, Government Code Section 27491. Retrieved from https://codes.findlaw.com/ca/government-code/gov-sect-27491.html

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Neonatal Death, Fetal Demise & Spontaneous Abortion Procedure
2. Death- Disposition of Body
3. Death in the Operating Room
4. Dead on Arrival

Supersedes: v.2 Coroner's Cases

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Handling of Soiled Linen		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope:		
Date Last Modified: 10/16/2024	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
The aim of this policy is intended to inform staff of the correct management and disposal of used linen, in order to protect patients, healthcare workers and laundry staff from contamination or injury.

POLICY:

1. All soiled linen is considered contaminated
2. Soiled linen shall be handled as little as possible and with minimum agitation to prevent contamination of the air and persons handling the linen
3. Bag contaminated laundry at the location of use. Do not sort or rinse laundry at the location where it is used.
4. Contaminated linen or linen bags should not be held close to the body when handling to avoid exposure
5. Hand Hygiene must be completed after each contact with soiled linen and before contact with clean linen
6. Appropriate PPE will be worn when handling contaminated linen
7. Linen heavily contaminated with blood or other bodily fluids shall be bagged and transported in a manner that prevents leakage.

PROCEDURE:

1. Linen bags should not be more than ¾ full and be tied securely. There will be a linen hamper in every patient room. Environmental services personnel will remove and replace line bags as required.
2. Personal protective equipment (PPEs) must be worn for sorting soiled linen.
3. Gloves, impervious gown, face shield, or mask and goggles must be worn to protect the sorter from body fluids.
4. Hand Hygiene must be completed after each contact with soiled linen, and before contact with clean linen.
5. Soap and Water must be used if gloves are soiled, and if linen is contaminated from a patient in C-diff precaution.
6. Contaminated linen bag from an enteric precaution room (e.g. C-diff or Norovirus) shall be place in a red biohazard bag before leaving the patient room.
7. Linen contaminated with Hazardous Drugs will be placed in the Chemo Spill Kit Bucket. If a large amount of spill occurs the linen will be double bagged using the labeled bags found in the Spill Kit and subsequently placed in a rigid, labeled bucket for disposal. Refer to Chemotherapy Spill Protocol

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REFERENCES:

1. Association for Professional in Infection Control and Epidemiology (APCI) (2024). Healthcare Textile Services. Retrieved from APIC Text https://text.apic.org/toc/infection-prevention-for-support-services-and-the-care-environment/healthcare-textile-services?Token=0AkUd000013LNOiKAO
2. Centers for Disease Control and Prevention (CDC), (2024) ~~(2017)~~. Infection Control Assessment and Response (ICAR) Tool for General Infection Prevention (IPC) Across Settings: Observation For,- Healthcare Laundry. ~~Acute Care Hospitals.~~ Retrieved from https://www.cdc.gov/infection-control/media/pdfs/icar-ipc-obs-form-hc-laundry-508.pdf ~~https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html~~
3. Centers for Disease Control and Prevention (CDC). (2024). G. Laundry and Bedding. Retrieved from https://www.cdc.gov/infection-control/hcp/environmental-control/laundry-bedding.html

Infection Control Today. (June 18, 2015). Best Practices to Prevent Infections during Laundering of Healthcare Textiles. Retrieved from http://www.infectioncontroltoday.com/news/2015/06/best-practices-to-prevent-infections-during-laundering-of-healthcare-textiles.aspx

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~~2. Centers for Disease Control and Prevention. (2017). Infection Control Assessment Tool for Acute Care Hospitals. Retrieved from https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html~~

~~3. Centers for Disease Control and Prevention. (2014). CDC's Infection Prevention and Control Recommendations for Hospitalized patients with Known or Suspected Ebola. https://www.cdc.gov/hicpac/pdf/guidelines/eic_in_HCF_03.pdf~~

~~4.~~2. ~~Infection Control Today. (June 18, 2015). Best Practices to Prevent Infections during Laundering of Healthcare Textiles. Retrieved from http://www.infectioncontroltoday.com/news/2015/06/best-practices-to-prevent-infections-during-laundering-of-healthcare-textiles.aspx~~

~~5. Occupational Safety & Health Administration. Laundry. Retrieved from https://www.osha.gov/SLTC/etools/hospital/laundry/laundry.html~~

~~6.~~5. Occupational Safety and Health Administration. (Site Accessed 9-24-24 Controlling Occupational Exposure to Hazardous Drugs. Retrieved from https://www.osha.gov/hazardous-drugs/controlling-occex~~https://www.osha.gov/dts/osta/otm/otm_vi/otm_vi_2.html~~

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Bloodborne Pathogen Exposure Control Plan
2. Severe Acute Respiratory Syndrome Coronavirus (SAS-CoV) Middle East Respiratory Syndrome Coronavirus (MERS-CoV) Infection Control Recommendations for Hospitalized Patients
3. Chemotherapy Spill Protocol
4. Aerosolized Transmissible Disease Plan
5. Linen Laundry Processes AB 2679
6. Bed Bug Infestation and Management
7. Handling of Soiled Linen

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Supersedes: v.4 Handling of Soiled Linen

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NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Information Technology Services After-Hours Call		
Owner: Harper, Bryan (ITS Director - CISO)	Department: Information Technology Services	
Scope: District Wide		
Date Last Modified: 07/03/2024	Last Review Date:	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE: To establish guidelines ensuring the Information Technology Services (ITS) department is consistently available and accountable for the operational functionality of IT resources, supporting Northern Inyo Healthcare District's mission.

POLICY:

1. The ITS department will provide 24/7 support for the hospital's IT needs.
2. Business hours for the IT department will be determined by the IT Director and may be adjusted as necessary to meet hospital requirements.
3. Hours outside of business hours will be referred to as "After-hours."
4. ITS personnel will be assigned to be on-call during "After-hours."
5. ITS personnel classified as FLSA exempt will be assigned to "After-hours" on-call duty without additional compensation.
6. ITS personnel classified as FLSA non-exempt will be assigned to "After-hours" on-call duty with compensation.
7. FLSA non-exempt ITS personnel may be contacted by the on-call person during "After-hours" to perform remote or on-site tasks. Hospital call-back pay rules will apply during such instances.

PROCEDURE:

1. Only the nursing staff member serving as the "house supervisor," the administrator on call, or an IT management personnel are authorized to contact the IT on-call person.
2. The current ITS on-call schedule shall be posted on any designated electronic platform for on-call personnel.

REFERENCES:

1. N/A

CROSS REFERENCE P&P:

RECORD RETENTION AND DESTRUCTION: N/A

Supersedes: v.1 Information Technology After-hours Call

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Inventory Control Obsolescence		
Owner: Director of Purchasing	Department: Purchasing	
Scope:		
Date Last Modified: 11/11/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

Inventory items that are no longer usable due to obsolescence will be removed from the active inventory as soon as the obsolete condition is noted. Department Directors or Managers will notify purchasing of obsolete supplies and Purchasing will gather supplies for processing.

PROCEDURE:

A. The most common reasons are:
    1. An item is damaged in handling.
    2. An item reached or passed the expiration date.
    3. A new item is purchased to perform the function previously performed by the old item, usually due to technology advances.
    4. The item is no longer used because of a change in procedures, patient population, or physician preference.

B. An expired item is removed from inventory. If an item is a known low-use product required by a specific department, it is charged to the department, otherwise it is charged to the inventory adjustment account.

C. When an item is replaced by a new item, the old item will be depleted whenever possible. When the items remaining cannot be used, it is taken out of inventory. The item is charged to the department that used the item.
    1. When usage of an item stops, the department that used the item reports why the change occurred.
    2. If the department believes usage of the item will resume, no action is taken, the item reviewed is reviewed in three months to determine the item's par level, if needed. If the department agrees that the item is no longer needed, it is removed from inventory.
    3. An item is not normally stocked when it was unused in the prior 12-month period, even if the department believes usage will resume. If there is stock in the warehouse, the stock is issued to the department on an as-needed basis.
        i. An item that is obsolete is charged to the department that used the item.

D. Efforts are taken to recover value for obsolete items.
    1. Expired pharmaceuticals are usually returned for credit.
    2. Other expired supply items might be returned for credit.
    3. Unexpired items might be returned for credit or offered for sale to other healthcare institutions.
    4. If none of the above options are feasible, the item is safely discarded.

E. If value is obtained due to return or resale, the value is credited to the department that was charged for the item.
F. Once an item is determined obsolete, the warehouse accepts inventory but the department is not credited and any item remaining in the department is returned to storeroom for disposal or resale and credit is not issued to the department except as noted above.

Supersedes: v.2 Inventory Control Obsolescence*

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: 09/05/2024	Last Review Date: No Review Date	Version: 4
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 – 4:30pm.

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, 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 Assistant Manager, 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.
- Request for application access must come from the Dept. Manager or Director and emailed to servicedesk@nih.org.

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.

Service Desk ticket requestors must provide the following information:

- 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.3 ITS Service Desk Work Order

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Maintaining Temperature & Humidity in Anesthetizing Locations		
Owner: Director of Facilities	Department: Plant Services	
Scope: Surgery		
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 ensure that temperature and humidity are properly maintained in anesthetizing locations.

POLICY:
It is the policy of Northern Inyo Healthcare District to develop and implement plans, programs and processes that will promote a safe and functional environment.

PROCEDURE:

1. The organization designs, constructs, and maintains features of the ventilation systems suitable for the care, treatment, and services provided.

2. Determination of appropriate temperature and humidity in the anesthetizing locations, such as operating rooms, shall be determined through a risk analysis, which is a collaboration between Infection Control, Maintenance and Surgery staff. Under consideration are, the NFPA 99 Standard for Healthcare Facilities ASHRE Standards, current Association of Perioperative Registered Nurses (ARON) recommendations and the CMS Waiver (Ref: S&C: 13-25-LSC & ASC April 19, 2013) along with Northern Inyo Healthcare District clinical experience.

3. Northern Inyo Healthcare District temperature range for operating suites are typically between 68° to 73°F or as may be appropriate for the care and treatment of patients. The humidity shall be within the acceptable practice and recommendation of ARON and CMS approval of 20% to 60%. Northern Inyo Healthcare District humidity range shall be 20% to 60%. Any changes to these ranges shall be reviewed with Infection Control, Maintenance, and surgery staff as described above and documented by the facility.

4. Maintaining the appropriate level of temperature and humidity shall be based on a utility system risk assessment and be monitored on a regular basis based on the risks in collaboration with Infection Control, Maintenance, and Surgery staff. The temperature and humidity system is monitored through the building automation system, and by (surgery staff). Should the system fall out of the appropriate range, Maintenance will adjust the appropriate systems to maintain the desired ranges of temperature and humidity in the operating rooms and verify that the appropriate ranges for temperature and humidity are being maintained after system adjustments.

REFERENCES: N/A

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Medical Staff Peer Review and Professional Practice Evaluations		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Medical Staff and Advanced Practice Providers		
Date Last Modified: 09/02/2024	Last Review Date: 05/18/2022	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/15/2016	

PURPOSE:
To clearly outline the purpose, function and procedures for Medical Staff peer review, Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE). The Medical Staff uses these processes to continuously monitor privileged practitioners and uses the results of such reviews to improve the quality of care provided to patients and to inform privileging decisions in accordance with applicable law and accreditation standards.

DEFINITIONS:
1. **Peer Review** is an evaluation of a practitioner's professional performance for all defined competency areas using multiple data sources. Peer review is a part of professional practice evaluation (FPPE and OPPE) and includes the identification of opportunities to improve care.
2. **Focused Professional Practice Evaluation (FPPE)** is the time-limited evaluation of practitioner competence in performing a specific privilege. This process is implemented for all initially-requested privileges and whenever a question arises regarding a practitioner's ability to provide safe, high-quality patient care.
3. **Ongoing Professional Practice Evaluation (OPPE)** is a summary of ongoing data collected during a defined time period for the purpose of assessing a practitioner's clinical competence and professional behavior. Through this process, practitioners receive feedback for potential personal improvement or confirmation of personal achievement related to the effectiveness of their professional practice in all practitioner competencies (defined below).
4. A **peer** is defined as an individual that is credentialed within the same specialty discipline and with the same scope of clinical privileges; an individual practicing in the same profession who has expertise in the appropriate subject matter under review.
5. **Practitioner** is an individual permitted by law and by the organization to provide care, treatment and services without direct supervision. A practitioner operates within the scope of his or her license, consistent with individually granted clinical privileges. This may include physicians, oral and maxillofacial surgeons, dentists, podiatrists, physician assistants and Advanced Practice Providers.
6. **Practitioner Competencies:** The Medical Staff has determined that for purposes of defining its expectations and measurements of performance for the Joint Commission General Competencies, it will use the American College of Graduate Medical Education (ACGME) framework outlined below:
    a. **Patient Care** - Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

b. **Medical/Clinical Knowledge** - Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.
c. **Practice-Based Learning and Improvement -** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
d. **Interpersonal and Communication Skills -** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.
e. **Professionalism** - Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.
f. **Systems-Based Practice** - Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

7. **Conflict of Interest:** A member of the Medical Staff requested to perform a peer review or performance evaluation may have a conflict of interest if he or she may not be able to render a fair and constructive opinion.
    a. An *absolute conflict* of interest would result if the practitioner is the provider under review or a first-degree relative or spouse.
    b. *Potential conflicts* of interest may result if the practitioner is directly involved in the patient's care but not related to the issues under review or a direct competitor, partner or key referral source. Potential conflicts may also result if the practitioner is involved in a perceived personal conflict with the practitioner under review.
    c. It is the obligation of the evaluator to disclose to the Medical Executive Committee (MEC), in advance, the absolute or potential conflict.
    d. It is the responsibility of the MEC to determine on a case-by-case basis if a potential conflict is substantial enough to prevent the individual from participating in the review process.

POLICY:

1. All peer review and professional practice information is privileged and confidential in accordance with Medical Staff bylaws, regulations, federal laws, and California Evidence Code 1157. This information is available only to authorized individuals who have a legitimate role in the peer review process.
2. All Medical Staff departments participate in peer review and professional practice evaluations in accordance with this policy and their departmental policies.
3. Medical Staff departments develop critical indicators which trigger an evaluation of the care provided. Critical indicators are reviewed by the department annually.
4. Medical Staff departments develop appropriate and relevant FPPE and OPPE criteria for accurate and fair monitoring of practitioners.
5. Oversight of departmental peer review and professional practice evaluations is provided by the Credentials Committee and/or the MEC.

PROCEDURE:

1. Peer Review
    a. Peer review is conducted on cases meeting critical indicators or cases otherwise referred for review (such as through Unusual Occurrence Reports). Cases are reviewed with a focus on

identifying opportunities for practice or technical improvement, clinical education, professional feedback, and/or systems improvements.

b. Cases are assigned an overall care rating as follows:
    i. No Further Action
        1. This rating would be assigned in instances where no quality of care concerns or other significant opportunities for improvement are identified. This is also appropriate when a case is determined to be a complaint or occurrence that is not validated.
    ii. Interesting; Worthy of Discussion
        1. This rating can be assigned when there is no concern for quality of care but the case could be reviewed for its educational value.
    iii. Track and Trend
        1. This rating would be assigned in instances where a single case may not rise to a level of concern, but a pattern of similar cases or occurrences would indicate a concern or opportunity for improvement. This rating may also be selected when additional monitoring is needed to ensure a pattern does not develop. Track and Trend may be selected in addition to other overall care ratings.
    iv. Opportunity for Improvement (OFI) – Minor
        1. This rating occurs when an opportunity for improvement is identified needing additional education or feedback. OFI-Minor is designated for cases when most practitioners would have done differently, but the potential for a negative outcome is low.
    v. Opportunity for Improvement (OFI) – Major
        1. This rating occurs when an opportunity for improvement is identified needing additional education or feedback. OFI-Major is designated for cases when most practitioners would have done differently and the potential for a negative outcome is high or a negative outcome did occur.
    vi. Refer to Committee Review
        1. This rating would be assigned when the case needs to be sent to a Medical Staff committee for additional review and/or possible escalation. The committee may be a department committee (e.g., Emergency Department), a multidisciplinary committee (e.g., Utilization Review/Medical Records Committee), the Credentials Committee, or the MEC.
c. A peer review case that is given a rating of "Opportunity for Improvement – Major" shall be automatically referred to the next Credentials Committee meeting and/or MEC meeting for review and determination if any additional action, such as institution of a FPPE for concerns, is warranted.
d. Case ratings are collated at initial FPPE and at each OPPE cycle for each practitioner. A FPPE or OPPE that has exceeded the departmental thresholds for acceptable peer review case ratings will be reviewed by the Credentials Committee and the MEC.
e. External peer review may be conducted whenever there are concerns about conflict of interest or the possession of the appropriate level of experience or skill by the internal reviewers.

2. Focused Professional Practice Evaluation (FPPE)
    a. A requesting committee or Medical Staff leader may initiate the FPPE process in the following ways:

i. Selecting and recommending an appropriate FPPE plan during the credentialing and privileging process in the case of initial appointments or new privileges.
ii. Submitting a FPPE monitoring plan to the MEC in the case of questionable performance or outcomes.
iii. A FPPE is indicated as the result of an OPPE.
iv. A FPPE is indicated as the result of a FPPE.

b. A FPPE for initial appointments and additional privilege grants will be determined by the Department Chief or designee. For Advanced Practice Provider members, the FPPE will include at least five proctored or reviewed cases by the collaborating/supervising physician.
c. A 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. Focused review of a practitioner's performance shall be referred to the MEC for decision and may be requested by any of the following: Officer of the Medical Staff, Department Chief, Credentials Committee, Chief Executive Officer, and Board of Directors
    i. If the MEC, on its own or in consultation with other appropriate committees and individuals, determines that a FPPE is warranted, then the MEC shall be responsible for defining the exact nature and scope of the FPPE. Any action, decision, finding or recommendation by the MEC shall be based upon the evaluation of the Practitioner's current clinical competence, practice behavior and ability to perform the clinical privileges under review.
d. If after the designated review period, the practitioner did not meet all FPPE requirements, then the evaluation period may be extended, a different type of evaluation process assigned, or evidence of successful proctoring from another facility may be accepted. Failure to complete FPPE may also result in modification to privileges and/or Medical Staff membership as outlined in the Medical Staff Bylaws.
e. Information to be considered in a FPPE may include, but is not limited to: chart reviews monitoring clinical practice patterns, simulation, proctoring, external peer review and/or discussion with other care givers of specific patients (i.e., consulting physicians, assistants, nursing or administrative personnel).
f. External sources may be utilized in the FPPE process if there are concerns about conflict of interest or the possession of the appropriate level of experience or skill by the internal reviewers.
g. Evaluation results and recommendations are documented by the evaluator and transmitted for review to the Credentials Committee and MEC, along with supporting documentation.

3. Ongoing Professional Practice Evaluation (OPPE)
    a. The OPPE process shall begin immediately after satisfactory completion of the initial appointment FPPE process and provide continuous monitoring of practitioner's performance. Such evaluations shall be factored into credentialing, privileging and appointment decisions.
    b. An OPPE will be completed for each clinical staff member every 8 months. This form includes performance measures for the six ACGME practitioner competencies as defined above.
    c. An evaluator may be the Chief of Staff, Department Chief or other designee selected by the MEC. The evaluation results and recommendations of the evaluator shall be reported to the Credentials Committee and the MEC.

d. Elements for review may include, but are not limited to: operative and other clinical procedure(s) performed and their outcomes; pattern of blood and pharmaceutical usage; medical record completion; infection control results; morbidity and mortality data; patient satisfaction/ complaints; additional elements of performance as defined by the department and organized Medical Staff. The information listed may be acquired through concurrent proctoring (direct observation), prospective proctoring/simulation, retrospective proctoring (medical record review), reciprocal proctoring (offsite/another facility), outcomes/performance measurement data review, monitoring of diagnostic and treatment techniques and/or discussion with other individuals involved in the care of each patient including consulting physicians, assistants, nursing, and administrative personnel.
e. If there are no elements available for review, the MEC may recommend continuing existing privilege(s), as long as there are no known issues/concerns regarding the practitioner. Recommendation without available elements, however, shall not occur for any two concurrent evaluations.
f. If there is uncertainty regarding the practitioner's clinical competence, practice behavior, and ability to perform the requested privileges, the organized Medical Staff may take actions including, but not limited to, the following: track and trend, referral to Physician Wellness Committee, referral/request for FPPE, reduction, revision, revocation or summary suspension of privileges, corrective and/or disciplinary actions.
    i. An OPPE designated as "Track and Trend" will result in more regular monitoring of the specific concern (i.e., behavioral or clinical) by the practitioner's Department Chief, Department Chair, or designee. Further repeated instances when a practitioner is on Track and Trend will be reported to the Credentials Committee and/or MEC as appropriate for review and determination of any further action.
    ii. Two OPPEs designated as "Track and Trend" in a 24-month period will be referred to the Credentials Committee and/or MEC for review and determination if any additional action(s), such as institution of a FPPE for concerns, is warranted.
g. Reappointment to the Medical Staff/Renewal of Privileges
    i. Data collected during the OPPE process shall be considered by the Credentials Committee and MEC when making decisions to approve/reject reappointment to the Medical Staff and/or renewal of privileges of the evaluated practitioner.

REFERENCES:

1. Providence Sacred Heart Medical Center. (2014). *Medical Staff Peer Review and Professional Practice Evaluation.* https://www.providence.org/-/media/project/psjh/providence/wa/files/shmc/medstaff/peerreview.pdf?rev=65fa6587f17e4e77bfe456a086a22aab&hash=B231EE9659A527DED42F3FC5ADA996A3
2. UCLA Ronald Reagan Medical Center. (2020). *Quality Management and Peer Review.* https://www.uclahealth.org/sites/default/files/documents/MS102%20Quality%20Management%20and%20Peer%20Review%2003312014%20gh.pdf?f=972ae679
3. The Joint Commission. "Medical Staff." Comprehensive Accreditation Manual for Critical Access Hospitals. Oakbook: Joint Commission Resources, 2015. MS-29-S-33. Print.
4. CNA. "Medical Staff Credentialing: Eight Strategies for Safer Physician and Provider Privileging." Vantage Point 9.3 (2009): n. pag. Web. 9 Mar. 2016. <https://www.cna.com/vcm_content/CNA/internet/Static%20File%20for%20Download/Risk%20Control/Medical%20Services/MedStaffCredentialing.pdf>.

RECORD RETENTION AND DESTRUCTION:

1. Peer review and professional practice evaluation documents are to be kept in the Medical Staff Office for the length of the practitioner's career, plus 6 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Northern Inyo Healthcare District Medical Staff Bylaws
2. Medical Staff Professional Conduct Policy

Supersedes: v.2 Focused and Ongoing Professional Practice Evaluation

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Monitoring Conditions		
Owner: Director of Facilities	Department: Maintenance	
Scope: District Wide		
Date Last Modified: 09/11/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE

The purpose of this policy is to establish annual performance improvement activities.

POLICY

It is the policy of Northern Inyo Hospital to establish annually a Performance Improvement Activity (PIA) which will be presented to the Safety Committee. The PIA will typically be selected for issues identified as short comings during annual EC Program reviews, or as a result of problems arising during the course of the year.

PROCEDURES

A. A recommendation for one or more PI activities is communicated at least annually to the organization's leaders based on the on-going performance monitoring of the environment of care management plans. A sample recommendation is provide in Attachment I.

B. The representatives from clinical, administrative, and support services will continue to monitor that performance activity for the remainder of the year.

REFERENCES: N/A

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure - Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Nurse Practitioner, Certified Nurse Midwife		
Date Last Modified: 10/18/2024	Last Review Date: 11/06/2024	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/15/2020	

PURPOSE:
This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines for the management of emergency care conditions.

POLICY:
1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROCEDURE:
1. Database:
    a. Subjective
        i. Obtain pertinent history related to emergency symptoms.
        ii. Collect appropriate information, including past medical history, review of systems, allergies, immunizations, and medications.
    b. Objective
        i. Perform limited physical examination pertinent to the emergency illness or injury, including any possible involved organ systems.
        ii. Obtain appropriate evaluative studies, including but not limited to, lab work and x-rays. (See *Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife*).
2. Assessment:
    a. Formulate diagnosis consistent with the data base collected.
    b. Document diagnosis in the patient chart.
3. Treatment Plan – Medical Regimen:
    a. Patients requiring emergency care will be stabilized to the best of the capabilities of the setting and transferred to or referred to an appropriate provider. The supervising physician will be involved if needed and the care of the patient transferred to the NIHD hospitalist or appropriate

practitioner from the emergency department for care or to an accepting outside physician if transfer to another facility is warranted.

i. Emergent referral will usually require transport to NIHD emergency department. This may be accomplished by use of the 911 system and Advanced Life Support ambulance if indicated by the patient condition. If in the opinion of the NP or CNM the patient can tolerate transfer by wheel chair, an RN must accompany the patient to the emergency department.
ii. Emergent transfers will be managed per NIHD Emergent Transfer Policy. All Emergency Medical Treatment and Labor Act (EMTALA) regulations will be followed and appropriate forms, including consent for transfer, will be utilized.
iii. Emergent referrals to facilities other than NIHD will be managed per NIHD policy.

b. The NP or CNM may, whenever necessary, attempt to sustain life. This includes, but is not limited to:
   i. Establishing and maintaining an airway
   ii. Cardiopulmonary resuscitation
   iii. Control of hemorrhage by external pressure or tourniquet
   iv. Establishing an intravenous line
   v. Administration of epinephrine for symptoms of anaphylaxis
   vi. Administration of oxygen for acute dyspnea
   vii. Splint skeletal injuries
   viii. Irrigate wounds
   ix. Apply heat or cold for exposure
   x. Administration of Narcan for suspected narcotic overdose
   xi. Administration of intravenous or oral glucose for suspected hypoglycemia
   xii. Follow resuscitation guidelines as appropriate
c. Physician Consultation: As described in the General Policy Standardized Procedure.
d. Referral to Physician: Conditions for which diagnosis and/or treatment are beyond the scope of the NP's or CNM's knowledge and/or skills, or for those conditions that require consultation.
e. Furnishing Medications – Medical Regimen:
   i. Follow *Furnishing Medications/Devices Standardized Procedur*e, utilizing formulary.

4. Documentation:
   a. All emergency care provided will be recorded in the patient chart.

REFERENCES:

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

ATTACHMENTS:

1. List of Authorized Nurse Practitioners or Certified Nurse Midwives

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.3 Standardized Procedure - Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure - General Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Nurse Practitioners, Certified Nurse Midwives		
Date Last Modified: 09/13/2023	Last Review Date: 11/06/2024	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/20/2018	

PURPOSE: To outline the general policy for the development of standardized procedures and the evaluation of those authorized to perform the standardized procedure functions, as promulgated by the guidelines of the Medical Board of California and the Board of Registered Nursing.

DEFINITIONS:

1. **Nurse Practitioner** (ANP, FNP, or PNP) is licensed by the State of California Board of Registered Nursing and possesses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards.

2. **Certified Nurse Midwife** (CNM) encompasses a full range of primary health care services for women from adolescence beyond menopause. These services include primary care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn during the first 28 days of life, and treatment of male partners for sexually transmitted infections. Midwives provide initial and ongoing comprehensive assessment, diagnosis, and treatment. They conduct physical examinations; prescribe medications; admit, manage and discharge patients; order and interpret laboratory and diagnostic tests and order the use of medical devices. Midwifery care also includes health promotion, disease prevention, and individualized wellness education and counseling.

POLICY:

1. Development and Review of Standardized Procedures
    a. All standardized procedures are developed collaboratively and approved by the Northern Inyo Healthcare District (NIHD) Interdisciplinary Practice Committee (IDPC) and must conform to all steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.
    b. All standardized procedures will be kept in a manual (either hardcopy or electronic) that includes dated and signed approval sheets of the standardized procedures and a list of persons covered by the standardized procedures.
    c. All standardized procedures are to be reviewed biennially by the NP(s), Medical Director of the setting the NP(s) function(s) in, and by the IDPC. Standardized procedures will be updated as practice changes.

d. All changes or additions to the standardized procedures are to be approved by the IDPC. All standardized procedures approved by the IDPC will be sent to the Medical Staff Executive Committee and, if so approved, to the NIHD Board of Directors.

2. Setting of Practice
    a. Northern Inyo Healthcare District (NIHD) and affiliated locations, as appropriate for specialty.
3. Scope of Practice
    a. The NP & CNM may perform the following functions within his/her specialty area and consistent with their experience and credentialing: assessment, management, and treatment of episodic illness, chronic illness, contraception, certifying disability, and the common nursing functions of health promotion, and general evaluation of health status (including but not limited to ordering laboratory procedures, x-rays, and physical therapies as well as recommending diets, and referring to specialty services when indicated).
    b. Standardized procedure functions, such as managing medication regimens, are to be performed at the approved setting of practice. The supervising physician, or his/her relief, will be available in person, by electronic means, or by phone. PNP(s) will consult the Pediatrician supervisor on call. CNM(s) will consult OB/GYN Physician on call.
    c. Physician consultation is to be obtained under the following circumstances:
        i. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
        ii. Acute decompensation of patient situation.
        iii. Problem which is not resolving as anticipated.
        iv. History, physical, or lab finding inconsistent with the clinical picture.
        v. Upon request of patient, nurse, or supervising physician.
    d. Medical Records
        i. Medical record entries by the NP or CNM shall include, for all problems addressed: the patients' statement of symptoms, the physical findings, results of special studies, the NP's or CNM's assessment and management plan including further studies ordered, medication or procedures, information given patient and the names of any physicians consulted.
    e. Supervision of Medical Assistants
        i. An NP or CNM may provide supervision of the medical assistant, although the supervising physician is ultimately responsible for the patient's treatment and care.
4. Qualifications and Evaluations
    a. Each nurse performing standardized procedure functions must have a current California registered nursing license, be a graduate of an approved Nurse Practitioner or Certified Nurse Midwife program, and have current certification as a NP or CNM by the California Board of Registered Nursing.
    b. Evaluation of competence in performance of standardized procedure functions will be done in the following manner:
        i. <u>Initial</u>: Within the initial focused professional practice evaluation (FPPE) period the Supervising Physician(s) will evaluate performance via direct observation, consultations and chart review/co-signature and provide feedback to the interim NP or CNM. Input from other physicians and colleagues will be utilized. Recommendations to move from interim status to full status once the FPPE has been satisfactorily completed will be considered. Nurse Manager(s) along with the Medical Director(s) and Supervising Physician(s) will provide feedback utilizing performance evaluation based upon the NP/CNM job description.
        ii. <u>Routine</u>: frequency in accordance with the Medical Staff Ongoing Professional Practice Evaluation (OPPE) policy.

iii. Follow-up: areas requiring increased proficiency, as determined by the initial or routine evaluation, will be reevaluated by the supervising physician at appropriate intervals until acceptable skill level is achieved.

c. Further requirements shall be regular continuing education in primary care, including reading of appropriate journals and new text books, attending conferences in primary care sponsored by hospitals, professional societies, and teaching institutions equaling as many hours as required by the California licensing board for renewal of licensure.
    i. A record of continuing education must be submitted to the Medical Staff Office every other year at re-credentialing.

5. Protocols
    a. The standardized procedure protocols developed for the use by the NP and CNM are designed to describe the steps of medical care for given patient situations. They are to be used in the following circumstances: health promotion exams, contraception, routine gynecological problems, trauma, infectious disease contacts, management of acute/episodic or chronic conditions, and furnishing of medications.

REFERENCES:

1. (2021) Title 16, California Code of Regulations, Section 1474. Standardized Procedure Guidelines.
2. (2021) Title 16, California Code of Regulations, Section 1366. Additional Technical Support Services.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years.

Supersedes: v.4 Standardized Procedure - General Policy for the Nurse Practitioner or Certified Nurse Midwife

APPROVALS

Chairman, Interdisciplinary Practice Committee	Date
Administrator	Date
Chief of Staff	Date
President, Board of Directors	Date

ATTACHMENT 1 – LIST OF AUTHORIZED NP's or CNM's

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

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

NORTHERN INYO HEALTHCARE DISTRICT
MEDICAL SCREENING EXAM
FOR THE OBSTETRICAL PATIENT

Title: Standardized Procedure - Medical Screening Exam for the Obstetrical Patient	
Scope: Perinatal	Manual: Perinatal
Source: Perinatal Nurse Manager	Effective Date: 4/15/2020

PURPOSE
To outline the methodology for the medical screening examination of the obstetric patient by the Registered Nurse (RN).

POLICY
1. It is the policy of Northern Inyo Healthcare District that all pregnant women 20 weeks or greater presenting to the obstetrical department for care will receive a Medical Screening Examination by a Registered Nurse with demonstrated competency in this standardized procedure, when requested and without discrimination and regardless of their ability to pay.
2. Registered Nurses shall demonstrate competency in the Medical Screening Examination on an annual basis following this Standardized Procedure.

PROCEDURE
1. Experience and educational requirements of the RN:
    a. Current California Registered Nurse (RN) license
    b. Current NRP and BLS certifications
    c. Successful completion of annual antepartum and intrapartum continuing education per department requirements
    d. Completion of electronic fetal monitoring program (Intermediate or Advanced Fetal Monitoring).
2. Method of initial and continued evaluation of competence:
    a. Initial Evaluation
        i. Successfully complete at least two (2) different obstetric patient medical screening examinations under the observation of a LIP or nurse preceptor.
        ii. A qualified “nurse preceptor” is a RN who may validate the competency of another RN to perform this procedure. A nurse preceptor must have completed at least five (5) obstetric patient medical screening examinations.
        iii. Determined competency must be documented on the Medical Screening Examination of Obstetric Patient Competency Validation Tool.
    b. Ongoing Evaluation
        i. Annual competency validation to be performed by successfully completing one obstetric patient Medical Screening Exam.
3. Maintenance of Records of those authorized in Standardized Procedure
    a. A list of RN’s competent to perform this standardized procedure is maintained with the Chief Nursing Officer and is updated annually.
4. Settings where Standardized Procedure may be preformed
    a. The Medical Screening Exam may take place in the Perinatal Department or the Emergency Department if necessary.

5. Standardized Procedure
    a. Circumstances under which Standardized Procedure may be performed:
        i. A pregnant women 20 weeks or greater presenting to Northern Inyo Hospital for care.
    b. Following examination and assessment of the patient, the RN will collaborate with the Licensed Independent Practitioner (LIP) to develop course of care.
    c. The on-call LIP must be notified immediately if:
        i. Delivery is imminent. Preparations should be made for immediate delivery.
        ii. Complications or abnormal assessments arise during the patient assessment. Such problems include:
            1. Fever (greater than100.4°F), and/or signs of infection
            2. Excessive vaginal bleeding (more than spotting)
            3. Elevated blood pressure
            4. Hyperreflexia
            5. Non-vertex presentation
            6. Tetanic contraction pattern
            7. Non-reactive NST, Category 3 or worsening Category 2 strip
            8. Premature gestation presenting in labor
            9. Ruptured membranes
    d. Contraindications to performing this procedure: Patient refusal
    e. Procedure
        i. Validate appropriate patient selection criteria:
            1. Patient must be an obstetric patient presenting for care
            2. Patient must give consent.
            3. Patient must have absence of complications as listed under Procedure, section 5.c. ii.
        ii. Explain procedure to patient
        iii. If delivery is imminent, call the LIP and prepare for immediate delivery.
        iv. If delivery is not imminent, continue assessment which will include but is not limited to:
            1. Gravida, parity, EDC
            2. Chief compliant/reason for visit
            3. Review of prenatal record if available, including obstetric history and risk factors
            4. Fetal movement
            5. Uterine contraction patterns
                a. Assess for:
                b. Frequency
                c. Duration
                d. Intensity
                e. Resting tone
            6. If normal, include this information with report to provider when total assessment is completed.
            7. Potential complications may include but are not limited to:
                a. Preterm gestation
                b. Tetanic contraction pattern.
            8. If potential complications are present – call the LIP
        v. Determine the status of the membranes:
            1. Ask and assess the patient for history or presence of leakage of fluid
                a. If patient reports leakage of fluid or possible rupture of membranes:
                    i. Check for pooling and/or gross rupture of membranes
                    ii. Collect fern sample for analysis

iii. If fern sample is indeterminate, laboratory sample may be sent with order
iv. Assess the color, odor, or amount of fluid present

2. Include this information with report to provider when total assessment is completed.

vi. Determine the status of the cervix by performing a digital cervical exam, unless contraindicated. If contraindications present, digital cervical exam may only be performed with an order.
1. Contraindications include:
a. Less than 36.0 weeks' gestation
b. Active vaginal bleeding
c. Known or suspected placenta previa
d. Leakage of fluid
2. Asses the cervix for:
a. Dilation
b. Effacement
c. Station
3. Include this information with report to provider when total assessment is completed

vii. Determine presenting part during cervical examination, unless contraindicated (see 5.b.vi.1 above)
1. If fetus is cephalic, include this information with report to provider when total assessment is completed.
2. If presenting part is other than cephalic, call the LIP

viii. Assess for signs and symptoms of preeclampsia, including:
1. Blood pressure (Normal: less than 140/90)
2. Proteinuria (Normal: using urine dip stick, less than +3)
3. Hyperreflexia (Normal: DTRs less than +3)
4. Epigastric pain (Normal: absence of epigastric pain)
5. Visual disturbances (Normal: absence of visual disturbance)
6. If normal, include this information with report to provider when total assessment is completed.
7. If abnormal– call the LIP.

ix. Assess for maternal infection
1. If temperature is greater than 100.4°F, suspect infection – call the LIP
2. If temperature is equal to or less than 100.5°F, include this information with report to provider when total assessment is completed.

x. Assess bleeding:
1. Call the LIP if bleeding is more than spotting
2. If bleeding (more than spotting) is absent, include this information with report to provider when total assessment is completed.

xi. Assessment of fetal wellbeing:
1. Identify fetal heart rate pattern with application of an electronic fetal monitoring system or, if gestation is less than 24 weeks, using a Doppler.
2. Utilizing NICHD criteria and nomenclature, assess NST reactivity or strip Category.
3. If NST is reactive or Category 1, include this information with report to provider when total assessment is completed.
4. If NST is non-reactive, or if strip is Category 3 or worsening Category 2, call the LIP

f. At the completion of the medical screening examination, the RN will report to on-call LIP, by phone or in person, the findings of the examination and any other pertinent information before any further procedures are performed. Regardless of the assessment, any patient meeting the following criteria will be examined, in person, by a LIP prior to discharge home:
    i. Maternal temperature greater than100.4°F, of uncertain etiology
    ii. Altered level of consciousness
    iii. Active vaginal bleeding
    iv. Rupture of membranes
    v. Category 3 or worsening Category 2 strip
    vi. Major maternal trauma.

g. In regards to a patient who is determined to not be in labor but needs additional evaluation to rule out an emergency condition:
    i. This patient will be seen in the Emergency Department and be provided with a medical screening examination to rule out other medical conditions prior to being discharged home. Prior to transfer back to the Emergency Department, the L&D RN will report to the on-call LIP the findings of the labor examination and any other pertinent information. This RN will also call report to the Emergency Department RN and/or the Emergency Department Attending provider to inform them of the patient's impending return to the Emergency Department.

h. Documentation:
    i. Patient assessment, including fetal assessment, will be documented in the EHR according to department policy.

6. Review of Standardized Procedure
    a. Standardized procedures are reviewed and approved annually by the Interdisciplinary Practice Committee.

    b. Quality improvement monitoring of this standardized procedure is ongoing.
        i. Chart audits will be performed for all births occurring outside of a hospital facility following a Medical Screening Exam by a RN

Approval	**Date**
Interdisciplinary Committee	10/31/19
Perinatal/Pediatrics Committee	12/5/19
Medical Executive Committee	1/7/20
Board of Directors	4/15/2020
Last Board of Directors Review	4/15/2020

Developed:
Reviewed:
Revised: 12/2018af

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure for Admission of the Well Newborn		
Owner: PERINATAL NURSE MANAGER	Department: Perinatal	
Scope: Perinatal RN		
Date Last Modified: 03/16/2023	Last Review Date: 11/06/2024	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 4/21/2021	

PURPOSE:

To ensure well newborns receive immediate and short-term ongoing assessment, care, and timely administration of prophylactic ophthalmic erythromycin to prevent opthalmia neonatorum, intramuscular Hepatitis B vaccine for perinatal Hepatitis B prevention, and intramuscular Vitamin K to prevent Vitamin K deficient bleeding (VKDB), pending notification of the pediatrician and receipt of physician orders for continuing care.

POLICY

It is the policy of Northern Inyo Healthcare District (NIHD) that all well newborns will be assessed and provided care upon admission under the direction of a Registered Nurse (RN) with annual documented competencies following this Standardized Procedure. All well newborns will receive prophylactic administration of erythromycin ophthalmic ointment, Hepatitis B vaccine, and Vitamin K by an RN/LVN, unless there is a documented refusal by the parent, under this Standardized Procedure.

PROCEDURE

1. Experience, Training, and/or Education Requirements of the RN
    a. Current California RN licensure
    b. Current Neonatal Resuscitation Program (NRP) card
    c. Successful completion of orientation to newborn care at NIHD
2. Method of Initial and Continued Evaluation of Competence
    a. Initial evaluation: successful completion and demonstration of competency and clinical decision making in assessment of the newborn, as documented in the unit-specific clinical competency orientation checklist.
    b. Ongoing evaluation: annual completion of competency validation of the newborn assessment and administrations of prophylactic medications to a neonate.
3. Maintenance of Records of those authorized in Standardized Procedure
    a. A list of RNs competent to perform this standardized procedure is maintained with the Chief Nursing Officer and is updated annually.
4. Settings where Standardized Procedure may be performed
    a. Admission of a well newborn and administration of prophylactic medications may take place in the Perinatal unit at the mother's bedside, newborn nursery, or in the Post Anesthesia Care Unit.

5. Standardized Procedure
    a. Circumstance under which Standardized Procedure may be performed:
        i. Well newborn delivered at NIHD
    b. Procedure
        i. The RN will perform an admission assessment according to policy
        ii. The RN will initiate the Newborn Admission Orders:
            - Code Status:
                - Full Code
            - When to call Pediatrician:
                - Call Pediatrician Between 0630-0730 to inform them of any delivery after 5pm the previous day.
                - If born before 5pm, call Pediatrician ASAP
            - Please call Pediatrician immediately**, at any hour,** in the event of:
                - Infant requiring resuscitation efforts following birth
                - Maternal Chorioamnionitis
                - Maternal GBS positive without adequate maternal antibiotic coverage if infant is <37 weeks or ROM ≥18 hours' even if otherwise well
                - Immediately for infant fever ≥100.4°F
                - For sustained HR abnormalities, >5 minutes when infant calm, HR >180 and or < 100
                - Respiratory Rate >60
                - Immediately for other concerns that cannot wait until normal rounding time
                - If indicated per Pulse Ox Screening, Hyperbilirubinemia, or Hypoglycemia policies
            - Vital signs every 30 minutes x4 and PRN
            - Vital signs every 8 hours for the term, uncomplicated infant born via vaginal birth
            - Vital signs every 4 hours x24 hours, then every 8 hours for infants born via cesarean-section
            - Vital signs every 4 hours for infants <37 weeks' gestation
            - Infant diet: Breastfeed only unless maternal refusal or medical need per policy
                - Breastfeed on demand
            - Oximetry per protocol
            - Drugs of Abuse Screen:
                - If mother's DOA positive for THC only:
                    i. File CPS Report
                    ii. Consult to social worker
                    iii. Cord Segment to be sent
                    iv. Advise patient that breastfeeding is not advised if planning to continue use of marijuana/THC containing products
                - If a mother's DOA positive for drugs other than THC: -RN to file CPS report
                    i. Consult to social worker

ii. Cord Segment to be sent

iii. Newborn urine drug screen

- Newborn Hearing Screening before discharge
- Newborn Screening Test before discharge
- Bili scan at 24 hours or earlier, then daily until discharge
- Bili Scan PRN for worsening jaundice or any jaundice prior to 24 hours of age
- Congenital Heart Disease Screen at 24 hours
- Sweet Ease for pain control only
- Pacifier use for pain control only unless requested by parent and pacifier use education provided
- Collect cord blood workup specimen
- Heel Stick Blood Sugar per *Newborn Blood Sugar Monitoring Policy*
- Inform Provider of any medication refusal by family, during normal office hours
- Erythromycin Ophthalmic Ointment 0.5 %, 1 application within 2 hours of delivery
- Phytonadione IM (Vitamin K) Give 1 mg. Give within 2 hours of delivery
- Hepatitis B Vaccine IM 0.5 mL within 24 hours if mother is Hepatitis B negative. Give as soon as possible within 12 hours of age if mother is Hepatitis B positive or unknown.
    - Notify Pediatric Provider on call if the mother is Hepatitis B positive
- Cholecalciferol Oral Drops 400 unit every day. Start day of discharge
    - 400 IU = 1 DROP Q day to start on the day of discharge.

6. Review of Standardized Procedure
    a. Standardized procedures are reviewed and approved annually by the Interdisciplinary Practice Committee.

REFERENCES:

1. AWHONN (2021) Perinatal Nursing (*5th Ed.*) Wolters Kluwer.
2. American Academy of Pediatrics & College of Obstetricians and Gynecologist (2017*). Guidelines for Perinatal Care (8th Ed.).* Elk Grove Village, IL: Author
3. California State and Consumer Services Agency, Board of Registered Nursing. (2011). "*An explanation of the scope of RN practice including standardized procedures*". Retrieved from www.rn/gov Section 2725 of California Nurse Practice Act.

CROSS-REFERENCED POLICIES AND PROCEDURES:

1. Admission, Care, Discharge and Transfer of the Newborn
2. Drugs of Abuse Maternal and Infant
3. Transcutaneous Bilirubin Testing (Bili Scan)
4. Infant Feeding Policy
5. Newborn Pulse Oximetry Screen
6. Newborn Hearing Screening Program
7. Newborn Blood Glucose Monitoring

8. Lippincott: Newborn assessment: https://procedures.lww.com/lnp/view.do?pId=7149440&hits=neonatal,newborn,neonate,neonates&a=false&ad=false&q=newborn

RECORD RETENTION AND DESTRUCTION:
Documentation is maintained within the patient and medical record, which is managed by the NIHD Medical Records Department.

Supersedes: v.2 Standardized Procedure for Admission of the Well Newborn

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedures for Medical Functions by RN in the Emergency Department		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: Emergency Department RN's		
Date Last Modified: 02/08/2023	Last Review Date: 11/06/2024	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/15/2020	

PURPOSE:

The purpose of the policy is to define designated medical functions that may be performed by the RN as a standardized procedure in the ED.

POLICY:

It is the policy of Northern Inyo Healthcare District (NIHD) that only standardized procedure functions based on defined circumstances as outlined in this document may be performed by a Registered Nurse (RN) in the Emergency Department (ED) without previous written authorization of the Emergency Department Physician.

PROCEDURE:

1. Competency Requirements
    a. To be eligible to perform this standardized procedure in the ED, the RN must:
        i. Hold a current CA RN License
        ii. Complete an initial training course specific to the elements of the standardized procedure outlined in this policy.
        iii. Competency is demonstrated annually and documented in the employee's competency assessment files.
        iv. A list of RN's competent to perform this standardized procedure is maintained with the Chief Nursing Officer and is updated annually.
2. Abdominal Pain
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 18 years of age and older presenting with complaint of Abdominal Pain with a documented Emergency Severity Index (ESI) level 2-5.
    b. Circumstances under which the Physician must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition

c. Standardized procedure:
    i. Upon presentation to the ED with complaint of Abdominal Pain and assigned an ESI level 2-5, if the physician cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician.
        1. Saline Lock
        2. NPO
        3. CBC with automated differential
        4. Comprehensive Metabolic Panel
        5. Urine Dip and Hold Urine
        6. Urinalysis, culture and sensitivity if urine dip shows leukesterase or nitrates
        7. Female 10 years of age to 60 years of age:
            a. Pregnancy Test Urine Qualitative
        8. For Upper Abdominal Pain:
            a. Lipase
            b. EKG if age >35
        9. If nausea present:
            a. Ondansetron (Zofran) 4 mg IV X1
        10. If vomiting present:
            If no medical history of Chronic Renal disease or heart failure, Normal Saline Bolus 1000ml
d. Complications:
    i. Immediate Physician notification of abnormal Vital Signs and or change in status to higher priority category.
e. Documentation:
    i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

3. Chest Pain 35 years of age and older
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 35 years of age and older presenting with complaint of Chest Pain with a documented ESI level 2-5.
    b. Circumstances under which the Physician must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Chest Pain and assigned an ESI level 2-5, if the physician cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician.
            1. STAT EKG
            2. Continuous Pulse Oximetry
            3. Continuous Cardiac Monitoring
            4. Saline Lock
            5. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable

6. CBC with automated differential
7. Comprehensive Metabolic Panel
8. Troponin I
9. If patient takes Coumadin:
    a. Prothrombin Time (PT) and INR
    b. Partial Thromboplastin Time
10. Oxygen via nasal cannula to keep oxygen saturation >95%
11. Aspirin 325mg PO Stat if not taken prior to arrival, or equivalent to equal 325mg if partial dose taken prior to arrival, and no contraindications to aspirin

d. Complications:
    i. Immediate Physician notification of abnormal Vital Signs and or change in status to higher priority category.
e. Documentation:
    i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

4. Chest Pain 16 years of age to 34 years of age
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 16 years of age to 34 years of age presenting with complaint of Chest Pain with a documented ESI level 2-5.
    b. Circumstances under which the Physician must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Chest Pain and assigned an ESI level 2-5, if the physician cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician.
            1. STAT EKG
            2. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable
    d. Complications:
        i. Immediate Physician notification of abnormal Vital Signs and or change in status to higher priority category.
    e. Documentation:
        i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.
5. Dysuria
    a. Circumstances under which the procedure maybe performed:
        i. Any patient presenting to the ED with complaint of Dysuria with a documented ESI level 2-5.
    b. Circumstances under which the Physician must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.

iii. Any significant change in patient condition

c. Standardized procedure:
    i. Upon presentation to the ED with complaint of Dysuria and assigned an ESI level 2-5, if the physician cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician.
        1. Urine Dip and Hold Urine
        2. Urinalysis, culture and sensitivity if urine dip shows leukesterase or nitrates
        3. Female 10 years of age to 60 years of age:
            a. Pregnancy Test Urine Qualitative

d. Complications:
    i. Immediate Physician notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:
    i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

6. Fever 16 years of age and older
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 16 years of age and older presenting with complaint of fever with a documented ESI level 2-5.
    b. Circumstances under which the Physician must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of fever and assigned an ESI level 2-5, if the physician cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician.
            1. Acetaminophen 650mg PO X one for temperature >100.4 Fahrenheit if unable to swallow may order PR.
            2. If Acetaminophen has been administered in the last 6 hours, and Ibuprofen has not been administered in last 6 hours, order will be placed for Ibuprofen 600mg PO X1.
    d. Complications:
        i. Immediate Physician notification of abnormal Vital Signs and or change in status to higher priority category.
    e. Documentation:
        i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.
7. Fever 3 months of age to 15 years of age
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 3 months to 15years of age presenting with complaint of fever with a documented ESI level 2-5.

b. Circumstances under which the Physician must be contacted:
    i. Any patient classified as an ESI Level 1.
    ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
    iii. Any significant change in patient condition
c. Standardized procedure:
    i. Upon presentation to the ED with complaint of fever and assigned an ESI level 2-5, if the physician cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician.
        1. Acetaminophen Suspension 15mg/kg PO X1 (maximum dose 1000mg) for temperature >100.4 Fahrenheit if unable to swallow notify ED Physician. If patient is greater than 6 months of age and Acetaminophen has already been administered in last 6hours and Ibuprofen has not been administered in last 6 hours, order will be placed for Ibuprofen 10mg/kg PO X1 (maximum dose 600mg) for temperature greater than 100.4 Fahrenheit.
d. Complications:
    i. Immediate Physician notification of abnormal Vital Signs and or change in status to higher priority category.
e. Documentation:
    i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

8. Extremity Deformity or pain from trauma
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 5 years of age and older presenting with extremity deformity or pain from trauma with a documented ESI level 2-5, and assessed to have normal circulation, movement, and sensation in the distal extremity.
    b. Circumstances under which the Physician must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with extremity deformity or pain from trauma assigned an ESI level 2-5, if the physician cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician.
            1. If Ibuprofen has not been administered in the last 6 hours order will be placed for Ibuprofen 10mg/kg max dose of 600mg PO X1, if no NSAIDS have been taken in the last 6 hours.
            2. Contact ED Physician for pain medication order if needed
            3. Obtain Radiology: X-ray of the affected extremity
            4. Ice Therapy
            5. Elevate affected extremity
    d. Complications:
        i. Immediate Physician notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:
    i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

9. Vomiting 18 years of age and older
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 18 years of age and older presenting with complaint of vomiting with a documented ESI level 2-5.
    b. Circumstances under which the Physician must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of vomiting and assigned an ESI level 2-5, if the physician cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician.
            1. Place Saline Lock
            2. If no medical history of Chronic Renal disease or heart failure, Normal Saline Bolus 1000ml
            3. Ondansetron (Zofran) 4mg IV X1
    d. Complications:
        i. Immediate Physician notification of abnormal Vital Signs and or change in status to higher priority category.
    e. Documentation:
        i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

10. Vomiting 6 months of age to 17 years of age
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 6 months to 17 years of age presenting with complaint of vomiting with a documented ESI level 2-5.
    b. Circumstances under which the Physician must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of vomiting and assigned an ESI level 2-5, if the physician cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician.
            1. Ondansetron (Zofran) 0.5mg/kg Oral Disintegrating Tab (ODT), max dose 4mg.
    d. Complications:
        i. Immediate Physician notification of abnormal Vital Signs and or change in status to higher priority category.
    e. Documentation:

i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

11. Shortness of Breath WITH history of Asthma (patients of all ages)
    a. Circumstances under which the procedure maybe performed:
        i. Any patient presenting to the ED with complaint of Shortness of Breath with history of Asthma and with a documented ESI level 2-5.
    b. Circumstances under which the Physician must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Shortness of Breath with history of Asthma and assigned an ESI level 2-5, if the physician cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician.
            1. Continuous pulse oximetry
            2. Oxygen administration titrate to keep saturation >90%
            3. Duoneb x1
    d. Complications:
        i. Immediate Physician notification of abnormal Vital Signs and or change in status to higher priority category.
    e. Documentation:
        i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.
12. Shortness of Breath 18 years of age and older WITHOUT history of Asthma
    a. Circumstances under which the procedure maybe performed:
        i. Any patient presenting to the ED 18 years of age and older with complaint of Shortness of Breath without history of Asthma with a documented ESI level 2-5.
    b. Circumstances under which the Physician must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Shortness of Breath without history of Asthma and assigned an ESI level 2-5, if the physician cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician.
            1. Saline Lock
            2. Continuous pulse oximetry
            3. Continuous cardiac monitoring
            4. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable
            5. EKG if patient >35 years of age

6. Oxygen administration titrate to keep saturation >90%
7. If wheezes are present:
    a. Duoneb x1

d. Complications:
    i. Immediate Physician notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:
    i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

13. Shortness of Breath 17 years of age and younger WITHOUT history of Asthma
    a. Circumstances under which the procedure maybe performed:
        i. Any patient presenting to the ED 17 years of age and younger with complaint of Shortness of Breath without history of Asthma with a documented ESI level 2-5.
    b. Circumstances under which the Physician must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Shortness of Breath without history of Asthma and assigned an ESI level 2-5, if the physician cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician.
            1. Continuous pulse oximetry
            2. Oxygen administration titrate to keep saturation >90%
            3. If wheezes are present in patients 2 years of age or older:
                a. Albuterol 2.5mg via hand held nebulizer x1
    d. Complications:
        i. Immediate Physician notification of abnormal Vital Signs and or change in status to higher priority category.
    e. Documentation:
        i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

14. Standardized procedures are reviewed and approved annually by the Interdisciplinary Practice Committee.

REFERENCES:

1. **California State and Consumer Services Agency, Board of Registered Nursing. (2011). "*An explanation of the scope of RN practice including standardized procedures*". Retrieved from www.rn/gov Section 2725 of California Nurse Practice Act.**

2. **Emergency Severity Index (ESI) Implementation Handbook, 2012 Edition. Retrieved from www.ahrg.gov/researdh/esi/esi7.htm.**

RECORD RETENTION AND DESTRUCTION:

Documentation is maintained within the patient medical record, which is managed by the NIHD Medical Records Department.

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROTOCOL

Title: Standardized Protocol - Emergency Care Policy for the Physician Assistant		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Physician Assistants		
Date Last Modified: 10/18/2024	Last Review Date: 11/06/2024	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/15/2020	

PURPOSE:
This standardized protocol developed for use by the Physician Assistant (PA) is designed to establish guidelines for the management of emergency care conditions.

POLICY:
1. This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the General Policy for the Physician Assistant.
2. Circumstances:
    a. Patient population: pediatric and adult patients.
    b. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in Delegation of Services Agreement.

PROTOCOL:
1. Definition: this protocol covers the management of Emergency Care conditions which may present to NIHD and its affiliated locations.
2. Database:
    a. Subjective
        i. Obtain pertinent history related to emergency symptoms.
        ii. Collect appropriate information, including past medical history, review of systems, allergies, immunizations, and medications.
    b. Objective
        i. Perform limited physical examination pertinent to the emergency illness or injury, including any possible involved organ systems.
        ii. Obtain appropriate evaluative studies, including but not limited to, lab work and imaging studies.
3. Assessment:
    a. Formulate diagnosis consistent with the data base collected.
    b. Document diagnosis in the patient chart.
4. Treatment Plan – medical regimen:
    a. Patients requiring emergency care will be stabilized to the best of the capabilities of the setting and transferred to or referred to an appropriate provider. The supervising physician will be involved if needed and the care of the patient transferred to the NIHD hospitalist or appropriate

practitioner from the emergency department for inpatient care or to an accepting outside physician if transfer to another facility is warranted.

i. Emergent referral will usually require transport to NIHD emergency department. This may be accomplished by use of the 911 system and Advanced Life Support ambulance if indicated by the patient condition. If in the opinion of the PA, the patient can tolerate transfer by wheelchair, an RN must accompany the patient to the emergency department.
ii. Emergent transfers will be managed per NIHD Emergent Transfer Policy. All Emergency Medical Treatment and Labor Act (EMTALA) regulations will be followed and appropriate forms, including consent for transfer, will be utilized.
iii. Emergent referrals to facilities other than NIHD will be managed per NIHD policy.

b. The Physician assistant(s) may, whenever necessary, attempt to sustain life. This includes, but is not limited to:
   i. Establishing and maintaining an airway
   ii. Cardiopulmonary resuscitation
   iii. Control of hemorrhage by external pressure or tourniquet
   iv. Establishing an intravenous line
   v. Administration of epinephrine for symptoms of anaphylaxis
   vi. Administration of oxygen for acute dyspnea
   vii. Splint or reduce skeletal injuries
   viii. Incision and drainage of abscesses
   ix. Irrigate and repair wounds
   x. Apply heat or cold for exposure
   xi. Administration of Narcan for suspected narcotic overdose
   xii. Administration of intravenous or oral glucose for suspected hypoglycemia
   xiii. Follow resuscitation guidelines as appropriate
c. Physician Consultation: As described in the *General Policy Standardized Protoco*l.
d. Consult specialty physician or transfer care of patient.
e. Refer to Physician: Diagnosis and/or treatment are beyond the scope of the PA's knowledge and/or skills, or for those conditions that require consultation.
f. Medications – see Delegation of Services Agreement and *Medication/Device Policy for Emergency Department Physician Assistant*

5. Documentation
   a. All emergency care provided will be recorded in the patient chart.

REFERENCES:

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

ATTACHMENTS:

1. List of Authorized Physician Assistants and Supervising Physicians

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.3 Standardized Protocol - Emergency Care Policy for the Physician Assistant

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

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROTOCOL

Title: Standardized Protocol – Physician Assistant in the Operating Room		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Physician Assistants		
Date Last Modified: 04/28/2023	Last Review Date: 11/06/2024	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/01/2018	

PURPOSE:
To establish guidelines for the adequate supervision and qualifications of the Physician Assistant (PA) who assists the surgeon during a surgical procedure.

POLICY:
1. The Physician Assistant (PA) assists the attending surgeon during a surgical procedure by providing aid in exposure, hemostasis, and other technical functions which will help the surgeon carry out a safe operation with optimal results for the patient.
2. Only a PA currently licensed in California, who meets all the criteria specified in Appendix A may perform this procedure.
3. The PA will be evaluated for continued competency as per the *General Physician Assistant Protocol.*
4. The PA may function under this protocol only when the following conditions are met:
    a. The attending surgeon has determined that the PA can provide the type of assistance needed during the specific surgery.
    b. The PA functions under the supervision of the attending surgeon. The attending surgeon does not need to be physically present in the operating room for those portions of the procedure (usually setup and final closure) which in the judgment of the attending surgeon the PA may safely do without direct and in-person supervision. The attending surgeon must be able to be present immediately if needed and must have a reliable way to be contacted and summoned, such as a cell phone, if needed. Specifically, the attending surgeon may be in such places as the recovery room, the pre-op area, the wards of the hospital, an on campus office, or the Emergency Department.
5. The PA practices within the appropriate limitations and may choose not to perform those functions for which he/she has not been prepared or which he/she does not feel capable of performing.

PROTOCOL:
The PA will:
1. Assist with the positioning, prepping and draping of the patient, or perform these actions independently, if so directed by the surgeon.
2. Provide retraction by:
    a. Closely observing the operative field at all times.
    b. Demonstrating stamina for sustained retraction.

c. Retaining manually controlled retractors in the position set by the surgeon with regard to surrounding tissue.
d. Managing all instruments in the operative field to prevent obstruction of the surgeon's view.
e. Anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures.

3. Provide hemostasis by:
    a. Applying the electrocautery tip to clamps or vessels in a safe and knowledgeable manner, as directed by the surgeon.
    b. Sponging and utilizing pressure, as necessary.
    c. Utilizing suctioning techniques.
    d. Applying clamps on superficial vessels and the tying or electrocoagulation of them, as directed by the surgeon.
    e. Placing suture ligatures in the muscle, subcutaneous and skin layer.
    f. Placing hemoclips on bleeders, as directed by the surgeon.
4. Perform knot tying by:
    a. Having knowledge of the basic techniques of knot tying to include, two-handed tie; one-handed tie; instrument tie.
    b. Tying knots firmly to avoid slipping.
    c. Avoiding undue friction to prevent fraying of suture.
    d. "Walking" the knot down to the tissue with the tip of the index finger and laying the strands flat.
    e. Approximating tissue rather than pulling tightly to prevent tissue necrosis.
5. Perform dissection as directed by the surgeon by:
    a. Having knowledge of the anatomy.
    b. Demonstrating the ability to use the appropriate instrumentation.
    c. For abdominal surgery: dissection includes only layers above the fascial layer.
6. Provide closure of layers of tissue as directed by the surgeon; sutures fascia, subcutaneous tissue and skin by:
    a. Correctly approximating the layers, under direction of the surgeon.
    b. Demonstrating knowledge of the different types of closures, to include but not be limited to: interrupted vs. continuous; skin sutures vs. staples; subcuticular closure; horizontal mattress.
    c. Correctly approximating skin edges when utilizing skin staples or suture.
7. Assist the surgeon at the completion of the surgical procedure by:
    a. Affixing and stabilizing all drains.
    b. Cleaning the wound and applying the dressing.
    c. Assisting with applying casts; splints, bulky dressings, abduction devices.

REFERENCES:

1. "Medical Services Performable." California Code of Regulations. 16 CCR § 1399.541.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.2 Standardized Protocol – Physician Assistant in the Operating Room

APPENDIX A

A Physician Assistant who is approved as a PA at Northern Inyo Healthcare District may function as first assistant if all of the following conditions exist:

1. Currently licensed as a PA in California.
2. Successful completion of an accredited Physician Assistant program. (A copy of the certificate of completion will be placed in the PA's personnel file and the Medical Staff credentials file.)
3. Demonstrated knowledge and skill in applying principles of asepsis and infection control and demonstrated skill in behaviors that are unique to functioning as a PA.
4. Demonstrated knowledge of surgical anatomy, physiology and operative procedures for which the PA assists.
5. Demonstrated ability to function effectively and harmoniously as a team member.
6. Current BLS certification; ACLS certification preferred.
7. Able to perform effectively in stressful and emergency situations.

ATTACHMENT 1 – LIST OF AUTHORIZED PHYSICIAN ASSISTANTS

1. _____ _____ _____
   NAME SIGNATURE DATE

2. _____ _____ _____
   NAME SIGNATURE DATE

3. _____ _____ _____
   NAME SIGNATURE DATE

4. _____ _____ _____
   NAME SIGNATURE DATE

LIST OF SUPERVISING PHYSICIANS

1. _____ _____ _____
   NAME SIGNATURE DATE

2. _____ _____ _____
   NAME SIGNATURE DATE

3. _____ _____ _____
   NAME SIGNATURE DATE

4. _____ _____ _____
   NAME SIGNATURE DATE

5. _____ _____ _____
   NAME SIGNATURE DATE

6. _____ _____ _____
   NAME SIGNATURE DATE

7. _____ _____ _____
   NAME SIGNATURE DATE

8. _____ _____ _____
   NAME SIGNATURE DATE

Northern Inyo Rural Health Clinic

153 Pioneer Lane, Suite B. Bishop, California 93514

NIHD
RURAL HEALTH CLINIC

Northern Inyo RHC

Policy and Procedure Development and Review Statement

Policy #001

Northern Inyo RHC, a department of Northern Inyo Healthcare District (NIHD), follows the standard described in the NIHD Policy and Procedure titled *Development, Review and Revision of Policies and Procedures.*

Policy development, review and revision is performed by staff at the Northern Inyo RHC, including leadership, physician(s), and Advanced Practice Provider(s).

All policies and procedures are reviewed via multidisciplinary processes via committees with final approval at the Board of Directors, or their delegated committees (Executive Committee or Medical Executive Committee). All documents are review, revised as necessary, and sent for final approval via the NIHD Board of Directors at least biennially.

Policies or procedures that involve patient care delivery, are reviewed via medical staff committees. The medical staff committee process is defined within the NIHD Medical Staff Bylaws. This assures that medical staff oversees the quality of patient care, treatment and services, as required by the NIHD accrediting organization, The Joint Commission.

Policy and Procedure development aligns with regulatory requirements from the State Operations Manual, Appendix G, section 42 CFR 491.8 and 491.11; as well as the California Code of Regulations Title 22, section 51211.5.

References:

1. The Joint Commission (CAMCAH Manual) Standard MS.03.01.01(Jan 2022).
2. California Code Regulations, Title 22, 51211.5 – Rural Health Clinic Standards for Participation.
3. State Operations Manual; Appendix G – Guidance for Surveyors: Rural Health Clinics (RHC) (Rev. 200, 02-21-2020).

Cross Referenced Policies and Procedures:

1. Development, Review and Revision of Policies and Procedures. Located in the NIHD Policy and Procedure Manager software. (Updated: June 16, 2021).
2. NIHD Medical Staff Bylaws. Located on the NIHD Intranet>Resources>Links>Medical Staff>Forms.

file://root.nih.org/home/Public/Intranet%20Redesign/Intranet%20Links/Links/Medical%20Staff%20Resources/NIHD%20Med%20Staff%20Bylaws%20rev2021-01-20.pdf

NIHD
RURAL HEALTH CLINIC

Regulatory Compliance Policy		
J Tag References: J-0011; J-0012; J-0013 § References: 491.4	**Policy Type:** Administrative	**Policy Number: 100.0**
Adopted or Revised Date: 1/31/2022		

Policy Declaration: This is the Clinic's Regulatory Compliance Policy. The Clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to acknowledge and document the conditions of coverage as an RHC concerning compliance with Federal, State and Local laws pursuant to 42 CFR §491.4.

Policy Statement: It is the intention of the Clinic to remain in regulatory compliance as a Rural Health Center in respect to federal, state and local laws which generally and specifically apply to the operation of the clinic. More specifically, it is the intent of the clinic to adhere to **Section 6401 of the Affordable Care Act** and the corresponding revision to **Section 1902 of the Social Security Act** which, in part, states that a "provider of medical or other items or services or supplier within a particular industry or sector or category" establish a compliance program as a condition of enrollment in Medicare, Medicaid, or the Children's Health Insurance Plan. It is the intention of the clinic to establish a compliance plan of its own or in collaboration with its parent entity or home office identified as Northern Inyo Healthcare District.

Policy Scope: This policy is informational and regulatory in nature.
Policy Body:

1. **General Compliance with Federal, State and Local Laws**
   a. The clinic shall comply with all Federal regulations governing the certification of Rural Health Clinics (RHCs) as published in the Federal Register, 43 FR 136, and subsequent federal publications which address the conditions for coverage or participation for RHCs.

   b. The clinic shall comply with directives given by the Center for Medicare and Medicaid Services (CMS) and its contractors for the provision of services to Medicare participants as well as the billing of those services as described and explained in ***Chapter 13 of the Medicare Benefits Manual, Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) Services and Chapter 9 of the Medicare Claims Processing Manual, Rural Health Clinics/Federally Qualified Health Centers*** and any other subsequent CMS publications, notices, statements or correspondence which give practical guidance on the application of the RHC regulations for program participation, benefits and claims processing.

c. The clinic shall comply with all laws and regulations governing the licensing and operation of a Rural Health Clinic in the State of California.
d. State licensure, *if required*, shall be continuously maintained with the understanding that a lapse in state licensure can jeopardize certification status granted by CMS.
e. Additionally, the clinic shall comply with the conditions of participation in the state Medicaid program as administered by either the state and/or approved Managed Medicaid Organizations (MMO) and to all publications, notices, statements, correspondence or communication which gives practical guidance on program participation, benefits and claims processing.
f. The providers of the RHC will maintain current professional licensure in their respective disciplines and comply with the Scope of Practice of their discipline as defined by state law.
g. The clinic shall comply with state directives and guidelines for the provision of services to Medicaid recipients and the billing of those services as mentioned above.
h. The clinic shall comply with any applicable local laws which regulate the operation of a medical clinic or business in Inyo County, California.
i. The clinic shall comply with any applicable local laws which regulate the operation of a medical clinic or business in city/town of Bishop.
j. The clinic shall maintain and renew licenses in a timely manner. The clinic shall have a process in place for monitoring license and certification expirations.
k. The clinic shall complete or be subject to annual inspections, application renewals, and annual reports as required to maintain federal, state, and local regulatory compliance.

2. Objectives of the Formal Compliance Program

The objectives of a Compliance Program as described above are to:

a. Avoid the potential for fraud, waste and abuse related to the provision of Medicare and Medicaid services (Federal and State False Claims Acts);
b. Increase the potential for proper submission and payment of claims;
c. Reduce coding and billing errors;
d. Promote patient safety and the delivery of quality patient care;
e. Educate and inform providers and employees in a way which encourages the proper utilization of resources and optimizes training and work processes

3. Core Compliance Program Elements

a. Written Compliance Policies and Procedures: The clinic shall provide written compliance policies and procedures and a formal, written Compliance Plan which identify the Compliance Officer and further explain the responsibilities of all ownership, management, and employees in adherence to the Plan. Accordingly,
    i. The policies and procedures or Plan will be readily available to all employees in a clearly written and understandable format;
    ii. The polices and plan shall be reviewed and updated on a regular basis and employees shall be informed and educated regarding material changes to the policies and procedures;
    iii. The policies and procedures or Plan shall include a Code of Conduct, which shall also be posted in an employee access area of the clinic;
    iv. The policies and procedures shall include reporting mechanisms;
    v. The policies and procedures shall include a non-retaliation statement which ensures employees and contracted parties that the reporting of

vi. alleged compliance violations shall not jeopardize the individual's relationship with the Rural Health Clinic.

b. **Compliance Program Oversight:** The clinic shall identify a Compliance Officer who is responsible for approving the Standards of Conduct, administering the aspects of the program, reporting on enforcement activity, and evaluating the effectiveness of the program on a regular basis. The Compliance Officer shall also be responsible for maintaining relationships within the organization which promote training, communication and awareness of the Program.

The Compliance Officer is:

Patty Dickson
760-873-2022
patty.dickson@nih.org

c. **Education and Training:** The clinic shall provide compliance training (as part of the Compliance Plan) for all employees including physicians, non-physician providers, licensed clinical staff, managers, supervisors and support staff:

vii. At or near the individual's hire initial date; and
viii. Annually as a refresher course with highlights of changes and developments; re-emphasizes the Code of Conduct; and provides examples of non-compliance;
ix. The training shall include information about Federal and State False Claims Acts;
x. Upon the reporting of a potential violation of a Compliance Plan, a focused training may be conducted to reinforce a particular compliance area or concern.

d. **Communication**: The clinic shall provide and promote clear communication concerning how to report compliance issues in a timely manner to the Compliance Officer. ***Communication of a compliance concern by an employee shall be taken seriously by the Clinic and shall not result in any consequence, retaliation, or negative outcome to the employee's job security or stability. The organization shall maintain an open-door policy and an employee shall not be hindered, dissuaded, or harassed in his/her efforts to report concerns.*** Any communication can be made by any of these methods discussed in the employee training.

e. **Auditing and Monitoring:** The clinic shall conduct periodic and ongoing auditing and monitoring functions to ensure compliance with all federal, state, and local regulations and compliance with participation within the Medicare and Medicaid programs for which it provides services. Auditing is defined as an independent formal compliance review which occurs at least annually. Monitoring is defined as periodic procedural checks. As part of the auditing and monitoring activities, The Rural Health Clinic shall also conduct risk assessments in order to evaluate the risk of non-compliance in specific areas brought to the organization's attention by CMS, OIG, State Agencies or the concerns of providers and staff.

f. **Disciplinary Actions:** The clinic shall establish as part of its formal Compliance Plan conditions which apply for employee discipline in respect to violation of the Standard of Conduct and/or for which the employee's behavior can be attributed to non-compliance of federal, state, or local regulations, including breaches the conditions of participation in Medicare and Medicaid programs or in the rendering of services to beneficiaries of the programs and failure to detect or report such activities.

g. **Corrective** The clinic shall clearing identify in the Compliance Plan the actions that will be taken to remedy any violations. This shall include a description of the processes and actions which shall occur when any or all of the actions below are necessary:

   i. Self-reporting violations; or
   ii. Making repayments of any credit balances or overpayments due a program; or
   iii. Disciplining employees; or
   iv. Re-training of employees at the point of detection.

4. **Biennial Review of Compliance Policies, Procedures and Plan:** The clinic shall review the Compliance Policy and Plan as a part of the biennial RHC evaluation process and shall revise the policy to reflect any changes, revisions or amendments necessary. If the RHC is part of a larger healthcare system, the Compliance Plan shall be reviewed according to the system's policy and/or the RHC portion of the review shall be forwarded to the appropriate committees within the system.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Local Inspections, Licenses or Permits on File	
	County (Parish) Inspections, Licenses or Permits on File	
	State Inspections, Licenses, or permits on File	
	Credentialing and HR Policies; Credentialing/HR Files	
	Formal Written Compliance Plan	
	Compliance Training Material	

NIHD
RURAL HEALTH CLINIC

Formal Corporate or Organization Compliance Plan Policy		
J Tag References: J-0011 **§ References: 491.4**	**Policy Type:** Administrative	**Policy Number: 105.0**
Adopted or Revised Date: 1/31/2022		

Policy Declaration: This is the Formal Corporate or Organization Compliance Plan Policy of the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to acknowledge and document the conditions of coverage as a RHC concerning compliance with Federal, State and Local laws pursuant to §491.4 and to mandate the establishment of a formal, written Compliance Plan in accordance with Section 6401 of the Affordable Care Act.

Policy Statement: It is the intention of the Clinic to remain in regulatory compliance as a Rural Health Center in respect to federal, state and local laws which generally and specifically apply to the operation of the clinic. More specifically, it is the intent of the Clinic to adhere to **Section 6401 of the Affordable Care Act and the corresponding revisions to Section 1902 of the Social Security Act** which states that a "provider of medical or other items or services or supplier within a particular industry or sector or category" establish a compliance program as a condition of enrollment in Medicare, Medicaid, or the Children's Health Insurance Plan. It is the intention of the Clinic to establish a compliance plan of its own or in collaboration with its parent entity or home office, and to have written policies and employee training pertaining to Federal and State False Claim Acts.

Policy Scope: This policy is informational and regulatory in nature.

Policy Body: It shall be the policy of the clinic to have a formal Compliance Plan which is reviewed at least annually and includes the core elements which are required by Section 6401 of the Affordable Care Act as described within the section and discussed in Policy #100 of this collective documents. The most recent version of the Compliance Plan and any supporting documents, training material, internal memos or other relevant documents shall be readily available for review by any federal or state agencies, payers, or other third-party representatives to which compliance must be demonstrated.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Compliance Plan Document	
	Compliance Training Material	

NIHD
RURAL HEALTH CLINIC

Organizational Structure and Ownership		
J Tag References: J-0060, J-0061, J-0062, J-0081, J-0084, J-0086 **§ References: 491.7, 491.8, 491.9**	**Policy Type:** Administrative	**Policy Number: 110.00**
Adopted or Revised Date: 1/31/2022		

Policy Declaration: This is the Organizational Structure and Ownership Policy of the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to disclose in a written document the organizational structure of the Clinic which is Rural Health Clinic (RHC). Furthermore, the policy is designed to give detailed information about the governance, management and staffing of the clinic.

Policy Statement: The Clinic seeks to fully disclose its current ownership and organizational structure, as it pertains to both operational and medical direction, to all interested parties.

Policy Scope: This policy is informational in nature.

Policy Body: **Organizational Structure and Ownership**

1. **Legal Entity:** The legal entity name is Northern Inyo Rural Health Clinic.
2. **dba Trade Name:** The dba/trade name of the Clinic is:

   Northern Inyo Rural Health Clinic.
3. **Ownership Type**: The ownership type of the Clinic is a Governmental.
4. **Legal Organization:**

   a. The entity was officially created, incorporated or chartered in the State of California.
   b. This entity was organized on 1/7/1946.
   c. All trade names, trademarks or logo have been registered with the Secretary of State as required by state or federal regulation.
   d. Any changes in ownership or managing control shall be reported to federal and state authorities, including CMS, in a prompt manner.
5. **Clinic Type:** The RHC Clinic Type is provider-based entity.

6. **Clinic Administrator/Director**: The individual principally responsible for directing the operation of the clinic is:

7. **Medical Director**: The individual responsible for medical direction of the clinic is:

   a. The medical director is a duly licensed physician in the State of
   b. The medical director's license number is
   c. The medical director's license is in good standing and was first issued on

8. **Staffing and Staff Responsibilities:** The organization of the RHC allows for the following medical staff positions:

   a. At least one physician who is the individual responsible for the medical direction of the clinic;
   b. At least one physician assistant or nurse practitioner who is available to furnish medical services at least 50% of the time that the clinic operates, i.e, regular posted patient care hours.
   c. Sufficient ancillary and/or support staff who are supervised by the professional staff.

   The responsibilities of each position are further delineated through written job descriptions. Written job descriptions identify the employee or staff member's supervisor. The adequacy of staffing and the current staffing model is reviewed at least once annually during the Annual Evaluation process.

9. **Organizational Chart:** More details about the clinic's organizational structure is graphically represented on the clinic organizational chart which is a supplemental document related to this policy. The organizational chart illustrates the lines of authority.

10. **Staff Roster:** The Clinic Administrator maintains a roster of current employees and medical staff.

11. **Written Policies:** Written policies have been established and implemented to further outline the policies and procedures related to 1) the administrative functions of the clinic, including human resource management; and 2) clinical care of patients. Patient care policies are developed with the advice of a group of professional personnel that includes one or more physicians, and one or more nurse practitioners or physician assistants. The policies are reviewed at least once biennially for appropriateness, completeness and relevance as part of the Biennial Evaluation process.

These written policies seek to ensure:

a. Compliance with local, state, and federal regulations;
b. Consistency within the performance of administrative and clinical functions, tasks and responsibilities;
c. A level of performance with respect to best practices; and
d. Guidance for the administration, employees, healthcare providers, and contracted third-parties, as applicable.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Organizational Chart	Administrative Section
	Job Descriptions	HR Files/HR Section
	Clinical Staffing Policies	Patient Care Section
	Current Staff Roster	Administrative Section

NIHD
RURAL HEALTH CLINIC

Organizational Chart Policy		
J Tag References: J-0062 **§ References: 491.7**	**Policy Type:** Administrative	**Policy Number:** 120.00
Adopted or Revised Date: 1/31/2022		

Policy Declaration: This is the Organizational Chart Structure Policy of the Clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to disclose the organizational structure of the Clinic in the form of an organizational chart which is a graphic representation of the lines of authority.

Policy Statement: The Clinic seeks to fully disclose its organizational structure. The graphic representation shall be updated any time there is a significant change in the lines of authority.

Policy Scope: This policy is informational in nature.

Policy Body: See Org Chart as evidence to this policy.

Additional Organizational Information:
None

Specific Procedures: The organizational structure and the accuracy of this graphic will be reviewed at least once annually as part of the Annual Evaluation process. Also see additional procedures as described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS
Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
110.00	Organizational Structure and Ownership	Administrative Section
	Job Descriptions	HR Files
	Current Employee Roster	
	Board Roster	

Non-Discriminatory Policy		
J Tag References: J-0011 **§ References: 491.4** **Other References: See Citation in Body of Policy**	**Policy Type:** Administrative	**Policy Number:** 130.00
Adopted or Revised Date: 1/31/2022		

Policy Declaration: This is the Non-Discriminatory Policy of the Clinic. The Clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purposes of this policy are to clearly outline the civil rights protection and anti-discriminatory policies which protect the patients, employees and public of the Clinic.

Policy Statement: The Clinic seeks to clearly define the processes by which civil rights are protected and by which those protections are communicated and safeguarded. This statement is written in accordance with the provisions of Title VI of the Civil Rights Of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, and the Regulations of the US Department of HHS issued pursuant to these statutes at Title 45 Code of Federal Register Parts 80, 84, and 91. Furthermore, the Clinic complies with Section 1557 of the Patient Protection and Affordable Care Act of 2010, 42 U.S.C. § 18116.

As a Recipient of Federal financial assistance, the Clinic does not exclude, deny benefits to, or otherwise discriminate against any persons on the grounds of race, religion, color, sexual orientation, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs or activities, which carried out by the provider directly or through a contractor with which the provider arranges to carry out its programs and activities.

Policy Scope: This policy is procedural and regulatory in nature.

Policy Body: Non-Discriminatory Policy

1. **All Inclusive Policy To Ensure Civil Rights: There exists an all-inclusive policy to ensure the civil rights of employees, patients, and other individuals as provided for above in the statutes.**
    a. **Provision of Medical Services and Benefits--**
        i. No patient will be denied the provision of medical services or benefits based on the grounds of race, color, religion, national origin or on the basis of disability or age.
        ii. No patient will be denied provision of medical services or benefits on the basis of sex including but not limited to gender identity or sexual orientation.

b. **Provision of Employment Opportunities-**
   i. No individual will be denied an employment opportunity based on the grounds of race, color, religion, national origin, or on the basis of disability or age.
   ii. No patient will be denied provision of medical services or benefits on the basis of sex including but not limited to gender identity or sexual orientation.

c. **Accommodation-** Patients and employees will be afforded reasonable accommodation within the available resources of the Clinic in order to make the building and the provision of services safely and conveniently accessible to any individual with the full intention that all persons be afforded all the rights and benefits associated with the clinic.

2. **Identification of Individuals with language barriers and impaired sensory skills:** The following steps will be used to identify and facilitate communication obstacles concerning individuals with limited speech, hearing or vision and in the case of individuals for whom a disability or native language restricts communication.
   a. The clinic staff will identify the individual's need for assistance.
   b. The clinic staff will enlist the help of a family member, companion or acquaintance to assist in interpreting the immediate needs of the patient. ***A family member, and more specifically a minor child, may not be used as a medical interpreter.***
   c. The clinic staff shall maintain a current list of all local, county/parish, and state resources which can provide assistance to and on behalf of patients with impairment or disabilities related to speech, language, hearing, and vision. These agencies, institutions, or programs shall be contacted to assist patients with these conditions. To the extent that the clinic is able to reasonably accommodate patients with these disabilities, it will do so to ensure that medical care is not hindered or compromised.
   d. The clinic providers and staff will use a number of other resources in an effort to meet the communication needs of patients and other individuals for whom English is not the primary language:
      i. Certified medical interpreters or internet-based services which allow face to face translation in person or via an audio/video application. The clinic has an agreement with
      ii. Certified medical interpreters or services available through parent entity hospitals or health care systems or available under agreement with other healthcare organizations.
      iii. Internet-based interpreter programs and tools
      iv. Other organizations or services include:

   e. These consolidated resources will be used to communicate the availability of communication access services, that these services are without charge and that the services will be used to ensure the provision of medical services without discrimination.

3. **Employee and Staff Training:** The following aspects of civil rights and non-discriminatory training will be provided:
   a. All employees will receive initial training about the clinic's non-discriminatory policy and the related laws and statutes for which this policy is implemented.

b. Employees will be directed to workplace notices which further communicate or explain the non-discriminatory actions.
c. Employees will be given examples of possible situations in which an individual's civil rights may not be protected for the purpose of instructing them on how to make provisions for equal and fair services and benefits.
d. Subsequent, periodic training will be conducted as needed to make sure that the staff has an adequate understanding of issues and concerns related to the protection of civil rights.

4. **Notice: A copy of the non-discriminatory policy in the form of a notice will be publicly posted at all time.** Additional methods of communication will be utilized to ensure that all parties are aware of the protections offered against discrimination and the types of discrimination for which the federal law offers these protections. Tag lines in non-English languages shall be placed on forms, notices, and patient communications. These tag lines will represent all foreign languages known to exist in the service area as reported in current US Census data or identified by OCR.

5. **Questions or Comments: Questions from patients or from the public concerning the non-discriminatory practices and accommodation of the Clinic, may be directed to:**

Email: OCRMail@hhs.gov

Or

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS
Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Copy of Posted Notice	
	Copies of Translation Agreements or Service Contracts	
	US Census Data for Service Area	
	List of Community and State Resources	

NIHD
RURAL HEALTH CLINIC

RHC Service Area (Location)		
J Tag References: J-0020, J-0021, J-0022, J-0023 § References: 491.5	**Policy Type:** Administrative	**Policy Number: 140.00**
Adopted or Revised Date: 1/31/2022		

Policy Declaration: This is the RHC Service Area (Location) Policy of the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to acknowledge and document the conditions of coverage as an RHC pertaining to the location and service area.

Policy Statement: It is the intention of the Clinic to remain in regulatory compliance as a Rural Health Clinic.

Policy Scope: This policy is informational and regulatory in nature.

Policy Body: **RHC Service Area**

1. **Location of the Clinic:**
   - **a.** The Clinic location meets the requirement "that it is not an urbanized area" as defined by the Bureau of the Census; AND
   - **b.** The Clinic is located in an area that has been designated as having a shortage of personal health services; OR
   - **c.** The location qualifies under one of the program exemptions as defined in 42 CFR §491.5 as determined by CMS; AND
   - **d.** The rural location and HPSA status has been validated by the state rural health officer or other state agency as meeting the location requirements prior to pursuing initial CMS certification.

2. **Type of Structure:**
   - **a.** Permanent Structure: The clinic is housed in a permanent structure located at 153 Pioneer Lane, Suite B. Bishop, California 93514.
     - i. Floor plans and/or drawings have undergone any necessary architectural site plan reviews and/or inspections by the state fire marshal's office, if required; and,
     - ii. Any other local, county or state office reviews that are required to initial or zoning, building codes and occupancy.
   - **b.** Mobile Units: The clinic operates no mobile units. The clinic does not provide services at any other location.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	State Site Verification Letter, if applicable	Administrative Section
	HRSA HPSA/MUA Printout	Administrative Section
	If mobile units are in service, the same information is needed for each stop and proof of published route.	

NIHD
RURAL HEALTH CLINIC

Advertising, Web-Presence and Social Media Representation		
J Tag References: J-0023, J-0062 § References: 491.5, 491.7	**Policy Type:** Administrative	**Policy Number: 150.0**
Adopted or Revised Date: 1/31/2022		

Policy Declaration: This is the Advertising, Web-Presence and Social Media Representation Policy of the Clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to establish the guidelines that will be used to represent the RHC via advertising, web presence and social media sites.

Policy Statement: It is the intention of the Clinic to remain in regulatory compliance as a Rural Health Clinic.

Policy Scope: This policy is informational and regulatory in nature.

Policy Body: Advertising, Web-Presence and Social Media Representation

1. **Representation of the RHC**
    a. The RHC shall be held out to the public under the same legal name or trade name, ownership and medical directorship that has been approved by CMS at the time of initial certification;
    b. If the rural health clinic is one of several medical offices, RHC and non-RHC, operated by same organization or ownership:
        i. Each RHC shall be distinguished from other clinics or clinic types;
        ii. An individual RHC shall not be held out as one of several locations without distinction; the RHC shall not operate or advertise satellite location or be mistaken by the public as a satellite office.
        iii. Any mobile units operated under the RHC's CCN number shall be held out in the same way as the permanent structure.
    c. If changes are made in the ownership or management structure, clinic name, medical directorship or physical location, such changes will not be advertised prior to written approval of any 855-A or CMS-29 changes in enrollment have been received.

2. **Promotion of Clinic Services and Activities:** No services or activities shall be promoted or advertised which are not consistent with the Rural Health Clinic Program and with requirements for providing both RHC and non-RHC services.

The guidance as provided in 42 CFR §491, in sub-regulatory guidance such as the IOM CMS Policy Benefit Manual Chapter 13, and in state Medicaid RHC program regulations shall be considered prior to:

a. Deciding to provide a new service;
b. Deciding to participate in or promote a community activity or event;
c. Advertising a new service or promoting an activity;
d. Development of a new website or social media site

3. **Proofing of signage, print advertising, web-site designs or social media sites:** All signage, advertising, web publishing or promotion materials shall be proofed and approved prior to publication by a member of the RHC administrative team who is familiar with RHC regulations as pertaining to public disclosure requirements and program compliance.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Policy #100- Organizational Structure & Ownership	Administrative Section
	HR Policies on Employee Social Media Use	HR Section

NIHD
RURAL HEALTH CLINIC

Physical Plant Safety: General Policy		
J Tag References:J-0041 § References: 491.6	**Policy Type:** Physical Plant and Environment	**Policy Number:** 200.0
Effective and Revision Date(s): 1/31/2022		

Policy Declaration: This is the Physical Plant Safety: General Policy of (labeled as "Clinic" throughout this policy) the clinic.

The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to acknowledge and document compliance with state and local building, fire, and safety codes.

Policy Statement: It is the intention of the Clinic to remain in compliance with applicable regulations and codes which are related to the Clinic's physical plant.

Policy Scope: This policy is informational and regulatory in nature.

Policy Body: Physical Plant Safety

1. **General Design and Construction:** The Clinic design and construction accommodates patient care in a traditional layout suitable for a medical clinic. Historically, the design has proved adequate in space for the patient load. Construction, renovation, or remodeling of the clinic shall conform with local and state codes and shall be subject to appropriate permitting, inspection, and review. Any architectural changes shall be consistent with the use of the building as a Rural Health Clinic which provides medical services.

2. **Office of the State Fire Marshal:**

    a. The Clinic has submitted or will submit all necessary plans, drawings, photos, or building specification to the State office or agency, as applicable, to the construction, renovation, or normal operation of a Rural Health Clinic.
    b. The Clinic shall comply with any annual or periodic inspections or re-inspections required by the Office of State Fire Marshal.
    c. The Clinic shall comply with all requirements for fire safety equipment and fire prevention systems including, but not limited to, fire extinguishers, smoke alarms, sprinkler systems, exit ways and signage.

3. **Office of Public Health:**
    a. The Clinic shall comply with initial inspections required by the state's Office of Public Health or similar agencies which may include, but are not limited to,

sanitation inspections, inspections of the water supply/water quality or sewerage systems.

b. The Clinic shall comply with any subsequent re-inspections as required by law or regulation.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Office of State Fire Marshal Reports	
	Office of Public Health Inspection Report	
	Clinic Floor Plan and Drawings/ Photos	
	Other review documents	

NIHD
RURAL HEALTH CLINIC

Preventive and Required Maintenance		
J Tag References: J-0042, J-0043, J-0044 **§ References: 491.6**	**Policy Type:** Physical Plant and Environment	**Policy Number:** 210.0
Effective and Revision Date(s): 1/31/2022		

Policy Declaration: This is the Preventive and Required Maintenance Policy of (labeled as "Clinic" throughout this policy) the clinic.

The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to outline the procedures related to preventive and/or required maintenance.

Policy Statement: It is the intention of the Clinic to maintain all essential mechanical, electrical and patient care equipment in safe working order.

Policy Scope: This policy is informational and procedural in nature.

Policy Body: Preventive Maintenance

1. **Responsibility for Building Maintenance:** The Clinic building/suite is Owned under written agreement or arrangement with the Parent Entity.
   Maintenance and upkeep of the building, necessary to ensure that the RHC maintains an appropriate work space and safe environment, is provided under a contractual agreement, arrangement or clear understanding. Periodic maintenance and upkeep shall be scheduled at appropriate intervals.

2. **Essential Equipment Systems**: Periodic and preventive upkeep of essential mechanical electrical systems, and equipment used or accessed by patients is the responsibility of The Clinic shall notify the designated representative(s) of any suspected concerns or of malfunctions for essential systems which arise in between periodic servicing. Whenever a maintenance service has been contracted or provided under agreement, the Clinic shall notify the vendor or supplier when maintenance is required in between regular servicing. This policy shall apply to the maintenance of electrical and other utility supplies & systems, HVAC systems, elevators or any other essential equipment system.

3. **Biomedical and Equipment Used to Deliver Patient Care**
   a. The clinic shall maintain a service agreement or have an arrangement to routinely inspect and maintain equipment related to direct patient care, diagnostic procedures, or therapeutic procedures. The agreement or arrangement shall provide for:

i. An initial inspection of all bio-medical equipment shall be made in preparation for initial RHC certification.
ii. Regularly scheduled inspections shall be conducted at subsequent intervals which shall not exceed 12 months from the initial inspections (at least annually).
iii. The service provider shall be notified immediately of any suspected malfunction or operational concern of which the Clinic becomes aware so that immediate inspection and/or repair can be made.
iv. The biomedical equipment inspections are performed annually by

b. The appropriate actions shall be taken to utilize provisions for warranties and manufacturer service agreements when applicable. Service technicians and vendors shall ensure that manufacturer's recommendations for operation and repair of equipment are followed and not voided.
c. A record of all inspections and repairs shall be maintained by the Clinic.
d. Service record of any type, essential equipment or biomedical equipment, shall be maintained.
e. The RHC's program evaluation shall include information on the maintenance of essential mechanical, electrical and patient care equipment.
f. The staff shall visually inspect the equipment during regular use or prior to point of care.
g. Any equipment suspected of having an operational or safety issue shall be taken out of service, marked as "DO NOT USE" until the equipment can be tested and repaired.
h. Equipment which has not been routinely serviced or which is not currently used shall be removed from the clinical areas of the building.
i. If essential equipment needed to provide any mandatory service become inoperable, the equipment shall be replaced immediately to prevent disruption of services.
j. Major disruptions in utility service or essential systems which could potentially require the need for emergency response shall be addressed in the RHC's Emergency Preparedness Plan.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Biomedical Equipment Service Agreements	Clinic Administrator
	Maintenance Records and/or Asset Lists/Repair Logs	Clinic Administrator
	Leases or Service Agreements	
	Parent Hospital Policy (if applicable)	
	EPP, if applicable	

NIHD
RURAL HEALTH CLINIC

Building Sanitation and Cleanliness		
J Tag References: J-0044 **§ References: 491.6**	**Policy Type:** Physical Plant and Environment	**Policy Number:** 215.0
Effective and Revision Date(s): 1/31/2022		

Policy Declaration: This is the Building Sanitation and Cleanliness Policy of the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to acknowledge and document compliance with state and federal regulations concerning building sanitation and cleanliness.

Policy Statement: It is the intention of the Clinic remain in compliance with applicable regulations and codes which are related to maintaining a clean and orderly environment for patients, employees and the public.

Policy Scope: This policy is informational and regulatory in nature.

Policy Body: Sanitation and Cleanliness

1. **Cleanliness of Food Storage and Dining Areas:** The Clinic shall keep all areas where food is stored, prepared or served neat and clean. Employees shall be informed during orientation or other on-the-job training of the procedures for maintaining clean and neat break rooms, meeting rooms and other common areas of the RHC.
    - **a.** Employees are responsible for cleaning up after themselves and properly disposing of trash and leftover food in accordance with procedures implemented by the clinic;
    - **b.** Employees may not eat or drink at work stations located in patient care area.
    - **c.** Employees are responsible for food items they have placed in cabinets, refrigerators or on surfaces of common areas. Leftover food, partially eaten food, or food waste shall not be left in common areas of the clinic for more than a reasonable amount of time. Employees are responsible for disposing of or taking away leftover or opened and uneaten food items.
    - **d.** Food items shall only be stored in designated areas, cabinets or refrigerators, which are labeled "Food Only".
    - **e.** Employees shall be responsible for clearing surfaces (countertops, tables, microwave surfaces) of food debris, spills, crumbs, used paper products created from their own dining activities.
    - **f.** The clinic shall use disposable paper goods and utensils in the serving or consuming of food items.
    - **g.** Coffee pots, counter-top appliances, or stove-tops are allowable.

h. Trash or waste from areas where food has been consumed must be disposed of daily and taken to exterior garbage receptacles or bins.
i. No food items shall be consumed in patient care or treatment areas even if that area is the employee's regular work space.
j. Patients shall be discouraged from eating or drinking in the waiting room or other public areas of the clinic. Should an employee notice that food or drink has been consumed in these areas, the employee should dispose of the waste or notify the appropriate housekeeping staff whichever is most expediate.
k. Kitchen areas, breakrooms and other common areas shall be included in regular cleaning schedule of the clinic.

2. **Pest (Vermin) Control Management:** The Clinic shall make provisions for pest control management and treatment that is appropriate for the geographic location, climate, season and building structure type. Pest and vermin control management and treatment shall apply to both interior and exterior areas of the clinic and to any outbuildings or storage sheds. Pest control management shall be provided by service contract or arrangement either periodically or as needed.
    a. Employees shall be notified in advance of scheduled pest treatment spraying. Such disclosure shall be consistent with state requirements for notifying employees of chemical and insecticide use in the workplace.
    b. Employees shall notify the clinic manager or clinic administrator if they see or suspect insect infestation inside (cockroaches, ants, mice, etc.) or outside (ants, wasps, bees, termites, etc.) of the clinic.
    c. Providers shall immediately notify the clinic manager or clinic administrator if they treat a patient for an insect or parasite-related conditions (lice, bedbugs, or scabies, for example) which might require special cleaning or treating of an area occupied by the patient and/or family members. The manager in cooperation with the clinical staff shall implement actions to detect, control and limit exposure and the spread of disease. The medical staff shall determine if specific medical management polices are needed in situations of outbreaks of infestation within the community.
    d. Caution should be exercised by pest control contractors, maintenance workers, and employees to ensure that the safest possible environment is maintained during extermination and other deployment of pest management services.

3. **Maintaining a Clean Environment During Renovation/Remodeling:** The Clinic shall maintain a clean and orderly environment during renovation or construction projects. When such projects require active construction, access to the area shall be restricted with caution or warning signs. Employees and patients shall be given written instructions on alternative entrances and routes throughout the building. Debris, construction waste, old carpeting or wall coverings and trash shall be disposed of according to local and state guidelines. Remedial construction to remove mold, asbestos or other hazards shall be performed by licensed contractors who are recognized by the city or state. Any building renovation or remodeling shall be subject to federal, state or local requirements that apply to the RHC. The state rural health office, the state department of health (if the RHC is licensed) and the CMS MAC shall be informed of changes in address or in the original certified space, as is applicable.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Medical Waste Disposal Agreement/Policy	
	Pest Control Service Agreement	
	Clinic Cleaning Schedule	
	Pest Control Notice to Employees, if applicable	

NIHD
RURAL HEALTH CLINIC

Storage, Handling & Administration of Drugs, Biologicals, and Pharmaceuticals		
J Tag References: **J-0043, J-0125** **§ References:** **491.6, 491.9, 491.12**	**Policy Type:** Physical Plant and Environment	**Policy Number: 220.0**
Effective and Revision Date(s): 8/23/2024		

Policy Declaration: This is the Storage, Handling & Administration of Drugs, Biologicals, and Pharmaceuticals Policy of the clinic.
The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to outline the procedures related to the storage and handling of drugs, biological and pharmaceuticals.

Policy Statement: It is the intention of the Clinic to ensure that drugs, biological, and pharmaceuticals are stored, handled and administered in a manner that safeguards the products and controls usage.

Policy Scope: This policy is informational and procedural in nature.

Policy Body: Storage, Handling and Administration of Drugs, Biologicals, and Pharmaceuticals

1. **General Storage and Handling Guidelines:**

   a. Drugs, biological and other pharmaceuticals shall be ordered, received, stored retrieved, and administered by authorized clinic employees only.
   b. The storage of drugs, and specifically DEA scheduled drugs, shall be secured according to federal and state laws.
   c. The clinic shall designate authorized clinical staff to monitor, handle, and administer drugs and biologicals.
   d. Drug storage shall be located in an area which prevents unmonitored or unauthorized access. Authorized staff should be able to continuously monitor storage areas.
   e. All drugs, biological, and other pharmaceuticals, including sample medications, shall be stored in a secure area or areas that have secure, controlled access.
   f. Unsecured drugs or biologicals shall be in the custody of an authorized individual at all times. If a medication cart is used, for example for immunizations, the cart shall be remain under the control of an authorized individual at all times.
   g. All drugs shall be stored in their original containers with legible labeling.
   h. All drugs shall be stored according to the specific environmental conditions (temperature, lighting, humidity, etc.) as labeled by the FDA or as recommended by the U.S. Pharmacopeia (USP) requirements. If it is unclear how to correctly

store a drug, biological or pharmaceutical or if the original insert is unavailable, the clinic shall contact the manufacturer, the distributor or otherwise access the USP database via a pharmacy or other third-party.

i. If the clinic is unable to determine if a drug has been stored or handled correctly, the clinic should use caution and err on the side of caution by not using or administering the substance.

j. Multiple-Dose Vials must not be stored in areas of immediate patient care. Multi-dose vials must be dated with first-opened date and discard date. The discard date must not be later than 28 days after the first-opened date. Exceptions may be made to the 28 day discard date if the manufacturer's package insert specifies a longer discard date. In which case, the manufacturer's package insert must be maintained as evidence of compliance.

k. Single-dose vials must be for single patient, single use only.

l. Any emergency drug cart or case should be secured to prevent tampering or unauthorized access.

m. Portable Oxygen tanks should be secured via cart, chains, or crate and have appropriate tubing and masks immediately available for use.

n. All Scheduled drugs, if stocked, shall be accounted for when purchased, received, stocked, administered or dispose as evidenced by a log. Controlled drugs shall be securely stored and double-locked.

o. All drugs and biologicals shall be inventoried for expiration dates (beyond use dates) on a monthly basis by a designated staff member, usually a member of the nursing staff or medical assistant. The Clinic Manager shall periodically spot check the supply area to ensure compliance.

p. All medications shall be labeled with an open and discard date when applicable.

q. Any expired, deteriorated, or adulterated drugs shall be stored separately to prevent use and shall be discarded following the appropriate method as set forth by state and federal laws, regulations, and guidelines.

r. The Clinic shall have current drug references and antidote information available. Employees shall be trained on how to access and use these resources.

2. **Compounding of Drugs:** The clinic shall only prepare solutions that are common in a medical office. Solutions shall be mixed by qualified clinical staff who have been trained, are knowledgeable, and who are within their scope of practice to perform the task. Solutes shall only be mixed according to the package insert using the correct solvent. In no case, should a substitute solvent be used to create the solution

3. **Administration of Drugs**

   a. Use of Patient Identifiers: The clinic shall use acceptable patient identifiers to confirm that the patient name, the order, and the selected drug are in agreement prior to administration. The clinic has selected the patient's name and date of birth to be the two unique patient identifiers.

   b. The Six Rights: All staff who are responsible for medication administration shall follow the "Six rights" to ensure accurate adm

   c. Clarification of Orders Prior to Administration: If the clinic staff has questions or concerns about a medication order, the employee shall ask the ordering provider for clarification prior to administration.

4. **Drugs and Products Requiring Refrigeration**
   a. All products requiring refrigeration will be kept in refrigerators that are monitored daily for temperature control. Temperatures should be logged at least twice a day using a temperature monitoring device. Purpose-built refrigerators are preferred. The use of dorm-style or mini-refrigerators will be prohibited. Household refrigerators may be used if the freezer and refrigerator compartments have separate doors which seal completely. Single door units should not be used for medication or vaccine storage. The freezer section of a household refrigerator should not be used for storage of frozen vaccines.
   b. A purpose-built freezer storage unit shall be used for frozen vaccines.
   c. Drugs shall be stored at the manufacturer's recommended temperature as found in the FDA package insert and labeling.
   d. No food items or personal items will be stored in the same refrigerator(s) as drugs, biological, and pharmaceuticals.
   e. Refrigerators that are used for drug storage will be marked with signs:
      1. No Food
      2. Do Not Unplug
   f. Only one refrigerator or freezer unit shall be plugged into each receptible. Breaker boxes should be marked with a sign warning about drug storage if the power is disconnected.
   g. Refrigerators used for food or personal items shall be marked "No Drugs":
   h. Drugs should be centrally stored in the refrigerator with appropriate space observed between the top, bottom and sides of the unit. No drugs or biological shall be stored in the door areas or bottom crisper units of the refrigerator. The door areas will be stocked with ice packs or water bottles to prevent use of the door areas and to help maintain constant temperature control. The placeholder bottles should be marked as "Do Not Drink". The door areas of the freezer section of any refrigerator will be stocked with ice packs or frozen water bottles.

5. **Vaccines (VFC and Private Stock):**
   a. Private stock vaccines and vaccines that are provided through the ***Vaccines for*** **Children** program shall be stored separately on open shelves or open bins. Each vaccine should be clearly identified and marked by type of vaccine and type of stock.
   b. Thermometers shall be used to monitor storage temperatures as required by the program and per best practices. The CDC recommends the use of a temperature monitoring devise (TMD) with a digital data logger (DDL).
   c. Vaccines will be inventoried periodically for the purpose of maintaining appropriate levels of stock and for reconciling usage as needed. All state requirements for inventory rotation, monitoring, and reordering shall be followed.
   d. Vaccines will be checked for expiration dates on a regular basis. VFC guidelines shall be followed for reporting vaccines which are received with short expiration dates and for returning vaccines under program guidelines.
   e. All other terms and conditions of the VFC program will be observed. This includes reporting of immunization administration, recordkeeping and exception reporting.

6. **Patient-Supplied/Third-party supplied Drugs:** The clinic does not typically store, handle or administer patient or third-party supplied drugs and biologicals. Exceptions may include immunotherapy (allergy shots); other medications, prescribed by a known physician, that necessitate administration by a qualified medical professional; and sample medications received by a known and vetted pharmaceutical company representative.

7. **Controlled Substances, Scheduled Drugs:** If the clinic chooses to stock, distribute or administers controlled substances even in limited amounts, the federal DEA diversion and state pharmacy board regulations for secure storage, administration and recordkeeping shall be strictly followed.

8. **Sample Drug Distribution:** The following procedures apply if sample medications are dispensed to patients.
    a. Sample drugs shall be received, stored and managed in a secure manner.
    b. Sample drugs which are distributed to patients should be logged with the following information:
        1. Patient Name
        2. Date dispensed
        3. Name of Drug
        4. Dosage
        5. Lot Number of Drug
        6. Quantity Given (# of samples)
    a. Sample medications will only be dispensed to a patient if the product:
        1. Is in the original tamper-proof packaging;
        2. Is clearly labeled;
    b. If the clinic becomes aware of a recall, the log shall be reviewed. Patients affected by the recall will be notified.

9. **Loss of Power:** In the event of loss of electricity or a malfunction of a refrigerator, the specific emergency preparedness plan shall be activated. In the event that an alternative action is taken, one or more of these procedures shall be followed:
    a. Move the drugs and biological to temporary coolers or ice chests using the frozen water bottles and ice to maintain the proper temperature.
    b. The clinic administrator or provider on-site will be responsible for moving the drugs to an alternate location with a back-up power supply or generator. The clinic administrator or provider on-site will maintain custody of the drugs during the transport and alternate storage periods.
    c. The clinic has made arrangements for being notified of power outages which may occur outside of normal operating hours.

Specific Procedures: As described in the body of the policy.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Patient-Supplied Drug Policy	
	Sample Medication Log Sheet	
	Correspondence with Energy Providers	
	Emergency Preparedness Plans	
	Drug Medication Error Poster	

NIHD
RURAL HEALTH CLINIC

Blood Borne Pathogens: Exposure Control (Including Needle Sticks)		
J Tag References: J-0040 **§ References: 491.6** **Other References:**	**Policy Type: Physical Plant and Environment**	***Policy Number: 230.0***
Effective and Revision Date(s): 1/31/2022		

Policy Declaration: This is the Blood Borne Pathogens: Exposure Control Policy of the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purposes of this policy are to clearly outline the immediate steps that should be taken if an employee is exposed to blood-borne pathogens and biohazards in the workplace.

Policy Statement: The clinic has a high regard for the health and safety of its employees and, in particularly, in those incidents when those occupational hazards might also create a situation in which employees may be at risk of exposure of blood-borne pathogens. The intent is to safeguard employees from occupational hazards in compliance with federal and state laws and regulations.

Policy Scope: This policy is informational, procedural and regulatory in nature.

Policy Body: Blood Borne Pathogen Exposure Control

1. **Exposure Control Administration**: The Clinic Administrator shall be responsible for:
   - **a.** Identifying the exposure risk of an employee by job description;
   - **b.** Notifying the clinic employees of potential exposure risks and safeguards and providing training on exposure control;
   - **c.** Providing proper labeling of bio-hazardous materials and storage areas;
   - **d.** Providing Personal Protection Equipment;
   - **e.** Maintaining a cleaning schedule;
   - **f.** Offering Hepatitis B vaccination to all employees at risk of exposure free of charge;
   - **g.** Providing post-exposure examination and follow-up including a medical record outlining the treatment;
   - **h.** Maintaining records of exposure incidents and other documentation as needed.
   - **i.** Conducting a post-exposure evaluation of exposure incidents.

2. **Biohazardous Materials**: Bio-hazardous Materials, as defined by OSHA, include:
   - **a.** Human Blood
   - **b.** Semen
   - **c.** Vaginal Secretions
   - **d.** Cerebrospinal Fluid
   - **e.** Synovial Fluid
   - **f.** Plural Fluid
   - **g.** Pericardial Fluid

h. Amniotic Fluid
i. Saliva
j. Other body fluids that are contaminated with blood or situations in which it is impossible to differentiate between fluids.

3. **Personal Protection Equipment**: The Clinic shall supply and make available appropriate personal protection equipment (PPE), such as gloves, masks, gowns, or facial protection as needed to prevent or limit exposure to biohazards during the performance of job tasks.

4. **Prevention of Accidental Needle Sticks**: The incidence of accidental needle sticks can be prevented and/or greatly reduced by several simple procedures, which include:
   a. Proper sharps disposal;
   b. Never recapping needles;
   c. The provision and use of PPE (personal protection equipment);
   d. Staff education on the risks of transmission;
   e. Staff education on the techniques and methods.

5. **Immediate First Aid Procedures:** In the event of an accidental needle stick or other biohazard exposure, the following actions should be taken immediately by the employee. If the employee needs help in performing these tasks, he or she shall ask a supervisor or co-worker to assist. PPE should be worn and all efforts to minimize additional exposure or contamination should be exercised. The immediate steps should include:
   a. Wash needle sticks and cuts with soap and water;
   b. Flush splashes to the nose, mouth, or skin with water;
   c. Irrigate eyes with clean water, saline, or sterile irrigates;
   d. Report the incident to your supervisor;
   e. Immediately seek medical treatment;
   f. If you have questions about appropriate medical treatment for occupational exposures, 24 hour assistance is available from the Clinicians' Post Exposure Prophylaxis Hotline (PEPline) at **1-888-448-4911**.

6. **Diagnostic Testing and Prophylaxis Treatment Guidelines:** The clinic follows all recommendations of the CDC for the management of accidental exposure to blood-borne pathogens. Resources and best practices can be located at cdc.gov/niosh/topics/bbp/guidelines.html.

7. ***Subsequent Testing and Treatment**: The* subsequent ordering of diagnostic testing and treatment shall be the direct responsibility of the clinic administrator, or in the absence of the clinic administrator, the direct responsibility of the supervising healthcare provider. The clinic may refer additional treatment of the exposed individual to a specialty healthcare provider.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures.

POLICY #	Policy or Document Name	Location
	Cleaning Schedule	
	Updated U.S. Public Health Service Guidelines (referenced above) or OSHA for Medical Practices Guide	

NIHD
RURAL HEALTH CLINIC

Infection Control Policy		
J Tag References: J-0040 § References: 491.6	**Policy Type: Physical Plant and Environment**	***Policy Number: 235.0***
Effective and Revision Date(s): 1/31/2022		

Policy Declaration: This is the Infection Control Policy of the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.
Policy Purpose: The purposes of this policy are to clearly outline the procedures which shall be taken to protect patients and employees from infections and communicable diseases.

Policy Statement: The clinic has a high regard for the health and safety of its patients and employees in regard to preventing the spread of infectious disease.

Policy Scope: This policy is informational, procedural and regulatory in nature.

Policy Body: Infection Control Policy

1. **Hand washing**: Hand washing is an essential means of preventing the spread of disease. Employees and clinical staff shall thoroughly wash their hands with an antibacterial soap and water ***or*** use an alcohol-based sanitizer in the following situations:
   - **a.** Before examining or performing a procedure on a patient
   - **b.** After examining or performing a procedure on a patient
   - **c.** Before and after eating
   - **d.** After using the toilet
   - **e.** Before and after Handling contact lens or other personal health devices
   - **f.** Any other situation or activity in which exposure or contamination could have occurred

2. **PPE**: PPE--including gloves, masks, and gowns--shall be used in all clinical situation where the judgment of the clinician and according to best practices it is necessary to prevent exposure or contamination by blood or airborne particles.

3. **Blood-Borne Pathogens**: Refer to the Blood- Borne Pathogen Policy for more specific guidelines and procedures.

4. **Communicable Diseases**:
   - **a.** The Clinic shall ensure that all employees have been or shall be appropriately screened for communicable diseases as required by federal, state or local law.
   - **b.** The Clinic shall report incidents of communicable diseases as required by federal, state, or local law.
   - **c.** The Clinic shall use universal and standard precautions when treating patients who are known or suspected of being infected with a communicable disease.

5. **Universal and Standard Precautions:**
    a. Blood and body fluid precautions are used with every patient and specimen.
    b. Disease-specific precautions are used as indicated.
    c. Gloves are used when touching body fluids and non-intact skin of all patients.
    d. Gloves are used when handling items and surfaces which have been soiled with blood or body fluids.
    e. Sharps are handled with great care and are disposed of in tamper-proof containers which are secured.
    f. Mouthpieces or bags for use during emergency mouth-to-mouth resuscitation are available.
    g. Employees with open skin lesions or open wounds refrain from patient care.

6. **Clean and Dirty Areas**: The Clinic maintains clearly marked areas to separate Clean and Dirty equipment and/or instruments. The providers and nursing staff ensure that the path used when transporting contaminated/dirty supplies or instruments minimized the chance of cross-contaminating clean areas or surfaces.

7. **Cleaning Between Patients:** The exam rooms or treatment areas shall be cleaned after each patient use. Staff shall be trained on proper methods for disinfection of surfaces.
    a. Soiled or used disposable items are properly discarded and replaced.
    b. Medical waste is properly discarded.
    c. Hard surfaces are disinfected or decontaminated following the wet and dry times per the manufacturer's directions for disinfecting.
    d. Dirty instruments are properly handled, stored, and cleaned.
    e. Any spills are properly handled and the effected surfaces cleaned and disinfected.

8. **Contaminated Clothing or Fabric Items:** If an employee's clothing or any other fabric item is contaminated, the items shall be placed in a red bag for disposal or until such time that complete decontamination can be properly performed.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS
Please refer to these other related policies or attachments for more specific information or procedures.

POLICY #	Policy or Document Name	Location
	Blood Borne Pathogen Policy	
	Housekeeping Policy	

NIHD
RURAL HEALTH CLINIC

Disinfection and Sterilization Policy		
J Tag References: **J-0040** **§ References: 491.6** **Other References:**	**Policy Type: Physical Plant and Environment**	***Policy Number: 238.0***
Effective and Revision Date(s): 1/31/2022		

Policy Declaration: This is the clinic's disinfection and Sterilization Policy. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purposes of this policy are to clearly outline the procedures which shall be taken to disinfect and sterilize equipment, supplies, instruments, and surfaces.

Policy Statement: The clinic has a high regard for the health and safety of its patients and employees in regard to the spread of infectious disease.

Policy Scope: This policy is informational, procedural and regulatory in nature.

Policy Body: Disinfection and Sterilization

1. **Sterile Instruments and Supplies**: The Clinic does not perform sterilization of medical instruments or reusable medical devices or supplies on-site.
    a. **Disposable, Single Use Items**
        i. All sterile supplies, trays and kits shall be purchased in a prepackaged and disposable form from a reputable medical supply company.
        ii. The integrity of the item (package condition, expiration date and appearance) shall be verified prior to use.
        iii. Sterile single use items shall not be reused.
        iv. After single use, disposable supplies or trays shall be disposed of in the appropriate manner.

    b. **Receiving and Using Instruments that are processed off-site**
        i. Should supplies or instruments be sent to an outside source for sterile processing, the items shall be packaged appropriately in sealed pouches using appropriate methods of disinfection and sterilization.
        ii. The integrity of the items is validated:
            1. at the time there are received back into the clinic, and
            2. prior to patient care use
        iii. Should a problem with the item be detected (pouch condition, expiration, chemical marker, position of instrument), the item will not be used for patient care. It shall be returned to the off-site processing department for reprocessing.
    c. Dirty instruments shall be handled and transported to the designated dirty area in a manner which prevents contamination of other areas.

2. **Handling and Pretreating of Instruments After Use**: When dirty instruments are to be returned to the off-site location for sterile processing the following procedures should be followed.
    a. Dirty items shall be transported to a designated dirty area within the clinic. Care shall be taken to prevent contamination during transport.
    b. Appropriate PPE shall be used by staff during the handling of instruments and when using or mixing solutions.
    c. If the instruments are to be pre-treated or soaked prior to pick-up by the off-site processing department, follow the instructions for mixing the cleaning solution making sure that the product is used according to manufacturer's directions.
    d. Hinged instruments should be soaked in the open position when possible.
    e. Follow the manufacturer's directions on how long to soak or rinse the instruments.
    f. Follow the off-site sterile processing department's specific procedures for pretreating the instruments.

3. **Transporting of Instruments to the Sterile Processing Location**
    a. Pretreated or dirty instruments should be transported in an appropriate container with a securely fitting lid.
    b. The container should be clearly marked as a containing biohazardous material.

4. **Disinfection of Surfaces and Non-Submersible Equipment**: The following procedures shall be used to disinfect surfaces and non-submersible equipment.
    a. A hospital-grade sanitizer/disinfectant/viricide will be diluted per the manufacturer's recommendation, placed in clearly labeled spray bottles or containers and stored appropriately. Wipes which contain a hospital-grade sanitizer/disinfectant/viricide may be used when appropriate for the surface being cleaned.
    b. Other surfaces, equipment, furniture and fixtures shall be cleaned periodically, and as needed, in accordance with all manufacturers' directions for optimal cleaning.
    c. Upholstered furnishings (exam tables, side chairs, exam stools, etc.) shall not have rips or tears which could compromise disinfection.
    d. Toys shall only be present areas accessible to patients and visitors when the items can be adequately cleaned between patient use.

5. **Cleaning Solutions and Trays**: Any trays or containers which have been filled with disinfecting cleaning solution shall include information or dates which clearly state when the solutions should be replaced or refilled.

6. **Reusable DME and Supplies:** Any durable medical equipment (wheel chairs, walkers, crutches, etc.) or supplies which may be reused by multiple patients shall be labeled as either clean or dirty to alert staff of the condition of the item

7. **Third-Party Cleaning Services**: The section of this policy pertaining to the disinfection of surfaces shall be discussed with any third-party cleaning service to ensure the procedures are understood and followed.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures.

POLICY #	Policy or Document Name	Location
	Blood Borne Pathogen Policy	
	Infection Control Policy	
	Cleaning Service Agreement	
	Cleaning Schedule	
	Recipe for mixing solutions	

NIHD
RURAL HEALTH CLINIC

Accidental Needle Sticks		
J Tag References: **J-0161** **§ References: 491.6**	**Policy Type: Physical Plant and Environment**	**Policy Number: 240.0**
Effective and Revision Date(s): 1/31/2022		

Policy Declaration: This is the Accidental Needle Sticks Policy of the Clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purposes of this policy are to clearly outline the immediate steps that should be taken if an employee is exposed to an accidental needle stick.

Policy Statement: The Clinic has a high regard for the health and safety of its employees and, in particularly, in those incidents when those occupational hazards might also create a situation in which employee or other individual may be at risk to the exposure of blood-borne pathogens through accidental needle stick.

Policy Scope: This policy is informational and procedural in nature.

Policy Body: **Accidental Needle Sticks**

1. **Prevention of Accidental Needle Sticks**: The incidence of Accidental needle sticks can be prevented and/or greatly reduced by several simple procedures, which include:
    a. Proper sharps disposal;
    b. Never recapping needles;
    c. The provision and use of PPE (personal protection equipment);
    d. Staff education on the risks of transmission;
    e. Staff education on the techniques and methods.

2. **Immediate First Aid Procedures:** In the event of an accidental needle stick, the following actions should be taken immediately by the employee. If the employee needs help in performing these tasks, he or she shall ask a supervisor or co-worker to assist. PPE should be worn and all efforts to minimize additional exposure or contamination should be exercised. The immediate steps are:

    a. Wash needle sticks and cuts with soap and water;
    b. Flush splashes to the nose, mouth, or skin with water;
    c. Irrigate eyes with clean water, saline, or sterile irrigates;
    d. Report the incident to your supervisor or provider on duty;
    e. Immediately seek medical treatment;

f. If you have questions about appropriate medical treatment for occupational exposures, 24-hour assistance is available from the Clinicians' Post Exposure Prophylaxis Hotline (PEPline) at **1-888-448-4911**.

3. **Diagnostic Testing and Prophylaxis Treatment Guidelines:** The Clinic follows all recommendations of the CDC for the management of accidental exposure to blood-borne pathogens. The following publications, or a similar publication, will be used if needed for as written references:

   a. ***Updated U.S. Public Health Service Guidelines for the Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis, 9/25/2013 Update (May 23, 2018) which can be found at*** https://stacks.cdc.gov/view/cdc/20711 ***and;***

   b. ***Management of Occupational Exposures to HBV, HCV, and HIV and Recommendations for Postexposure Prophylaxis, MMWR Recommendations and Reports, Volume 50, Number RR-11 which can be found at*** http://www.cdc.gov/mmwr/PDF/rr/rr5011.pdf

4. ***Subsequent Testing and Treatment****: The* subsequent ordering of diagnostic testing shall be the direct responsibility of the clinic administrator, or in the absence of the clinic administrator, the direct responsibility of the supervising healthcare provider. The clinic may refer additional treatment of the exposed individual to a specialty healthcare provider.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS
Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Blood Borne Pathogen Policy	
	Infection Control Policy	

NIHD
RURAL HEALTH CLINIC

Medical Waste Handling and Disposal		
J Tag References: J-0040, J-0044 § References: 491.6.	**Policy Type:** Physical Plant and Environment	***Policy Number: 250.0***
Effective and Revision Date(s): 1/31/2022		

Policy Declaration: This is the Medical Waste Handling and Disposal Policy of the Clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to provide information about the disposal of bio-hazardous and medical waste.

Policy Statement: The Clinic is committed to the appropriate disposal of potentially infectious or bio-hazardous waste (Regulated Medical Waste) in accordance with federal, state and local laws.

Policy Scope: This policy is informational, procedural and regulatory in nature.

Policy Body: Medical Waste Handling and Disposal

1. **Trash Receptacles:** All trash receptacles in patient care areas shall be well kept and emptied regularly.

2. **Red Bags**: Regulated Medical Waste (soft waste) shall be discarded into containers with closable, puncture-proof, leak-resistant red bags.
   a. Receptacles for medical waste which are located in patient treatment areas shall be equipped with lids. The receptacles shall be red in color and/or marked as containing medical waste.
   b. Medical waste shall be removed from the patient care or treatment area as soon after the performance of a procedure as is practical and placed in the secondary storage area.
   c. Secondary containers for medical waste shall be located in areas with secure access away from patient care areas. The containers are marked as bio-hazardous waste.
   d. Medical waste shall not be stored in areas where clean medical supplies are stored.
   e. Red bags and other waste containers are provided through the service vendor under agreement.

3. **Sharps Containers**: Contaminated needles are discarded in closable, puncture-resistant, leak-resistant containers which are labeled as bio-hazardous. The containers are emptied or replaced when the manufacturer-placed indicator is reached. Containers shall be placed at an appropriate height and be out of reach of children. Containers

should be mounted and secured. Containers shall be dated if the state regulations require them to be discarded based on duration of use and not full status.

4. **PPE and Disposable Items:** Providers and clinical staff shall use PPE, as needed, to protect themselves from exposure to contaminated equipment and exposure to body fluids. Contaminated PPE (gloves, masks, gowns) and disposable laundry items (gowns, drapes, sheets) shall be discarded in red bags

5. **Disposal of Bio-Hazardous Waste**: The off-site disposal of Regulated Medical Waste is performed under a service agreement with a third-party which is compliant with federal, state and local laws pertaining to medical waste management. The agreement covers the disposal of sharps and red bag waste. The service provider makes routine, scheduled pick-ups of regulated medical waste and is available as needed for additional services. The Clinic's agreement for waste disposal is currently with MediWaste.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS
Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Agreement for Medical Waste Disposal	

Hazardous Materials		
J Tag References: J-0040, J-0044 § References: 491.6.	**Policy Type:** Physical Plant and Environment	***Policy Number: 260.0***
Effective and Revision Date(s): 1/31/2022		

Policy Declaration: This is the Hazardous Materials Policy of the Clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to provide information about the presence and use of hazardous and/or chemical materials in the workplace.

Policy Statement: The Clinic seeks: 1) to provide employees and third-parties with information about materials and chemicals which might be hazardous; 2) to define precautions for handling and using these substances; and 3) to outline procedures to be followed in the event of exposure to these substances. Furthermore, it is the intent to comply with federal, state, and local laws which regulate hazardous materials, as applicable.

Policy Scope: This policy is informational, procedural and regulatory in nature.

Policy Body: Hazardous Chemicals and Materials

1. **Definition:** According to the Department of Labor, Occupational Health and Safety Administration (OSHA), hazardous and toxic substances are defined as those chemicals present in the workplace which are capable of causing harm. The link to the OSHA web page can be found here: *https://www.osha.gov/SLTC/hazardoustoxicsubstances/*

2. **Identification of Hazardous Chemicals and Materials:** The clinic administrator or manager is responsible for identifying these substances in the workplace. A master list of materials is found in the SDS notebook. (See #3.)

3. **Safety Data Sheets**:
   a. The Clinic shall maintain Safety Data Sheets on all potentially hazardous and toxic materials including those used in or for:
      i. Procedures and Treatments as part of patient care
      ii. Cleaning and Disinfecting of skin
      iii. Cleaning and Disinfecting of the clinic surfaces
      iv. Cleaning and Disinfecting of equipment, instruments, and reusable supplies
      v. Cleaning and Disinfecting of air or water, if applicable
      vi. Operation of office and clinical equipment
   b. The SDS Sheets contain information about precautions, exposure risks, and first aid measures for each substance in the clinic.

c. The SDS sheets shall be organized in a notebook and assessable to all employees. The notebook includes a master list of materials. Alternatively, the sheet may be available electronically as long as all employees know how to locate and access the data sheets.
d. The employees have been in-serviced on the location and use of SDS sheets.

4. **Patient Care and Public Areas**: Care shall be taken to restrict the presence of hazardous chemicals and toxic materials in the patient care or common areas of the Clinic. Soaps, cleansers, or other products required for hand-washing or hygiene which may be located in these areas shall be in the original packaging and are clearly labeled.

5. **Storage and Handling of Chemical or Hazardous Materials**: The following procedures shall be followed in respect to toxic and chemical products.

   a. The products shall be stored in a secure area away from direct patient access.
   b. The products shall be stored in original packaging and clearly labeled.
   c. Employees shall be instructed on the appropriate use of products that are required for the performance of their job duties.
   d. Proper PPE (personal protection equipment) shall be used, when indicated, by individuals handling these products.
   e. New products shall be added to the master list and the SDS data shall be updated.

6. **Eye Wash Station**: The clinic maintains an eye wash station. Employees have been in-serviced on the location of the eye wash station. The SDS notebook is located within proximity of the station.

7. **Blood Spill Kit:** The Clinic shall have a blood spill kit on the premises.

8. **Accidental Exposure or Misuse**: In the event of exposure to a chemical or hazard material, an employee should:

   a. Remove patients and employees from the area a spill has occurred. Take precautions to further exposure.
   b. Notify the Clinic Administrator or provider on-site of the incident.
   c. Consult the SDS sheet for the first aid instructions related to the product or substance. A co-worker or supervisor should assist with this step if the employee is impaired due to the exposure.
   d. Seek further medical treatment if indicated.
   e. Consult or contact local, county/parish, or state agencies, if necessary.
   f. Document the incident in the clinic records.
   g. Conduct a post-exposure evaluation to determine how future incidents of like-kind could be prevented. Re-train employees or revise policies as needed.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	SDS Notebook	
	Employee Training Records	

NIHD
RURAL HEALTH CLINIC

Smoke-Free Workplace		
J Tag References: J-0040, J-0044 § References: 491.6, 491.9	**Policy Type:** Physical Plant and Environment	***Policy Number:*** *270.0*
Effective and Revision Date(s): 1/31/2022		

Policy Declaration: This is the Smoke-Free Workplace Policy of the Clinic. The Clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to reinforce the position of maintaining a smoke-free workplace.

Policy Statement: The Clinic acknowledges state and local laws, as applicable, which mandate that a healthcare facility be a smoke-free workplace. Furthermore, the Clinic seeks to reinforce the health benefits of not smoking or using tobacco products to its patients and employees.

Policy Scope: This policy is both informational and procedural in nature.

Policy Body: Tobacco Free/Smoke-Free Workplace

1. **Designation as Smoke-Free Workplace:** The clinic is a tobacco free/smoke-free workplace.
   a. Cigarette or cigar smoking, as well as pipe use, within the clinic building is prohibited.
   b. The use of e-cigarettes or vapors is also prohibited.
   c. This policy applies to employees, patients, and the general public.
   d. International NO SMOKING signs shall be posted.
   e. Tobacco use in clinic-owned vehicles or auxiliary buildings is also prohibited.

2. **Designated Smoking Areas**: The Clinic Administrator may choose to designate smoking areas outside of the clinic away from the main entrance. The designation of smoking areas is discretionary and subject to state and local ordinances. Smoking areas must be away from main entrances and handicapped access areas.

3. **Use of Other Tobacco Products:** The use of smokeless tobacco products is also prohibited on the Clinic premises.

4. **Smoking Cessation Counseling and Assistance**: The Clinic shall offer smoking cessation counseling and assistance to patients and employees who wish to stop smoking. The services may be billable, covered services under some health plans.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location

NIHD
RURAL HEALTH CLINIC

Fire Safety, Training and Evacuation		
J Tag References: **J-0040** **§ References: 491.6**	**Policy Type:** Physical Plant and Environment	***Policy Number: 280.0***
Effective and Revision Date(s): 1/31/2022		

Policy Declaration: This is the Fire Safety, Training and Evacuation Policy of the Clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to reduce to writing the policies and procedures related to fire safety, employee training, and evacuation.

Policy Statement: The Clinic assures the safety of its patients and employees by having policies and procedures in place for fire safety and fire emergencies.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: Fire Safety, Training, and Evacuation

1. **Fire Safety:** The Clinic follows measures in place to assure the safety of its patients and employees in a fire emergency.
   a. The Clinic shall be equipped with ABC rated fire extinguishers that are in working order and which are regularly inspected and tagged. Fire extinguishers shall be mounted in the building as either required by the total square footage of building or by local or state regulation.
   b. The Clinic shall be subject to any required initial and on-going inspections by the Office of the State Fire Marshal. Any deficiencies shall be corrected promptly.
   c. The Clinic shall maintain unblocked/unlocked access to all exterior doors.
   d. The Clinic must have at least two exterior doorways which are accessible to all persons.
   e. Designated fire exits shall not pass through a mechanical room or a kitchen with a heat source.
   f. The Clinic shall maintain a smoke-free environment.

2. **Employee Training**: Employees shall receive training on fire safety.
   a. Employees shall be trained in the proper use of a fire extinguisher using the acronym, PASS: Pull, Aim, Squeeze and Sweep.
   b. Employees shall be trained in rescue procedures using the acronym, RACE: Rescue, Alarm, Contain, Evacuate or Extinguish.
   c. The Clinic shall perform fire drills periodically.
   d. The Clinic shall maintain records of training which are updated at least annually.
   e. Floor Plans are posted in each hallway of the Clinic with evacuation routes marked.

3. **Evacuation**: The following procedures shall be in place if a fire emergency occurs. The staff shall follow the steps in the RACE acronym.
    i. Rescue or remove any patients from immediate danger.
    ii. Alarm emergency officials and occupants that a fire emergency is present.
        1. Notify others in the building.
        2. Call 911.
    iii. Obtain a headcount of all persons in the building prior to evacuation.
    iv. Contain the fire by closing doors or taking other precautions.
    v. Evacuate patients and other individuals using the closest evacuation route away from the fire location.
    vi. Attempt to extinguish the fire ONLY after all persons are removed from the building and IF it is safe to attempt.
    vii. Use the acronym PASS when using a fire extinguisher.
    viii. Gather occupants outside at a designated meeting safe spot and take a second headcount.
    ix. Follow all directions and instructions given by local law enforcement and fire department personnel concerning management of the evacuation including when to re-enter the building.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS
Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Clinic Evacuation Route Floor plan	
	Office of Fire Marshal inspection reports	
	Disaster Training Logs	
	Employee Training Records	

NIHD
RURAL HEALTH CLINIC

Severe Weather and External Disaster Policy		
J Tag References: **J-0040** **§ References: 491.6, 491.12**	**Policy Type:** Physical Plant and Environment	***Policy Number:*** *290.0*
Effective and Revision Date(s): 1/31/2022		

Policy Declaration: This is the Severe Weather and External Disaster Policy of the Clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Purpose: The purpose of this policy is to provide information about how to handle non-medical emergencies or conditions which threaten the safety of employees or patients as related to severe weather conditions.

Policy Statement: The Clinic is committed to protecting and safeguarding the wellbeing of our patients and staff during a weather-related emergency.

Policy Scope: This policy is informational and procedural in nature.

Policy Body: Severe Weather and External Disaster Emergencies

1. **Severe Weather Definition**: This policy applies to unexpected or severe weather conditions or natural disasters which pose a potential threat to the safety and health of individuals in our community and service area. These conditions may include:
   - Wild Fire
   - Earthquake
   - External Flood
   - Volcano Eruption
   - Landslide

2. **External Disaster Definition**: This policy applies to external disasters which pose a potential threat to the safety and health of individuals in our community and service area. External disasters may include the following types of situations:
   - Mass Casualty
   - Pandemic
   - Supply Shortage
   - IT Failure
   - Biological Terrorism

3. **Warnings and Announcements**: Clinic Management and Staff shall take advantage of emergency notification systems and warnings from:
    a. Local media
    b. Local law enforcement
    c. Text and phone alerts from a) the National Weather Service; b) County/Parish or City automatic notification systems; c) Office of Homeland Security and Emergency Preparedness (OHSEP); and d) local television and radio stations. Other alert source: .
    d. Information about how to respond to specific types of disasters which are common to our geographic location can also be found here: inyocounty.us/services/emergency-services

4. **Emergency Preparedness & Response**: The primary concern in any threatening situation is the protection of life and limb.
    a. Warnings, instructions, and emergency declarations given by local and state agencies, including the OHSEP and law enforcement, should be heeded by all clinic employees.
    b. The clinic shall participate in available emergency preparedness training and drills as required by 42 CFR 491.12.
    c. The clinic shall communicate and collaborate with OHSEP and local agencies to prepare for and respond appropriately to emergencies and disasters.
    d. The Clinic shall have an emergency call plan.
    e. The Clinic shall independently comply with 42 CFR 491.12 and Appendix Z for emergency preparedness.

5. **Scheduling and Closure in Advance of an Emergency**: In anticipation of severe weather, road closures, or utility outages, if possible:
    a. Cancel or reschedule appointments to prevent patients or employees from traveling into and out of potentially hazardous conditions.
    b. Post closure signs with emergency instructions for obtaining care.
    c. Secure the clinic building and take precautions to protect and safeguard equipment, medical records, refrigerated drugs and other valuables.
    d. Follow all directives given by local and state authorities concerning evacuation routes, sheltering in place orders, or other disaster-related instructions.

6. **Unexpected, Sudden Weather Emergencies**: In the event that severe weather strikes unexpectedly, the clinic staff should:
    a. Move patients, visitors and employees into interior rooms or hallways away from doors, windows, or glass and away from the potential danger of flying objects.
    b. If flooding is probable, move people to the highest point.
    c. Make a head count and verify that all individuals are accounted for.
    d. Assess the immediate needs of patients.
    e. Have alternate sources of lighting available- flashlights or flashlight apps on devises.
    f. Communicate the evacuation routes within the clinic based on your current location.
    g. Depending on the amount of forewarning or known weather hazards, be prepared to shelter in place for a short period of time.
    h. Provide first aid if injuries or illnesses occur.
    i. Notify emergency personnel of your conditions and location.

j. Follow any other specific directives (for example: to stay indoors, boil orders, road closures, and shelter locations) given by local, state and federal authorities.
k. Instruct patients and employees clearly based on the instructions or protocols.
l. Follow other detailed directives in the formal EPP for the type of threat.

7. **External Disasters**: In the event of an external, non-weather-related disaster:
   a. Follow instructions as given by the OHSEP or local and state authorities pertaining to evacuations, shelter in place orders, or specific instructions.
   b. Assess the immediate needs of patients and employees.
   c. Have alternative methods of communication in case landlines are disabled.
   d. Notify emergency personnel of your specific location and needs.
   e. Secure the building as needed to protect life and limb.
   f. Be available to provide first aid and medical services to others as directed by emergency and law enforcement authorities.
   g. Follow other detailed directives in the formal EPP for the type of threat.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Letter To/From Parish Emergency Preparedness Agency	
	Drug Storage Policy	
	Emergency and Disaster Preparedness Training Policy	
	Emergency Call Plan	
	Employee Training Records	
	Formal EPP Documents	

NIHD
RURAL HEALTH CLINIC

Communication During Internal or External Situations		
J Tag References: **J-0040** **§ References: 491.6; 491.12**	**Policy Type:** Physical Plant and Environment	***Policy Number:*** *291.0*
Effective and Revision Date(s): 1/31/2022		

Policy Declaration: This is the Communication During Internal or External Situations Policy of the clinic.
The clinic is identified as Northern Inyo Rural Health Clinic.
Policy Purpose: The purpose of this policy is to provide information about how to the Clinic shall communicate internally and externally during emergency situations.

Policy Statement: The Clinic committed to open and clear communication with external agencies, local & state officials, and our employees & staff in either the preparation for an emergency or during the execution of internal or external disaster policies. An emergency call plan shall be established to facilitate appropriate response and communication.

Policy Scope: This policy is informational and procedural in nature.

Policy Body: Communication During Internal or External Situations

1. **Types of Emergencies**: Emergencies may arise from different situation which may be internal or external. Examples of situations which pose a potential threat or require emergency response for the Clinic could include:
    a. Severe Weather: Thunderstorms, High Winds, Tornados, Flooding, Fire Danger
    b. Other External Disaster Effecting the community: Industrial Accidents, Explosions, Derailments, Chemical Spills/Hazmat Response; School Disasters; Disruption of Transportation; Disruption of Public Utilities; Epidemic Disease.
    c. Internal Disaster Within the Clinic: Medical Emergencies including injury or death of a patient or employee; Fire; Damage or Destruction to the Building; Loss of Utilities; Loss of Communication; Disruptive or Violent Patient/Citizen; Active Shooter.
    d. Other urgent situations, which are neither internal nor external emergencies, may require open and clear communication between the Clinic and either internal or external stakeholders.
    e. Refer to the clinic's Emergency Preparedness Plan for all identified risks.

2. **Emergency Call Plan:** The Clinic shall create and maintain an emergency call plan. This plan shall include the names and contact information of all internal & external stakeholders who should be contacted in the event of an emergency. The call plan shall be updated at least biennially or whenever there is a change in local or state

agencies and/or personnel. The location of the written call plan shall be disclosed to all employees and/or posted as appropriate.

3. **Initiation of Emergency Call Plan**: The Clinic Administrator or the provider on call shall determine when the Emergency Call Plan (call tree) shall be initiated in response to an emergency, disaster or anticipated threat. In the absence of the administrator or a provider, any employee may initiate the call plan under appropriate circumstances. Refer to the Orders of Succession in the EPP.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Emergency Call Plan	
	Emergency/Disaster Preparedness Plan	

NIHD
RURAL HEALTH CLINIC

Visitor Policy		
J Tag References: J-0041 **§ References: 491.6; 491.12**	**Policy Type:** Physical Plant and Environment	**Policy Number:** 295.0
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: This policy discusses the presence of visitors in the clinic.

Policy Statement: The clinic seeks to ensure the safety of its patients and employees by protecting and safeguarding the clinic from access by unauthorized or uninvited individuals. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Scope: This policy is procedural and regulatory in nature.

Policy Body: Visitor Policy

1. **Presence of Visitors:** From time to time, it is necessary for visitors to be present in the clinic for purposes other than the provision of medical services. Visitors should not be left unattended or unobserved in the clinic at any time. Visitors may include the following individuals:
    a. Caregivers, family members and individuals who accompany patients or provide transportation services;
    b. Individuals who represent companies that provide supplies, materials, samples or equipment for the clinic;
    c. Individuals who provide third-party services, such as equipment maintenance, cleaning, pest control, consulting, etc., to the clinic under arrangement or contract;
    d. Community representatives (Chamber of Commerce, Local Governmental representatives, etc.);
    e. Officials from local, state, and federal regulatory agencies including administrative representatives, inspectors, surveyors, or auditors;
    f. Law enforcement officers and other emergency personnel;
    g. Other individuals with an occasion to visit the clinic other than to receive medical care.

2. **Visitors Accompanying Patients**:
    a. The clinic administrator, the provider on-site or other key personnel have the discretion to limit the number of family members or other individuals who are allowed to accompany the patient into the exam room or other treatment areas of the clinic.

b. The clinic administrator, the provider on-site or other key personnel have the discretion to limit the number of people in the waiting room to patients and an appropriate number of non-patient family members or friends in order to accommodate patients.

3. **Disruptive Visitors:** If a visitor becomes disruptive, engages in behavior that is offensive, hostile, or potentially harmful to others, the visitor will be asked to leave.
   - **a.** Clinic staff should call 911 or appropriate security personnel if they need assistance in removing a disruptive visitor from the premises.
   - **b.** Clinic employees should have a designated code word or other signal to alert clinic staff of a potentially dangerous situation. Employee training should include policies and procedures for dealing with disruptive or potentially dangerous individuals. Refer to the Emergency Preparedness Plan.

4. **Business-Related Visitors:** Before an individual is permitted into the back of the house, the front desk employee should confirm the identity of the person, the company which the person represents, and the reason for the visit. This verification can be made by:
   - **a.** The employee's personal knowledge of the person's identity and company affiliation based on the visitor's prior visits to the clinic or based on knowledge of the person in the community.
   - **b.** Business-related visitors can further be identified by name tags, name badges, business uniforms which include names or logos, or by presentation of a business card.
   - **c.** The visitor should remain at the front desk or waiting room area until it is an appropriate time for them to enter other parts of the building or meet the appropriate person responsible for the visit reason.
   - **d.** When required, a Business Associate Agreement shall be executed prior to the individual entering areas where protected health information can be accessed.

5. **Visitor Log:** It is at the discretion of clinic administrator to initiate the use of visitor log if visitor traffic in and out of the clinic becomes a security concern. In this case, a visitor log will be maintained at the front desk.

6. **Law Enforcement, Governmental and Agency Visitors:** These visitors should likewise be identified by name tag, name badge, uniform, business card, or through personal knowledge by the staff in the event of local officials or repeat visitors. Other considerations include:
   - **a.** Clinic personnel should abide by any emergency instructions or directives given by officials from local, state, or federal law enforcement agencies when these officials enter the building in an emergency or disaster situation.
   - **b.** Other governmental and agency officials should wait to be escorted to the back by the party who is responsible for coordinating the visit.
   - **c.** The clinic administrator or provider on duty has the discretion to mandate restrictions or ask for additional requirements when law enforcement officers accompany prisoners who are being seen as patients.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Employee Training Materials	
	Emergency Preparedness Plan	

NIHD
RURAL HEALTH CLINIC

Animals and Pet Policy		
J Tag References: J-0011, J-0044 **§ References: 491.6; 491.4; 491.12**	**Policy Type:** Physical Plant and Environment	**Policy Number:** 296.0
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: This policy discusses the presence of pets and animals in the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Statement: The clinic seeks to ensure the safety of its patients and employees by protecting and safeguarding the clinic from hazards created by animals being in the clinic. Patients and employees are prohibited from bringing animals inside the clinic during operating hours or after hours. The exceptions to this policy are provisions which involve service animals.

Policy Scope: This policy is procedural and informational in nature.

Policy Body: Pet Policy

1. **Presence of Pets:** Pets are NOT allowed in the Clinic because they potentially pose the following hazards or risks. Neither Patients nor Employees shall bring animals into the clinic unless the animals are trained service animals. The risks include:
    - Allergies to fur or dander;
    - Accidental animal bites or scratches;
    - Fear and Discomfort of other patients;
    - Parasite infestation;
    - Urine or Feces Contamination;
    - Exposure to other infectious diseases or agents.

2. **Exception for Specifically Trained Service Animals**: The clinic respects and promotes the use of service animals generally but not limited to dogs who have been trained to mitigate disabilities and conditions. We will accommodate service animals for our patients with disabilities and other illnesses for which the service animals have been specifically trained. Animals who provide only emotional support, companionship or comfort for the owner but are not specifically trained as service animals are not defined as service animals. These animals shall not be allowed under this provision unless support animals are afforded the same rights as service animals under specific state law.
    a. ADA/Civil Rights Requirements for Healthcare Facilities: The clinic shall abide by all guidance as prescribed by HHS and the US Department of Justice concerning ADA and Civil Rights requirements for non-discrimination of individuals requiring service animals including, but not limited to, these provisions:
        i. Healthcare facilities must recognize the use of service animals.

ii. Healthcare facilities can restrict the presence of the service animal if:
    1. The presence of the animal compromises infection control such as in operating rooms;
    2. The animal is uncontrollable and/or not housebroken;
    3. The environment is not safe for the service animal; or
    4. If the owner's condition precludes him/her from being able to control the service animal.
iii. The presence of service animals shall be allowed during the execution of emergency or disaster efforts unless conditions in section 2A(ii) prevail.
iv. Allergies or fear of animals shall not be considered substantial enough concerns alone to limit service animals in the healthcare environment.

b. Validation of Service Animal Training: When it is not obvious to the Clinic administrator or staff that an animal is actually performing a work or service task, the clinic may ask the patient-owner only two questions:
    (1) Is the dog a service animal required because of a disability, and
    (2) What work or task the dog has been trained to perform.

    The Clinic is prohibited from requiring the patient-owner to discuss his or her disability in detail or give the details of the animal's training.

3. **Exception for Therapy Animals Used in the Facility:** Should the facility engage in an organized, recognized pet therapy program as part of a treatment plan for its patients or for a subpopulation of clinic's patients, these animals shall be permitted in the clinic for the designated times for therapy programs. The trainer or therapist must accompany the animals at all times. The clinic administrator shall have the right to initiate or terminate pet therapy at his/her discretion.

4. **Companion Animals**: The Clinic shall **not** permit the presence of companion or emotional support animals unless specific state law affords companion animals the same rights as service animals. If state law requires that companion animals be treated on par with service animals, the provisions above shall apply.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS
Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	ASPR Service Animals in Healthcare Facilities	
	Department of Justice Service Animal FAQ	

NIHD
RURAL HEALTH CLINIC

RHC Provision of Services		
J Tag References: **J-0122, J-0123, J-0124, J-0125, J-0135, J-0140** **§ References: 491.9**	**Policy Type:** Administrative and Patient Care	***Policy Number:*** *300.00*
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purpose of this policy is to acknowledge the requirements for Conditions of Coverage: Provision of Services sections of the SOM, Appendix G for Rural Health Clinics.

Policy Statement: The Clinic provides patient care services within the nature and scope of both the federal and state regulatory guidance for Rural Health Clinics. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: RHC Provision of Services

1. **Primary Care Services:** The clinic provides primary care services which:
    a. Are provided at least 51% of the time that the clinic is open;
    b. Are the majority of services that the clinic provides;
    c. Include treatment for chronic and acute medical problems which usually bring a patient to a physician's office;
    d. Are within the scope of practice as determined by each specific provider's federal and/or state license;
    e. Provided within at least the minimum state-required hours of operation, if applicable.

2. **Description of Services:** The services provided by the Clinic include diagnostic and therapeutic services for illnesses, diseases, conditions, signs & symptoms, and minor injuries for which a patient would normally seek care from a medical clinic. The scope of services provided relate directly to the patient's chief complaint and other health conditions or factors determined to be significant to the patient's overall care plan and wellbeing. These services include, but are not limited to:
    a. Taking medical histories;
    b. Performing medical examinations;
    c. Assessments of health status;
    d. Performing or ordering of routine lab tests;
    e. Performing or ordering other diagnostic tests;
    f. Diagnosis and/or treatment of common acute medical conditions;
    g. Diagnosis and/or treatment of common chronic medical conditions;
    h. Participation in state immunization and EPSTD programs, if applicable;
    i. Counseling of patients concerning health status, family planning, and lifestyle;

j. Providing treatment for injuries within the scope and training of the providers;
k. Providing emergency care within the scope and training of the providers;
l. Coordinating care with other physicians, providers, and facilities.

3. **Direct Services**: The Clinic and its providers directly furnish services that are commonly furnished in a physician practice or at the entry point into the health care delivery system. These services include:
   a. Services of the like and kind described above under ***"Description of Services";***
   b. ***CLIA Waived, On-Site Laboratory Services*** which are essential to the immediate diagnosis and treatment of the patient, including:
      i. Chemical examinations of urine by stick or tablet method or both
      ii. Hemoglobin or hematocrit
      iii. Blood sugar
      iv. Examination of stool specimens for occult blood (FOB)
      v. Pregnancy tests
      vi. Primary culturing for transmittal to a certified laboratory
      vii. Other waived tests that have been approved by CMS.

4. **Indirect Services/Referrals**: The Clinic provides for indirect services and referred services when the services are not available in-house. These services may include:
   a. Ordering Send-out or Reference Lab Services;
   b. Ordering Ancillary Services not related to primary care or not furnished as a core RHC service;
   c. Referring of Patients to Specialists, other healthcare providers, and other facilities for services outside the scope and nature of the RHC core services;
   d. Other services by arrangement or agreement (either formal or informal) with other providers in the medical community within the service area.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Protocols for In-House Lab Testing	
	CLIA Certificate	
	Referral Policy/Referral List	
	Emergency Care and Treatment	

NIHD
RURAL HEALTH CLINIC

Medical Management Guidelines		
J Tag References: J-0100, J-0101, J-0124, J-0125 § References: 491.9	**Policy Type:** Patient Care	***Policy Number:*** *310.0*
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purpose of this policy is to document the medical management guidelines that are followed by the providers at the Clinic.

Policy Statement: The clinic utilizes medical management guidelines which provide the appropriate standard of care under best practices for the practice of family medicine. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: **Medical Management Guidelines**

1) **Clinical Guideline References: The providers at the Clinic shall rely on the following references for medical management guidelines:**
   up-to-date
   American Family Physician
   Epocrates
   USPStF
   Additional resources as recommended or agreed upon through collaboration with the physician or medical director.

2) **Medical Direction and Collaboration:** The providers at the Clinic shall rely on the medical direction of the physician/medical director who provides consultative and supervisory services. The collaborative physician of record or a staff physician on duty shall be consulted in cases where the Nurse Practitioners or Physician Assistants require guidance in addition to the established or previously agreed upon protocols in the medical management of acute and chronic conditions. Additionally, any medical management guidelines as prescribed or identified by federal or state scope of practice shall be followed.

3) **Specific Patient Care Policies**: Individual policies shall be established whenever the Clinic Administrator, in collaboration with the medical director and RHC providers, determines that a specific aspect of patient care would be better managed by a written directive to the professional staff. Best practices and the standard of care shall be followed.

4) **Specialty Referral:** The Clinic shall make referrals to specialists for appropriate treatment of patients whose conditions or diseases require further management

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	All Policies within the Patient Care Section.	
	Other Medical Management Policies, as applicable	
	Credentialing Files	

NIHD
RURAL HEALTH CLINIC

Protocols and Procedures Lab Testing		
J Tag References: J-0121, J-0123, J-0124, J-0125 § References: 491.9	**Policy Type:** Patient Care	**Policy Number:** 320.0
Effective and Revision Date(s): 7/29/2024		

Policy Purpose: The purpose of this policy is to establish the clinic's procedures and protocols for both in-house and sent-out laboratory services.

Policy Statement: The clinic is committed to having the standardization in clinical workflow and laboratory services as outlined in the policy.
The Clinic is identified as Northern Inyo Rural Health Clinic.

Policy Scope: This policy is informational and procedural in nature.

Policy Body: The following procedures and protocols shall be followed regarding laboratory services which are done either in-house or those which are sent out to another outside or reference lab for processing and resulting.

1. **Required RHC In-house tests:** 42 CFR 491.9, Conditions for Certification of Rural Health Clinics requires that the RHC to provide basic laboratory services essential to the immediate diagnosis and treatment of the patient. The clinic shall maintain all equipment and supplies needed to perform the point-of-care tests mandated in the CFR. The clinic may choose to perform additional tests within the scope of its CLIA certificate. The required tests per 42 CFR 491.9 include:

    a. Chemical examinations of urine by stick or tablet method or both (including urine ketones);

    b. Hemoglobin or hematocrit;

    c. Blood glucose;

    d. Examination of stool specimens for occult blood;

    e. Pregnancy tests; and

    f. Primary culturing for transmittal to a certified laboratory

2. **In-House Testing Protocols:** The clinic shall establish in-house lab protocols, as needed, when the clinic's medical staff determines that a specific set of signs and/or symptoms indicates the performance of a certain diagnostic lab test. The purpose of these testing protocols is to create efficiencies in clinical workflow and to expedite the diagnostic process for commonly occurring illnesses, diseases and conditions. The testing protocols may be preempted by either the provider or patient. The medical decision-making of the provider shall prevail when determining the appropriate diagnostic testing.

3. **Lab Controls and Logs:** The clinic shall maintain all lab testing equipment and supplies according to the manufacturer's guidelines for use. This includes running controls according to the manufacturer's recommended intervals. Control logs and other documentation shall be maintained to demonstrate compliance.

4. **Random Urine Drug Screens:** Urine drug screens may be used to monitor whether the patient is taking prescribed narcotics or other controlled substances as prescribed and directed by the prescribing provider. Further assessment of a suspected deviation of pain management or controlled substance management may also be determined through use of the state's prescription monitoring system. At his or her discretion, a provider may use additional means necessary to monitor the patient's use of controlled substances.

5. **Outside Laboratory Services:** The clinic shall also collect biological specimens consisting of blood, tissue, fluids, or other samples to outside labs to assist in the diagnostic process, obtaining a differential diagnosis or the staging of a disease process.

    a) **Collection and Handling Process**: When specimens are collected to be sent out, the appropriate methods of specimen collection and storage shall be observed as established for each type of specimen by the laboratory which is receiving the specimens.
    b) **Critical or Abnormal Lab Values**: When any laboratory test results in an abnormal (out of the normal range for that patient) or critical value, **the provider on duty shall review the lab results in a timely manner and document that the patient has been notified of said results**. **The documentation shall include the date and time that the patient was notified.** Results which are both within normal limits and are not considered abnormal for an individual patient's history shall be reported at the discretion of the provider who ordered the test and/or the results shall be published to the patient portal. All lab results shall be documented as reviewed by a member of the clinical staff.
    c) **Lab Draws for non-patients:** The clinic shall use its discretion when performing lab draw for patient who are not directly under their care or for whom the order originated from an external order. Should the clinic decide to perform such draws, the RHC shall have processes in place to notify the ordering provider of any abnormal or critical values if the findings have been resulted by the outside lab to the clinic instead of directly to the ordering provider. The providers and medical director may refuse to perform a lab draw for any non-patient if there is any uncertainty about the ordering provider or the patient's status.

6. **Information Blocking:** In compliance with Office of the National Coordinator for Health Information Technology's **Cures Act,** the clinic shall not prevent or delay a patient from obtaining electronic health information (EHI). This includes the publishing of lab results to the patient portal or providing results prior to a provider documented review of the findings.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Medical Management Policy	

NIHD
RURAL HEALTH CLINIC

Patient-Provided or 3rd Party Pharmaceuticals		
J Tag References: J-0043, J-0124, J-0125 § References: 491.6, 491.9	**Policy Type:** Patient Care	**Policy Number: 330.0**
Effective and Revision Date(s): 8/23/2024		

Policy Purpose: The purpose of this policy is to provide guidance for the storage, handling and administration of injectable drugs and pharmaceuticals which have been furnished to the clinic by a patient or a third party.

The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Statement: The clinic seeks to clearly define the processes and conditions under which these types of medications shall be stored, handled and administered.

Policy Scope: This policy is both informational and procedural in nature.

Policy Body: Patient-Provided Injectable Pharmaceuticals

1. **Reasons for these types of injectables:** From time to time it is necessary for a patient to bring an injectable drug into the clinic for the purpose of the clinic providers overseeing the administration of the substance. Sometimes these drugs are mailed directly to the clinic by a third-party. Examples of this type of arrangement include:
    a. Allergy shots/Immunotherapy provided by a specialist;
    b. Drugs considered as self-administered which have been obtained by a prescription;
    c. Drugs which have been legally dispensed by a licensed professional, but for which the patient needs assistance or oversight in administration.
    d. Drugs which are a pharmacy benefit under the patient's health plan.

2. **Medical Necessity**: The therapy will only be administered if the provider on-site determines that the treatment is medically necessary and consistent with existing treatment plans of the clinic or a referring physician.

3. **Storage of these substances:** These types of drugs should be stored by the clinic at the temperatures recommended on the labeling. General storage policies and procedures for storing drugs will apply to these substances. However, the clinic is not obligated to provide this service. If the storage of these drugs is provided, it is for convenience to the patients and with the continuity of treatment in mind.

4. **Packaging and Labeling:**

    a. The drugs must be in original packaging with legible labeling. The drugs must not appear to have been tampered with or altered.

b. These drugs will either be labeled with the patient's name, initials, or other patient identifier. The date that the drug entered the clinic's custody will also be either marked on the box or logged.

c. All other policies and procedures related to the storage, handling and administration of drugs and biologicals, including labeling and discarding, shall be applied to medications addressed in this policy as applicable.

5. **Expiration dates:** The expiration date of the drug, if applicable, will be checked prior to each administration. Expired drugs will not be administered. Expired drugs will be discarded by the clinic in accordance with federal and state laws,regulations, and guideline when authorized by the patient or returned back to the patient's custody marked "Expired-Do not use".

6. **Other restrictions and limitations:**

   a. If the origin of the drug cannot be verified, the drug will not be administered or stored.
   b. If a question exists concerning the storage method of the drug prior to the clinic taking custody of the drug, the drug will not be administered or stored;
   c. If the original packaging of the drug is torn, missing, or appears to have been altered, the drug will not be administered or stored.
   d. Only substances known to the healthcare provider as being commonly administered for a disease or condition for which the unique patient has been diagnosed will be stored or administered.
   e. The Clinic Administrator or on-site provider reserves the right to confirm the prescription status, dosage, and administration guidelines for any substance brought in by a patient.
   f. The Clinic Administrator or on-site provider reserves the right to refuse to administer a drug if the origin, medical necessity, or chain of custody of the substance is not verifiable.
   g. The patient is responsible for the acquiring and purchasing the injectables from the original source. Furthermore, the patient is responsible for the services related to the administration and for following the provider's instructions concerning wait times, reactions, or other warnings.

7. Other Patient Responsibilities: The patient shall agree to the terms and conditions described herein as it pertains to the administration of a self-provided drug. The patient shall respect and acknowledge any limitations or restrictions placed on the storage and administration of an outside drug. The patient will be responsible for the integrity of the source and chain of custody of the drug.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Storage and Handling of Drugs, Biologicals and Pharmaceuticals Policy	

NIHD
RURAL HEALTH CLINIC

Referral Policy		
J Tag References: J-0011, J-0140 § References: 491.9	**Policy Type:** Patient Care	***Policy Number: 340.0***
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purpose of this policy is to outline the policy of referring patients for indirect or outside services.

The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Statement: The clinic complies with the RHC requirement to be able to provide by arrangement or agreement, formally or informally, outside or indirect services for its patients.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: Referral Policy

1) **Specialty Care:** The clinic maintains professional relationships with a network of physician and specialty care providers for the purpose of referring patients who require consultation or the transfer of care due to a disease, condition or health status which requires services beyond the scope of a primary care clinic. These services may include specialists, ancillary services, and care required in other settings.

   - ***Scheduling of Appointments***: The Clinic staff, either a provider or a member of the nursing staff, shall make appointments for the patient at such time that the need for a specialty referral is identified.

   - ***Follow-up of Referrals***: A member of the nursing staff shall follow-up as necessary with the patient and the specialty provider concerning:

     i) The appointment status
     ii) Any test results or findings
     iii) Follow-up care requirement

   - ***Provider to Provider Communication***: As determined on a case to case basis, the providers shall communicate one-on-one with the specialty provider to ensure coordination and continuity of patient care.

2) **Hospital Admissions**: The clinic will arrange for any inpatient admission through the hospitalist program at the hospital of the patient's choosing. The Clinic maintains a professional, informal relationship with each facility within the service area. The Clinic will provide any necessary medical records and be available for provider-to-provider communication as needed for coordination and continuity of care related to admission and discharge of patients.

3) **Referral Tracking and Patient Follow-up**: The Clinic is able to track referral status within the features of the Practice Management and EHR information systems. The nursing staff is able to monitor referral requests, test results and follow-up actions either using tools within the software systems or through a manual process.

4) **Patient's Discretion**: The Clinic will facilitate in finding additional sources for indirect or outside services which meet the needs of the patient and which are compatible with the patient's personal preferences, the patient's insurance plan, or the patient's ability to access care. In these cases, additional referral sources other than those on the clinic's referral list will be used.

5) **Stark Law**: The Clinic shall not violate any provision of the Stark Law and/or other federal and state law during the course of referring patients for other healthcare services.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Referral List/ Referral Log	
	Letter or Agreement for Hospital admits, if applicable	
	Copy of Provider's hospital privileges, if applicable.	

NIHD
RURAL HEALTH CLINIC

Transitional Care and Continuity of Care Management		
J Tag References: **J-0011, J-0140** **§ References: 491.9**	**Policy Type:** Patient Care	**Policy Number: 341.0**
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purpose of this policy is to outline how the clinic shall participate in transitional care management and continuity of care management.

Policy Statement: The clinic shall be engaged in transitional care management and the continuity of care for its patients.

The clinic is identified asNorthern Inyo Rural Health Clinic.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: Continuity of care management and transitional care management are important aspects of managing the health and wellness of our patients.

1) **Transitional Care Management:** Our providers and licensed staff shall engage in transitional care management either when resuming care of our patients after inpatient or residential discharge or when facilitating in the transition of our patients to inpatient services, long term care services, skilled nursing services, or services in other care settings. The following professional and nursing tasks may be associated with transitional care management as pertinent to the specific case:

    - ***Review of Discharge Summary or Hospital Discharge Summary***
    - ***Review of other records, lab values or consultative reports***
    - ***Revision of any existing care or treatment plans based on the discharge data***
    - ***Medication Reconciliation***
    - ***Oversight or monitoring of outpatient services including, but not limited to, physical therapy, occupational therapy, speech therapy, home health services, or mental health counseling.***
    - ***Coordinating care with other healthcare providers***
    - ***Patient, Family or Caregiver counseling***
    - ***Referral to community and/or social services***

2) **Interdisciplinary Care Coordination:** Our providers and licensed staff shall engage in coordinating care & treatment interventions across all disciplines. This care coordination shall include:
    - ***Referrals for specialty, ancillary, and support services.***
    - ***Communication with other healthcare providers to assess progress, revise care plan or treatment options;***
    - ***Receiving care summaries via electronic exchange or hard copy report***
    - ***Communication with family members or care givers***
    - ***Additional referral to other providers or services***

3) **Advanced Care Planning**: Our providers shall participate in advanced care planning with our patients for whom end-of-life planning is determined to be an integral part of total care management. We are committed to the dignity of life and to providing information, guidance and support to our patients and their families/caregivers at this stage of life. Advanced care planning could include any of these services, as applicable to the patient's situation:
    - ***Preparation of Advanced Directives***
    - ***Admission to Palliative Care/Hospice***
    - ***Residential living alternatives***
    - ***Caregiver Respite***
    - ***Palliative treatment alternatives***
    - ***Patient and family counseling***
    - ***Referral to social or community resources***

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Referral List/ Referral Log	
	Community Resource Guide	

NIHD
RURAL HEALTH CLINIC

Missed Appointments		
J Tag References: J-0124, J-0125 § References: 491.9	**Policy Type:** Patient Care	***Policy Number: 342.0***
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purpose of this policy is to outline how the clinic will handle missed appointments and the rescheduling of appointments. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Statement: The clinic desires to promote continuity of care by encouraging patients to keep all scheduled appointments. Furthermore, the Clinic desires to treat all patients fairly when rescheduling appointments and to sustain provider-patient relationships.

Policy Scope: This policy is informational and procedural in nature.

Policy Body: Missed Appointments

1) **Appointment Reminders:** The clinic shall routinely notify patients in advance to remind them of upcoming, scheduled appointments. ***The patient's communication preferences shall be honored when reminding patients of appointments***. The following methods of communication may be used to notify patients:
   - Telephone Calls (Personal or Auto-dial)
   - Electronic reminders
   - Post cards or Letters

2) **Rescheduling Appointments:** The clinic shall encourage patients to reschedule appointments prior to missing a previously-scheduled appointment or within 72 Hours of a missed appointment. Should the patient not reschedule the appointment, the clinic staff shall try to reach the patient by phone to reschedule within a week of the missed appointment. Priority shall be given to reschedule patients who are in active treatment or who are due for scheduled preventative or screening services. The Clinic shall follow any guidance from health plans or managed care plans on how to notify the plan of missed appointments for EPSDT screenings or other required preventative services.

3) **Dismissing A Patient for Missed Appointments:** Patients may be dismissed if they habitually miss appointments. The conditions within **Policy 360: Discharging or Dismissing a Patient** shall be followed in this situation. No patient may be denied emergency care after dismissal.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS
Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
360	Dismissing A Patient	
340	Referral Policy	
	Sample Dismissing Patient Letter	

NIHD
RURAL HEALTH CLINIC

Emergency Care and Treatment		
J Tag References: **J-0136, J-0140** **§ References: 491.9**	**Policy Type:** Patient Care	**Policy Number: 350.0**
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purpose of this policy is to outline the policies and procedures related to medical emergencies.

Policy Statement: The clinic complies with the RHC requirement to be able to provide medical emergency procedures as a first response to common life-threatening injuries and acute illnesses. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: **Emergency Care and Treatment**

1) **Emergency Kit:** The clinic shall have on hand an emergency kit that includes drugs and biological commonly used in life saving procedures, such as:
   - Toradol
   - Xylocaine
   - Zithromax
   - Ceftriaxone
   - TDap

Antidotes and emetics, serums and toxoids*: Patients presenting to the clinic due to poisoning, either by ingestion or by venomous bite will not be administered antidotes, emetics, serums or toxoids due to: 1) the controversial practice of administering emetics; 2) to the short shelf life and cost of maintaining an inventory of serums and toxoids; and due to the limited availability of certain drugs and biological. (See Below for Poisoning)

a) The providers and medical director shall approve a list of the drugs which are appropriate to treat emergency illnesses and injuries for which patients might commonly present base on the geographic location of the clinic. This approved list shall be documented. Providers may choose not to stock ipecac. See Poisoning below.

b) Other drugs, such as those required in order to provide ACLS or if additional emergency treatments are required by any specific state requirement shall be available.

c) Other medical supplies and equipment that has been determined necessary for providing emergency care within the scope and training of the providers.

d) The emergency kit is securely stored with a list of contents visible on the exterior of the cart or box.

e) Oxygen should be securely stored on a rack or chained. Cannula, mask and tubing shall be attached to the tank for immediate use.

2) **Poisoning**: If the clinic becomes aware of an incident of patient poisoning, the staff and providers shall respond in this manner:
   a) If a patient notifies the clinic by phone of the incident:
      (1) The staff shall direct the patient to call the Poison Control Hotline at **1-800-222-1222** if the patient is not in a life-threatening situation.
      (2) The staff shall direct the patient to call **911** or to go to the Emergency Department at the closest hospital in the event of an emergency, life-threatening situation.

   b) If the patient presents to the clinic after a poisoning incident:
      (1) The staff shall attend to the patient and provide emergency medical care within the scope of training of the clinical staff and providers;
      (2) The staff shall call the Poison Control Hotline at **1-800-222-1222**;
      (3) The staff will call 911 or arrange for emergency transport via ambulance of the patient to the Emergency Department of the closest hospital.

3) **Life-Threatening Medical Emergencies**: The clinic shall provide the following medical care to patients with life-threatening emergencies.
   a) If a patient notifies the clinic by phone of a life-threatening emergency:
      (1) The staff shall direct the patient to immediately call **911**;
      (2) The staff shall direct patients to go to the Emergency Department of the closest hospital if the situation described is serious, but not immediately life-threatening.
      (3) The patient shall be directed to call **911**, if the seriousness of the situation cannot be ascertained by a layperson's description or judgment of the situation.
   b) If the patient presents to the clinic with a serious or life-threatening condition:
      (1) The staff shall call **911** or arrange for emergency transport of the patient to the Emergency Department at the closest hospital.
      (2) The staff shall attend to the patient and provide emergency medical care within the scope of training of the clinical staff until the patient can be transported.

4) **Emergency Training of Staff and Providers**: The clinic shall train staff and providers on medical emergency procedures periodically.

   (1) CPR/BCLS: The staff and providers shall maintain certification in basic life-saving procedures consistent with job function and responsibility.
   (2) ACLS/PALS: Providers shall maintain certification in advanced life-saving procedures consistent with any applicable federal or state regulations.
   (3) The staff shall be trained on the procedures outlined in this policy.
   (4) Clinical staff shall know the location of the Emergency Kit. The drugs within the emergency kit shall be inventoried and checked for expiration dates in a manner consistent with any other drug handling and storage policies.

5) **Transfer Agreements**: The clinic shall maintain transfer agreements with local emergency medical services/ambulance services and the nearest local hospital with an emergency department to ensure that patients may be transported by qualified services and received at an emergency department.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	CPR and ACLS Certificates	
	Transfer Agreements	
	Approved List of Emergency Drugs/Supplies	

NIHD
RURAL HEALTH CLINIC

Discharging/Dismissing a Patient		
J Tag References: J-0010, J-0124, J-0136 § References: 491.4, 491.8, 491.9	**Policy Type:** Patient Care	**Policy Number:** 360.0
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purposes of this policy are to define the situations which might result in a patient being discharged or dismissed or terminated from primary care provided by the clinic and to outline the procedures for dismissing a patient from the clinic.

Policy Statement: The clinic seeks to clearly define the process of patient discharge in order to maintain clarity and consistency during the termination of the provider-patient relationship. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Scope: This policy is both informational and procedural in nature.

Policy Body: **Discharging/Dismissing a Patient**

1. **Reasons for Patient Discharge/Dismissal:** A patient may be discharged or dismissed for one or more of the following reasons.
    a. **Non-Compliance with Treatment Plans**--the patient or guardian fails to follow established treatment plans even though the importance or benefit of the treatment is understood by the patient or guardian.
    b. **Disruptive, Hostile or Abusive Behavior**--the patient or guardian displays disruptive, hostile or abusive behavior(s) toward the providers, staff or employees of the clinic while on clinic premises or during conversations in person or on the telephone with providers or employees. These behaviors may include, but are not limited to, abusive language, profanity, outbursts of anger, threatening to harm or do ill toward the staff, inappropriate gestures, and inappropriate comments containing sexual, racial, or otherwise discriminatory inferences.
    c. **Failure to Keep Appointments**--the patient habitually fails to keep scheduled appointments.
    d. **Failure to Maintain Financial Responsibility**--the patient fails to pay deductibles, co-insurance, and other amounts determined to be the patient or guarantor's personal financial responsibility. All patients are provided with the clinic's financial policy upon initial patient registration at the clinic.
    e. **Other Reasons--**the Clinic Administrator, in collaboration with the providers may determine that in certain other circumstances it is in the mutual best interest of all parties to terminate the provider-patient relationship.

2. **Exclusions from Discharge:** The provider-patient relationship **cannot** be terminated under the following conditions or circumstances:
    - **a.** Reasons resulting out of any discrimination toward the patient (for example: race, gender, religion, national origin, or sexual orientation);
    - **b.** Reasons which would otherwise perpetrate a violation of the patient's civil rights;
    - **c.** A discharge which would violate the terms of an applicable managed care contract without due process;
    - **d.** A patient who is actively receiving on-going care or treatment for a condition which requires continuity in care may not be discharged until the patient's care has been transferred to another provider. A condition requiring on-going care is either deemed to be unstable in nature or such that it requires uninterrupted, direct provider involvement. Chronic, stable conditions would not normally be included in this classification.

3. **Notice of Termination:** The patient will be given written notice of the practice's intention to terminate the provider-patient relationship (e.g. *Patient Termination Letter*). The letter shall contain the following information:
    a. The reason(s) for which care is being withdrawn;
    b. The effective date of the termination (no longer than 30 days);
    c. Instructions for obtaining care from another provider;
    d. Instructions for the transfer of medical records to another provider;
    e. The circumstances in which emergency care will be provided to the patient;
    f. The limitations of care during the 30-day transition period.

    A copy of the termination letter will be retained as part of the clinic's records.

4. **Transfer of Records:** Upon the final discharge or dismissal of a patient, the clinic provided copies of the patient's record to the new provider upon receipt of an authorized request from the new provider or as needed for continuity of care/treatment.

5. **Emergency Care:** The clinic shall ***not*** withhold emergency medical care from any patient previously discharged from the practice. Emergency medical care is defined as medical treatment required to stabilize the patient in the event of a life-threatening acute illness or injury as a first responder.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Patient Termination Letter	Forms/Appendix
	Emergency Care Policy	Patient Care
	Civil Rights Policy	Administrative Section

NIHD
RURAL HEALTH CLINIC

After Hours Care		
J Tag References: J-0010, J-0011,J-0012 § References: 491.4	**Policy Type:** Patient Care	**Policy Number: 370.0**
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purpose of this policy is to disclose the arrangement for after hour care for patients.

Policy Statement: The clinic to provide information about access to professional medical care at all times. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: The clinic shall follow one or more of these processes in ensuring that patients are provided medical care at all time that the rural health clinic is not open or operating to provide patient care.

1. **Answering Machine/Voice Message**: An answering machine or voice message shall provide patients with the following information when the clinic's main phone number is called outside of normal clinic hours. The caller shall be instructed to

    a. Hang up and Call 911 if this is a medical emergency.
    b. Call during normal operating hours for non-emergency or non- urgent situations; or
    c. Leave a message for the provider on-call. If the managed care plans do not require that a provider be on call or that a call must be returned within a stated number of minutes, the clinic shall use its discretion in how on-call services are provided.

2. **Managed Care Plan Requirements**: The clinic shall comply with any managed care plan requirements or state requirements for after-hours patient care. Depending on the specific requirement or contract terms, the clinic may respond to after-hours calls with any of these actions, as allowed by the plan:

    a. Have the clinic phone forwarded to an answering service that would contact the provider on call;
    b. Have the clinic phone forwarded to a delegated back-up provider or to the parent hospital's emergency department.
    c. Have the voice message instruct the caller on how to reach their plan's nurse line;
    d. Use a service to transcribe voice messages to text that is forwarded either to the provider on-call or other designated staff to screen calls;
    e. Have the clinic phone forwarded to a dedicated after-hours cell phone that is assigned to either the provider on-call or another designated staff to screen calls.

3. **Follow-up on patients seen elsewhere after hours**: The clinic shall follow-up with the patient, patient's guardian or the outside provider when it comes to the clinic's attention that a patient has been seen in the emergency room or by another provider in an after-hours care situation. When determined relevant to the patient's on-going care and patient history, the clinic shall obtain copies of treatment records, reports and other clinical documents from the outside provider.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS
Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Managed Care Contracts	
	Call Schedule, if applicable	

NIHD
RURAL HEALTH CLINIC

Medical Records Policy		
J Tag References: J-0151, J-0152, J-0153 § References: 491.10	**Policy Type:** Patient Care	**Policy Number: 380.0**
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purpose of this policy is to outline the policy and procedures related to the creation, maintenance, storage and safeguarding of medical records.

Policy Statement: The clinic complies with federal and state regulations concerning medical records as well as the privacy and security of PHI. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: Medical Records Policy

1) **Custodian of Records:** The clinic shall have an individual designated as being responsible for maintaining the records and for ensuring that they are complete, accurate, and organized.

2) **Periodic Auditing of Records for Completeness:** The clinic staff shall periodically audit a random selection of charts to validate that all necessary documentation elements are present in the individual medical records per 42 CFR §491.10. The clinic administrator shall be made aware of the audit findings. The audit findings shall be presented to the appropriate individuals or committees at least quarterly.

3) **Medical Director/Physician Review**: Additionally, the medical director or a physician member of RHC medical staff shall conduct peer review of any nurse practitioner or physician assistant charts as required by state or federal guidelines. These reviews shall be documented and traceable. The chart review process shall be included in the annual RHC program evaluation.

4) **Individual Patient Records**: The Clinic shall maintain a medical record for each patient. The record shall contain the following components:
   a) Patient Demographic Information
   b) A clinic note for each encounter which shall include any or all of the pertinent data elements:
      1) Reason for the visit (Chief Complaint)
      2) Medical history which is pertinent to the visit and health status of the patient
      3) Personal, Social, & Family history which is pertinent to the visit/health status
      4) Assessments and Exam Findings
      5) Orders
      6) Problem List
      7) Medication List

8) Immunization record, if required
9) Lab test results
10) Other diagnostic test results
11) Consultative findings
12) Flow Sheets or Progress Notes
13) Treatment Plans
14) Follow up Plans
15) Patient Instructions
16) Other pertinent information required to monitor the patient's progress andhealth status.

c) The note for each encounter must be signed off by the provider either electronically or by another means of authentication. This finalization of the record shall be done ina timely manner.

3) **Protection of Medical Records:** The Clinic shall protect the privacy and security of the medical records and safeguard the records from loss, destruction or unauthorized use.
   a. The Clinic uses an Electronic Health Record information system. The clinic's practice management/EHR is Cerner.
   b. The system contains features which protect and safeguard the medical records:

      Unique user IDs and passwords for system access
      1. User Audit Trails
      2. Timestamps
      3. Authentication
      4. Security levels (permissions) which are set based on the individual user's job description
      5. Time out features to safeguard workstations
      6. Administrative features
   c. The information system vendor provides data back-up and disaster recovery for the medical records.
   d. If records are removed from the Clinic in any format, they will remain in the custody of an authorized employee or the custodian of the records.
   e. If any paper records are located within the clinic, those records are securely stored to prevent unauthorized access. Paper charts are also stored in a way to minimize damage or loss resulting from an internal or external disaster.

4) **Release of Information:** The Clinic shall require the patient's written consent for release of protected health information (PHI).
   a. The authorization form used to request PHI shall be a valid, HIPAA-compliant form which meets all state and federal requirements.
   b. The Clinic will not honor requests for release of PHI unless a signed and valid, HIPAA-compliant authorization is received.
   c. The Clinic may access charges for the reproduction and handling of medical records according to state statute.

5) **Business Associate Agreements**: The clinic shall execute Business Associate Agreements as appropriate with any outside vendors or contractors who would have access or use medical records and other sources of Protected Health Information (PHI) within the scope of their professional services.

6) **Retention of Records**: Medical records will be retained for at least 7 years from the date of last entry **or longer** if required by a state statute or any other regulatory agency. The Clinic recognizes the retention period is longer for minors and Medicare beneficiaries.

7) **Off-site storage of Records**: The clinic may choose to store inactive paper records which have been purged but are still within the legal retention period to be stored off-site. This off-site location shall be a secured location owned by the clinic or parent hospital or it may be another off-site location provided by a reputable records management company that guarantees HIPAA compliance for privacy and security. A Business Associate Agreement should be in place with any 3rd party vendor responsible for the transporting and storing of records which include PHI.

8) **Destruction of Records**: The clinic shall follow these guidelines when destroying medical records.
   a. One of these approved methods of destruction will be used:
      i. Paper record methods of destruction include burning, shredding, pulping, and pulverizing.
      ii. Microfilm or microfiche methods of destruction include recycling and pulverizing.
      iii. Laser discs used in write once-read many document-imaging applications are destroyed by pulverizing.
      iv. Computerized data are destroyed by magnetic degaussing.
      v. DVDs are destroyed by shredding or cutting.
      vi. Magnetic tapes are destroyed by demagnetizing.
   b. A written log shall be maintained to record the individual records destroyed, the dates of services included in the records, the destruction date, the method of destruction and signatures of the individuals who observed the destruction.
   c. The clinic may choose to contract with a vendor for the destruction of records. If doing so, the clinics must ensure that the 3rd party can provide indemnification and that a Business Associate Agreement has been executed. The vendor shall provide all necessary data to substantiate the proper destruction of records.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Authorization for Release of Medical Records	
	Chart Auditing Form	
	Quality and UR Policy	
	Medical Director UR Chart Review Form	

NIHD
RURAL HEALTH CLINIC

Medical Records Integration Policy		
J Tag References: J-0151, J-0121 **§ References: 491.10, 491.9, 413.65**	**Policy Type:** Patient Care	***Policy Number: 385.0***
Effective and Revision Date(s): 3/5/2024		

Policy Purpose: The purpose of this policy is to outline the policy and procedures used to create retrievable and/or integrated medical records between the provider-based RHC and Northern Inyo Healthcare District.
The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Statement: The clinic complies with federal regulations concerning the requirements for provider-based entities as stated in 42 CFR 413.65 (d)(2)(v).

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: Medical Records Integration

Any of the following processes and procedures may be used separately or in combination to ensure the medical records are either retrievable, integrated or cross-referenced between the parent organization and the provider-based rural health clinic when multiple information systems and/or electronic medical record platforms are maintained across the organization.

1. Cross-referencing of patient account information and medical record numbers when it is possible to use a custom-defined user field to cross reference these numbers.

2. Retrieval of records between the parent organization and the provider-based rural health clinic:

a. Access to the clinic systems by hospital-based providers, care management teams and other key hospital personnel to whom it has been determined have the level of access and need to know PHI as it relates to a rural health clinic patient being treated at another facility within the parent organization.
b. Access to the hospital systems by rural health clinic providers, care management teams and other key clinic personnel to whom it has been determined have the level of access and need to know PHI as it related to the hospital patient being treated at the rural health clinic.
c. The HIPAA "Need to know" requirement shall govern the access of any protected health information. Providers or designated employees shall only access the patient's medical record when the PHI is required for treatment, payment, or operations.

3. In cases where it is necessary to "break the glass", the parent organization's privacy and security policies shall be followed when in the provider's reasonable judgement, the PHI is required for emergency treatment and is not accessible any other way.

4. Integration of patient medical records: With the advancement of health information technology and the use of integrated systems across organizations, health information exchanges and care organizations, the provider-based rural health clinic medical records may be part of a broader integration of clinical documentation. In this case, all of the parent organization's policies for sharing and disclosing PHI shall be subject to those agreements and to any applicable state or federal regulations.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS
Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Authorization for Release of Medical Records	
	Clinic Medical Record Policy	

NIHD
RURAL HEALTH CLINIC

Health Information Technology/IT		
J Tag References: **J-0121, J-0121, J-0123, J-0124, J-0125** **§ References: 491.9**	**Policy Type:** Patient Care	**Policy Number:** 390.00
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purpose of this policy is to establish guidelines for the use of health information technology (HIT) and information technology (IT) and the safeguarding of the appropriate use of HIT and IT applications and access.

Policy Statement: The clinic is committed to using HIT for improved patient care, to comply with reporting requirements, and to optimize workflow.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: Health Information Technology and Information Technology

1. **System Maintenance**: The clinic shall maintain all hardware and software by performing routine maintenance, security checks and by installing updates in a timely manner.

2. **System Security:** The clinic shall ensure that all IT systems have adequate security features. The clinic is identified as Northern Inyo Rural Health Clinic.

3. **System Privacy** The clinic shall reduce the risk of breeches in privacy by training employees on HIPAA as it relates to specific job functions and by having guidelines in place for protecting PHI. Standard procedures shall be followed for accessing the electronic medical record and protecting the privacy of our patients through the safeguarding of data and information.

4. **HIPAA Security Risk Assessment**: The clinic shall conduct an annual HIPAA Security Risk Assessment. The assessment shall include all work processes and functions including electronic system-related functions as well as manual work flow processes.

5. **User Access:** The clinic shall ensure that users are trained on the systems needed for their specific job role or function. Users will be trained on privacy and security as it relates to the IT and HIT systems/applications. Appropriate privacy and security measures will be in place for all users. Users shall not share passwords, leave applications open when away from the work area, and must have screens set to "sleep" after 3 minutes. When an employee quits or is terminated, the employee's access to the systems shall cease immediately. This includes access to local systems, cloud-based applications, and third-party sites (payers, clearinghouses, banks, or vendors).

6. **Use of Personal Devices**: The clinic shall give directives on the use of personal devices in the workplace. PHI shall not be transmitted via personal devices (phone, text, or tablet) unless it is in adherence to clinic policies and is a patient communication preference.

7. **Personal Internet Use**: The clinic shall reserve the right to control personal internet use and to limit access to certain sites, pages or entertainment domains. Employees are prohibited from downloading applications or installing executable programs without permission from the Clinic Administrator or IT Manager.

8. **Additional Policies and Procedures**: The clinic shall implement additional policies and procedures as needed to adequately maintain and update all systems and to ensure that privacy & security measures are in place at all time.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	IT Services Agreements	
	HIPAA Training Records	
	HIPAA Security Risk Assessment	

NIHD
RURAL HEALTH CLINIC

General Employment Policies		
J Tag References: J-0013, J-0083 § References: 491.4	**Policy Type:** Employment	**Policy Number: 400.0**
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purposes of this policy are to clearly point employees and other interested third-parties toward the current employment policies of the clinic.

Policy Statement: The Clinic seeks to clearly define the processes by human resources are managed and administered.

The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Scope: This policy is procedural and informational in nature.

Policy Body: **Employment Policies**

1. The general employment practices and guidelines of the clinic are compiled in its Employee Handbook. The handbook is a resource for employees and contains information about employment at the clinic.

2. The clinic administration has the right to update or revise information in the handbook.

3. All employees shall be given a copy of the handbook and each will sign that they have received and read the material. Employees will be given a copy of the handbook at initial hire and subsequently whenever any significant changes are made to the document.

4. The following topics, at a minimum, are included in the current handbook:

    a. Employment Terms and Conditions
    b. Safety and Health Concerns
    c. Payroll Policies and Procedures
    d. Overtime Policies
    e. EOE Statement, Non-Discriminatory and Ethical & Legal Guideline Statements
    f. Employment and Payroll Forms (which may be given separately)
    g. Benefits and Calculation Method for PTO
    h. A list of paid Holidays
    i. Safe and non-hostile work environment (including harassment and violence)

5. Questions about employment practices and human resource management not found in the handbook shall be brought to the attention of the Clinic Administrator who will provide the necessary information and consider revisions or clarifications to the handbook.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Employee Handbook	Appendix

NIHD
RURAL HEALTH CLINIC

Credentialing and Employment Policy		
J Tag References: J-0011, J-0084, J-0085 **§ References: 491.4, 491.8** **Other References:**	**Policy Type: Human Resources and Employment**	**Policy Number: 410.0**
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: This policy describes the general steps that the clinic shall take when credentialing licensed professional employees and contracted professionals. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Statement: It is the intention of clinic to ensure that all professional clinical employees and staff are in good standing with federal and state licensing boards and in compliance with federal & state programs, as applicable. Pre-employment screening of all employees is also covered in this policy. Maintaining a quality workforce shall be a priority of the clinic.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: Credentialing Policy

1. **Professional Licenses**: All professional licenses of clinical staff will be verified for license status. All licenses must be current and in good standing with the board which oversees the discipline. These licenses could include one or more of these as is applicable to the individual's scope of practice:
    a. Medical License (physician, MD or DO)
    b. Nursing License (advanced practice, registered nurse, vocational)
    c. Physician Assistant License (often appended to the supervising physician's license)
    d. DEA (all applicable provider types)
    e. State Controlled Substance license (all applicable provider types)
    f. Other professional licenses or professional certifications per the scope of practice of services within the clinic.

2. **Professional Peer Reference**: Professional peer references will be contacted at the discretion of the clinic administrator. Another licensed professional in the clinic may participate in validating references.

3. **Education and Employment History**:
    a. Copies of diplomas and/or primary source verification of education shall be obtained for the purpose of credentialing professional clinical staff.
    b. Employment History shall be confirmed to establish that no unexplained gaps in work experience have occurred. A copy of a professional CV shall also serve this purpose.

4. **Certifications**: The clinic administration or other designated person shall verify current skill or competency certifications for specialty or provider type. A copy of the current certification shall be kept in the employee's file.

5. **Background Checks**: The Clinic Administrator or other designated staff shall conduct any required background checks, including those required by federal or state agencies.

6. **Pre-Employment Screening**: The Clinic Administrator or designated staff shall screen all employees to the extent necessary to establish:
    a. Education or Training
    b. Skill and competency level of job tasks
    c. Current licenses and certifications
    d. Prior Disciplinary Actions against professional licenses
    e. Employment history and references
    f. Background Checks (Criminal, Sex Offender and OIG Excluded Party Sanction)
    g. Drug Screens (pre-employment and random)

7. **HR Files**: The clinic administrator or designated staff shall keep an HR/Employment file on each employee which shall contain all the necessary information about the employee's job description, hiring process, qualification, education, health status and screenings.
    a. Personnel and Credentialing files shall be secured and safeguarded from unauthorized access at all times.
    b. Employee Health information shall be secured and safeguarded from unauthorized access at all times.
    c. Any negative findings shall be maintained in a separate Quality Assurance file for the purpose of peer review and performance improvement, if applicable.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Employment Files	
	Quality Files	

NIHD
RURAL HEALTH CLINIC

Periodic Performance Evaluation and Clinical Competency		
J Tag References: J-0011, J-0084, J-0085 **§ References: 491.4, 491.8** **Other References:**	**Policy Type: Human Resources and Employment**	**Policy Number: 415.0**
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: This policy describes the processes for the periodic performance evaluation of employees and the processes for evaluating clinical competencies that will be used by the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Statement: It is the intention for the clinic to conduct periodic performance evaluations to ensure: that employees are adequately performing the tasks within each respective job or role; that the job descriptions accurately reflect the present duties; and that clinical staff possesses the clinical competencies needed to perform nursing or direct patient care tasks.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: Performance Evaluation

1. **Performance Evaluation**: The Clinic provides on-going performance evaluation of all employees which shall include any or all of these aspects of evaluation:
    a. Evaluation of individual employees during any provisional or probationary period of employment;
    b. On-going performance evaluation of employees to promote performance improvement and to promote pro-active education and training as needed;
    c. 360° team-building activities including peer and self-assessment;
    d. Formal performance evaluation, at least annually.
2. **Clinical Competencies**: The Clinic provides periodic evaluation of all licensed and unlicensed staff who performs direct patient care or nursing tasks.
    a. New skills: Whenever a new skill is required, due either to a change in job function or to the provision of a new service, the staff shall be in-serviced on the required task. Training and competency shall be documented at the point of training.
    b. Existing skills: At least annually, a licensed medical professional who is at least one supervision level or licensure level above each respective employee shall perform a clinical competency check-off to ensure that the individual employee possesses the skills needed to provide the patient care services.
    c. Retraining and Refreshment of Skills: As needed, employees shall receive training to refresh clinical skills.
3. **Performance Improvement or Action Plans**: Whenever an employee performance evaluation activity or employee action warrants a performance improvement plan (PIP) or a performance action plan, the employee shall be made aware of the

performance expectations, the plan stipulations, the required timeframe, and the prescribed outcomes based on improved or unimproved performance. The Clinic Administrator, supervisor or a HR representative shall discuss the PIP with the employee, document any actions in the personnel file. Both the employee and supervisor shall sign the PIP. The Clinic shall follow all written human resource policies and federal or state labor laws when implementing a performance improvement plan.

4. **Documentation of Evaluations and Training**: The Clinic shall maintain adequate records of all performance evaluation activities, clinical competency evaluations, and employee training. The records shall be maintained for the period of time required by the state for business record retention.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Employment Files	
	Employee Training Records	

NIHD
RURAL HEALTH CLINIC

Program Evaluation Policy		
J Tag References: J-0100, J-0101, J-0102, J-0160, J-0161, J-0042 References: 491.9	**Policy Type:** Administrative/QA	**Policy Number: 500.0**
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purpose of this policy is to outline how the clinic will conduct the RHC Program Evaluation.

The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Statement: The clinic shall conduct a biennial (every two years) evaluation of all aspects of the RHC program according to federal regulations and to state regulations, if they apply. The review shall either be conducted by a qualified third-party or by the clinic administrator and/or providers. Interperiodic reviews of focused areas may also be conducted. The review findings shall be presented at an organized meeting once every twenty-four (24 months). Data shall be compiled for each of the two 12-month periods.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: Program Evaluation Policy

1) **Purpose of the Evaluation:** The purpose of the evaluation is to determine if:
   a) Utilization of Services were appropriate for an RHC;
   b) Established policies and procedures were followed; and,
   c) To evaluate the need to change or revise the program of the clinic.
   d) Financial, demographic and operational data may also be reviewed to determine areas for improvement and to access community needs.

2) **Utilization:** The Clinic shall review the utilization of clinic services including:
   (1) The number of patients served;
   (2) The volume of services provided; and,
   (3) Any other measure of utilization that contributes to the review findings.

3) **Medical Records**: The clinic shall review a representative sample of both active and closed clinical records for completeness, accuracy and the utilization of services. The review of these records can be performed throughout the review period; however, a summary of these findings along with any additional focused record reviews shall be presented as part of the program evaluation. Additionally, medical record reviews or audits neccessary to comply with requirements of the medical board, state nursing board or any other 3rd parties shall be conducted as required to maintain total compliance. Results of those additional findings may be reported on interperiodically as needed.

4) **Policies and Procedures:** The clinic shall conduct a review the written policies and procedures at least biennially. The providers of the clinic--medical director, physicians, nurse practitioners and physician assistants, and other qualified RHC providers--shall participate in the review process.

One outside professional not employed by the RHC shall also participate in the biennial review of the written policies and procedures. All Federal and state regulatory guidelines will be considered during the review. The review shall be used to determine if:

(1) Services have been provided in accordance with the existing body of policies;
(2) Policy additions, deletions, or revisions are necessary to properly reflect current practice and ensure regulatory compliance.

5) **Biomedical Equipment:** As part of the program evaluation, records pertaining to preventive and periodic maintenance of essential equipment shall be reviewed. All equipment placed in service shall be placed on the equipment log. Any repairs to equipment or any equipment taken out of service shall be noted. Any changes to the equipment inventory shall be included in the program evaluation report.

6) **Program Evaluation Meeting:** The Clinic shall present the biennial program evaluation findings during an organized meeting at least once every 24 months. The meeting shall be attended by the RHC providers and appropriate staff as well as representatives from the RHC's parent entity and other stakeholders whose involvement would contribute to performance improvement, operational efficiencies, organizational strategy, and regulatory compliance. Minutes of the program evaluation meeting shall be maintained.

7) **QAPI:** The Clinic shall report on any quality assurance initiatives or performance improvement projects at the biennial meeting, as applicable to the biennial review process and 42 CRF §491.

8) **Consideration and Corrective Actions**: The Clinic staff shall consider the biennial review findings and any recommendations that result from the biennial meeting. Corrective actions, if necessary, to improve the program performance and compliance, shall be taken. The staff will be in-serviced on any changes which result from the biennial evaluation.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Program Evaluation Report	
	Inter-periodic Minutes or Studies	

NIHD
RURAL HEALTH CLINIC

Quality Assurance and Utilization Review		
J Tag References: J-0151, J-0152, J-0161, J-0162 § References: §491.8, 491.10, 491.11	**Policy Type:** Patient Care	***Policy Number:*** *510.00*
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purpose of this policy is to outline the objectives of Quality Assurance (QA) initiatives and Utilization Review (UR) functions of the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Statement: The clinic is committed to compliance and quality patient care for which QA and UR activities are vital. The purpose of these activities is performance improvement and program integrity.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: Quality Assurance and Utilization Review

1) **Quality Assurance:** The clinic shall conduct QA initiatives, studies, or projects which are deemed helpful in measuring the quality assurance of different aspects of the clinic's operations. Such projects might include, but are not limited to these areas:

    a. Patient Satisfaction
    b. Employee Satisfaction
    c. Employee Performance
    d. Other Clinical and/or Operational Functions

2) **Utilization Review:** The Clinic shall conduct utilization review activities which may include:

    a. Medical record review by the physician or medical director to establish appropriateness of care as provided by the mid-level providers.
    b. Medical record review by the physician(s) in accordance with federal or state requirements as stated in regulations, collaborative practice agreements, or other official guidelines. If no other governing board dictates a specific quantity of records to be reviewed or the frequency of review, the clinic shall defer to the at least the minimum number established in the most recent version of the CMS, Appendix G, Interpretive Guidelines for Surveyors.
        i. The minimum number of charts per quarter that will be reviewed by a physician shall be .
        ii. Additional charts shall be reviewed as determined by the medical director.

c. Medical Record reviews by designated staff to determine the completeness of the medical records and the qualitative components of the records.
    i. The minimum number of charts per quarter that will be reviewed by designated personnel shall be
    ii. Additional charts shall be reviewed as determined by the medical director.
d. Medical record reviews by other qualified third-parties as determined helpful by the clinic administration or as established in any written compliance plan or corrective action plan, if applicable at any given time.

3) **Provider and Staff Involvement**: The clinic shall encourage the participation of professional staff and employees in designing and conducting QA and UR activities.

a. Quality initiatives shall be discussed at either routine staff meetings and/or during regular quality meetings as prescribed within the organization. Meeting minutes shall be kept for all meetings during which quality measures are discussed.
b. Employees and providers shall be made aware of all on-going or new performance improvement (PI) projects;
c. QA and UR activities shall be considered, evaluated or reviewed as part of the Annual Program Evaluation Process. The annual program evaluation findings shall serve as a source in the development of ongoing or future quality assurance/performance improvement (QAPI) initiatives.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Related Forms or Documentation, As Applicable	

NIHD
RURAL HEALTH CLINIC

Patient Satisfaction and Complaint Policy		
J Tag References: J-0010, J-1011, J-1062 § References: §491.4, 491.11	**Policy Type: QA and UR**	**Policy Number: 520.0**
Effective and Revision Date(s): 2/20/2023		

Policy Purpose: The purposes of this policy are to clearly define the processes which employees or patients shall take in order to file a complaint or grievance against the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Statement: It is the intention of the clinic to allow both employees and patients to freely express concerns, complaints and grievances in an effort to:

1. guarantee that individual civil rights are protected;
2. ensure that compliance with federal, state and local regulations and laws is maintained;
3. improve the quality of care and patient care experience;
4. improve the quality of the workplace; and
5. resolve failures or weaknesses within the existing policies and procedures.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: Grievance Policy

1. **Patient Complaints**: The following guidance shall be followed in receiving and resolving a patient complaint.

   a. The clinic has written processes and procedures which define the complaint process. Refer to Addendum 520-A1 or supplemental documents for the clinic's current complaint process.
   b. Patients may file a formal grievance by contacting the clinc by phone, by mail or electronic mail or in person.
   c. The employee receiving the complaint shall assist the complainant in completing the patient complaint form if necessary. The patient or patient representative may complete the form as is appropriate for the age and status of the patient.
   d. The form may be given to the individual to return to the clinic later.
   e. All patient complaints are confidential in nature. Clinic staff shall not discuss the patient complaint with others unless the communication is part of the formal investigative process or problem resolution process.

f. Negative comments or complaints which are collected through the patient satisfaction survey process shall be considered as formal complaints and shall be investigated for the purposes of resolution and performance improvement.
g. Clinic staff should not hinder or deter the individual from making a complaint.
h. Clinic staff shall not treat the patient or patient family differently because they have made a compliant or voiced dissatisfaction concerning their care.
i. All complaint forms shall be given to the clinic administrator or manager for the purposes of:

    1. Identifying any root cause;
    2. Clarifying Clinic policies and procedures with either employees and/or patients;
    3. Seeking resolution and restoring patient satisfaction;
    4. Taking any necessary corrective action; and
    5. Ensuring quality assurance and performance improvement.

j. The administrator or manager shall research or investigate the complaint.
k. The administrator or manager shall communicate with the patient for the purpose of further understanding the complaint and resolving the issue.
l. The administrator or manager shall communicate with staff and employees for purpose of further understanding the complaint and resolving the issue.
m. The administrator or manager shall document the investigation and resolution processes on the original Patient Complaint form.
n. Patients shall be given the contact information for the accreditation organization (AO) or state office for further reporting complaints which are not resolved through the internal process.

2. **Employee Complaints:** The following steps shall be taken concerning the resolution of an employee complaint or grievance.

    a. The employee should try to resolve any workplace conflict with co-workers or managers by discussing any problem as soon as possible.
    b. If informal conflict resolution is not successful or appropriate for the nature of the complaint, the employee may complete an Employee Complaint Form.
    c. The administrator or manager shall communicate directly with the employee concerning the grievance.
    d. The employee shall not be hindered or discouraged from voicing a complaint. No retaliatory actions shall result from an employee allegation of a grievance.
    e. The administrator or manager shall investigate the details of the complaint by interviewing other employees or individuals who may have knowledge of relevant facts.
    f. The administrator or manager shall seek to validate and resolve the employee complaint as quickly as possible.
    g. The administrator or manager shall document the investigation and resolution processes on the original Employee Complaint form.
    h. The administrator or manager shall take all necessary corrective actions related to any inappropriate personnel actions or behaviors discovered during the grievance resolution process.

3. **Quality Assurance/Performance Improvement:** All patient and employee complaints shall be taken seriously and considered an important part of the clinic's Quality Assurance and Performance Improvement (QAPI) activities.

    a. The original complaint forms shall be maintained as part of the clinic's regular record-keeping.
    b. The number of complaints and the nature of the complaints shall be included in the Clinic's annual review and QA evaluation or during inter-periodic reviews unless the nature of the complaint precludes disclosure due to federal or state law. The name of the complainant shall not be disclosed as part of the evaluation process.
    a. Grievances which suggest or substantiate non-compliance with local, state, or federal laws shall be reviewed by the organization's ownership and legal counsel as applicable to the situation.
    b. Performance Improvement activities shall be directed at correcting any trends or repeated issues that are brought to light through theses grievance processes.
    c. Revision of written policies, handbooks, or procedural guides, if applicable, shall be made in response to grievance findings.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS: ***Please refer to these other related policies or attachments for more specific information or procedures:***

POLICY #	Policy or Document Name	Location
	Nondiscriminatory Policy	
	Patient Complaint Form	
	Employee Complaint Form	
	Current Complaint Process	
	Posted Complaint Notice	
	Written Complaint Handout	

NIHD
RURAL HEALTH CLINIC

Risk Management Policy		
J Tag References: J-0041, J-0042, J-0010 § References: §491.6, 491.4	**Policy Type: QA and UR**	**Policy Number: 530.0**
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purposes of this policy are to clearly define the processes which employees or patients shall take in order to manage risk at the clinic. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Statement: It is the intention of the clinic to manage the risk of injury to patients, employees, and property. Other policies in the Physical Plant section of this manual may augment this policy by providing more detailed guidance on how the clinic maintains a safe environment as more specifically related to patient and employee safety issues. The clinic's culture of compliance and quality assurance is a vital part of our risk management plan.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: Risk Management

1. **Maintenance of Building & Grounds**: The Clinic shall maintain the building, grounds, and parking areas to prevent or minimize the risk of injury. This shall include:
    a. Removing, repairing, or replacing features which present a trip or fall hazard such as obstructions, uneven surfaces, or conditions which restrict access to entrances or exits;
    b. Maintaining appropriate signage for identification of hazards, directives, warnings, and other safety or environmental messages;
    c. Periodic inspection of the property and routine, scheduled maintenance;
    d. Safety meetings, as needed, with the employees and staff to help identify or mitigate potential areas of risk;
    e. Prompt repair of any hazardous condition.

2. **Injuries or Incidents**: If a patient, visitor or employee is injured while on clinic property, the administrator, manager or provider on-site shall:

    a. Immediately evaluate the need for first aid or emergency care and act appropriately;
    b. Complete an incident report to obtain details about the incident or injury and to record the occurrence;
    c. Obtain photographs, if applicable and authorized;

d. Report the incident to the ownership or management of the organization;
e. Assist in reporting the incident to the Clinic's insurance carriers;
f. Facilitate in any investigation, root cause analysis or corrective action required to manage or mitigate current or future risk.

3. **Insurance Coverage**: The Clinic shall secure and maintain adequate insurance coverage to include the following types of coverage, as appropriate or as required by state regulation, lenders, vendors, grantors, landlords, or any other third party or agency:

    a. Property and Casualty
    b. General Liability
    c. Automobile or Vehicle (comprehensive and/or liability)
    d. Worker's Compensation
    e. Malpractice Coverage
    f. Other professional errors and omissions coverage
    g. Any additional coverage needed for indemnification

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS
Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Other Policies in Section 200	
	Incident Report Form	

NIHD
RURAL HEALTH CLINIC

Financial Policies		
J Tag References: J-0011, J-0160, J-0161 § References: 491.4, 491.11	**Policy Type:** Administrative	***Policy Number:*** *600.00*
Effective and Revision Date(s): 1/31/2022		

Policy Purpose: The purpose of this policy is to establish the procedures for handling financial and patient accounting transactions of the Clinic.

Policy Statement: The clinic maintains policies and procedures for the financial operation of the RHC. These policies relate to patient account and business office functions. The clinic is identified as Northern Inyo Rural Health Clinic.

Policy Scope: This policy is informational, regulatory and procedural in nature.

Policy Body: Financial and Patient Accounting Policies

A. Patient Registration

1. **Verification of Insurance:** The clinic shall demonstrate a prudent effort in verifying patient insurance coverage prior to the provision of services. The clinic shall use one or more of these methods to verify coverage:

    a. Tools or services available within the PM system;
    b. Payer websites and tools;
    c. Telephone verification between payer and the clinic front desk staff.

2. **Patient Contact Information and Identity Verification:** The clinic shall demonstrate a prudent effort in verifying patient identity and current contact information at the initiation of service and periodically thereafter. The clinic shall use one or more of these methods to verify patient information and update patient demographics.

    a. Scan or copy the patient's driver's license or state-issued identification card making sure that the name and information matches the information on the insurance card;
    b. Collect the patient contact information from the patient registration forms;
    c. Verify patient identification using another photo id card or government document;
    d. Re-validate patient contact information periodically to ensure correct demographics are captured.

e. Investigate any suspicion or discrepancy which puts the patient's identity into question. The clinic is committed to the prevention of medical identity fraud.

3. **HIPAA, Consent to Treat, and Reassignment of Benefits:** The clinic is committed to informing its patients of rights and responsibilities associated with receiving care and treatment. Notices, acknowledgments, consents and agreements shall be provided and executed between the practice and the patient. All agreements shall These documents shall include, as applicable:

   a. Posted notices of Non-discrimination
   b. Availability of language translation services
   c. Posted ownership statement
   d. Acknowledgement of receipt privacy and security practices
   e. General Consent to Treat
   f. Acknowledgment of Financial Responsibility and financial policies
   g. Reassignment of Benefits to provider
   h. Informed procedural consent, as needed
   i. Authorization of Release of PHI
   j. Patient Grievance Process

B. Collection of Copays and Deductibles

1. **Deductibles:** The clinic shall make a prudent effort to collect deductible amounts according to the terms of the patient's insurance plan. The clinic shall not waive or write-off deductibles in violation of any managed care contract or as an incentive to reduce the patient's cost share of a service. The clinic as an RHC understands that the Part B deductible is due each calendar year for Medicare patients.

2. **Copayments:** The clinic shall make a prudent effort to collect patient copayments at the point of service to the extent that the patient liability is known and defined. Coinsurance amounts indicated on the patient's insurance card or verified with the payer shall be collected at the point of service. The clinic as an RHC understands that the co-insurance amount for Medicare patients is 20% of total charges. Coinsurance amounts shall not be waived in violation of any managed care contract or as an incentive to reduce the patient's cost share of a service.

C. Charge Capture, Coding and Billing for Services

1. **Charge Capture:** The clinic shall make a prudent effort to correctly capture and report all services provided to patients. Administration shall be responsible for correctly setting up charges in the PM/EHR. Providers shall be trained on correct charge capture methodology. All employees shall be trained on the aspects of the corporate compliance plan which relate to charging for services.

2. **Fees:** The clinic shall establish a consistent methodology for fee-setting. The method shall consider a baseline either as the MPFS, published claims data amounts, or regional charge data to determine the reasonableness of the gross charges. Periodically, the fee schedules should be analyzed for accuracy and consistency. The clinic shall maintain only one fee schedule for all financial classes.

3. **Coding:** The clinic is committed to correctly assigning diagnosis and procedure codes under the official coding guidelines which are published annually. The diagnosis codes (ICD-10-CM) shall be reported using the highest specificity of the clinical documentation and follow the most recent official coding guidelines. CPT® and HCPCS® shall be used to report the appropriate procedure based on the actual service performed and the most recent official coding guidelines. All payer guidelines shall be followed when reporting services. CCI and MUE edits shall be followed to prevent reporting services which should not be billed during the same episode of care. The clinic shall follow the basic monitoring and auditing measures found in the corporate compliance plan. Providers and internal staff shall be periodically trained on coding updates and changes in official coding guidelines.

4. **Billing and Claims Submission:** The rural health clinic or its parent entity directly performs the billing functions. The clinic shall follow payer-specific guidelines for bill types, claim format, revenue codes, place of service codes, condition codes and modifiers. The clinic is responsible for billing RHC core services and non-RHC services. The clinic prepares bills and submits claims to payers and third-parties through one or more of these methods:

    a. Its practice management/EHR system and clearinghouse relationship
    b. Through the parent entity's hospital information system (provider-based RHC)
    c. Direct date entry through a payer's portal or website
    d. Submission of paper claims when permissible
    e. Direct submission to the patient or a non-payer third party

5. **Rejections, Denials and Appeals**: Designated billing or business office staff shall review clearinghouse rejections after each batch submission to determine the reason for the rejection. The clinic shall not repeatedly resubmit claims without investigating the reason for the rejection or the "return to provider" status. Likewise, denials or claims which process with a zero-payment amount shall be reviewed by designated billing or business office staff to determine why the claim did not pay. The clinic staff shall contact the payer to seek resolution. If an appeal is needed, the appropriate staff shall follow the payer's specific appeal guidelines in a timely manner.

D. Payments, Posting and Account Follow-up

1. **Payments:** The following processes are followed concerning the receipt of payments:
    a. Upfront/Point of Sale Payments: Deductibles, copayments, and payments received for services in person shall be collected from the front desk staff and credited to the patient's account either through the practice management system or by paper receipt. The total amount collected for the day shall be reconciled to a daily system report and verified by the manager or administrator. Electronic payments are

encouraged for all types of transactions. Cash and check payments shall be processed through the system and reconciled daily. If the system report is not utilized, a manual reconciliation sheet shall be prepared.

b. Check payment received by mail: Checks received by mail shall be opened and logged by one person and the corresponding payments posted by another person if there is enough staff for adequate separation of duties. Check payments and posting activity shall be reconciled daily.

c. EFT payments: Electronic payments shall be reconciled to the system regularly. If electronic posting is also implemented, the billing staff shall verify that the payments and posting totals can be reconciled. Outstanding items shall be reconciled when transactions straddle the month-end.

d. Reconciliation of Payments and Posting Activity: There shall be standardized processes by which all payment types are reconciled to the patient account posting activity. Checks and balances shall be in place for adequate separation of duties to ensure that employees handling payments are not the same employees posting to patient accounts.

2. **Adjustments:** The following processes shall be followed when making or posting adjustments to patient accounts.
   a. Contractual Adjustments: Contractual adjustments shall be posted from the remittance advise. For an RHC, the contractual adjustment can be either a debit or a credit. Care should be taken to post the contractual correctly leaving the correct patient responsibility amount even if the payment is in excess of the charges. Should an employee have a question about how to post a specific adjustment, the manager should be consulted.
   b. Other Adjustments: The clinic shall have guidelines for making other adjustments to accounts for items such as sliding fee scale adjustments, prompt pay discounts or corrections to accounts. No employee shall make adjustments greater than 50% of the account balance without a supervisor's permission. Adjustments which are made to correct charges or a patient account balance shall be approved by a supervisor.

3. **Discounts:** No patient discounts shall violate the terms of a managed care contract. Furthermore, no patient discount shall result in the reimbursement for a particular service to be less than the average amount reimbursed by commercial payers for the same service unless created by a charity care policy based on patient income.

4. **Secondary or Corrected Claim Filing:** Payer-specific guidelines shall be followed when submitting secondary claims or when correcting original claims.

5. **Patient Billing:** Patients or the responsible party for the patient shall be billed for amounts deemed to be patient responsibility. Patient statements shall be sent promptly upon the determination of a patient balance and at repeated cycles until the account balance is resolved.

6. **Credit Balances:** Patient accounts with credit balances shall be reviewed at least quarterly to determine if a true credit balance exists and, if so, to determine the source of the overpayment. If the credit balance has been created by an overpayment or duplicate payment by CMS, the amount shall be reported to the MAC using either using the Quarterly Credit Balance Report (CMS 838) or the MAC's portal. Credit balances which

are due the patient shall be refunded in a timely manner. Credit balances which have resulted due to posting errors shall be corrected with a supervisor's approval.

7. **Bad Debt:** The clinic shall follow CMS guidelines for establishing that an account balance consisting of the patient's deductible and coinsurance amounts are considered to be a bad debt. The same guidelines for bad debt and collection efforts shall be applied to all financial classes. Bad debt should be reported according to the accounting policies of the organization and via cost reporting when appropriate.

Specific Procedures: As described within the body of this policy and as described in any accompanying addendums, attachments, supplemental or supportive documents and related policies of the organization.

RELATED POLICES AND SUPPLEMENTAL DOCUMENTS

Please refer to these other related policies or attachments for more specific information or procedures:

POLICY #	Policy or Document Name	Location
	Compliance Plan	
	Patient Registration Packet	
	Notice of Privacy Practices	
	Other Financial Policies	

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: Compliance Program for Northern Inyo Healthcare District		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 10/10/2023	Last Review Date: 10/25/2024	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/18/2016	

Contents

INTRODUCTION

It is the fundamental policy of NORTHERN INYO HEALTHCARE DISTRICT (hereinafter "NIHD" or "the District"), that quality patient care and governance is provided by the District, its governing board, medical staff, employees and affiliates, in a manner that fully complies with all applicable state and federal laws, and that all of the District's business and other practices be conducted at all times in compliance with all applicable laws and regulations of the United States, the State of California, all other applicable state and local laws and ordinances, and the ethical standards and practices of the medical profession, the health care industry and this organization.

There is significant concern about "waste, fraud and abuse" in healthcare. In light of this, the Office of the Inspector General (OIG) has issued a document entitled "Compliance Program Guidance for Hospitals." The OIG has recommended that an effective compliance program should contain the following seven elements:

> ***1.*** *The development and distribution of written standards of conduct, as well as written policies and procedures that promote the Company's commitment to compliance (e.g., by including adherence to compliance as an element in evaluating managers and employees) and that address specific areas of potential fraud, such as claims development and submission processes, code gaming, and financial relationships with physicians and other health care professionals;*
>
> ***2****. The designation of a compliance officer and other appropriate bodies charged with the responsibility of operating and monitoring the compliance program, and who report directly to the CEO and the governing body;*
>
> ***3****. The development and implementation of regular, effective education and training programs for all affected employees;*
>
> ***4.*** *The maintenance of a process, such as a hotline, to receive complaints, and the adoption of procedures to protect the anonymity of complainants and to protect complainants from retaliation;*
>
> ***5.*** *The development of a system to respond to allegations of improper/illegal activities and the enforcement of appropriate disciplinary action against employees who have violated internal compliance policies, applicable statutes, regulations or federal health care program requirements;*
>
> ***6.*** *The use of audits and/or other evaluation techniques to monitor compliance and assist in the reduction of identified problem areas; and*
>
> ***7.*** *The investigation and remediation of identified systemic problems and the development of policies addressing the non-employment or retention of sanctioned individuals.*

This Compliance Program outlines the process NIHD will utilize to assure that it is in compliance with all the various laws and regulations established by both the Federal government as well as the State of California.

This Compliance Program (the "Program") is intended as a guide to help implement this policy of compliance with all applicable standards. The federal, state, and local laws, regulations, and ethical rules that govern health care are too numerous to list in the Program. Fundamentally, all individuals associated with NIHD by employment, contract or otherwise, are expected to conduct all business activities honestly and fairly. Each employee or contractor is responsible for his or her own conduct in complying with the Program.

The Program provides for the designation of a Compliance Officer who has ultimate responsibility and accountability for directing, monitoring, and reporting on compliance matters. The Compliance Officer shall implement and administer this Program, together with training and education as necessary to affect the full participation of District governing board, medical staff, employees, affiliates, and other agents.

This Program provides a framework for individual or departmental compliance efforts, and applies to all District Personnel and activities. However, each individual employee or agent of the District remains responsible and accountable for his or her own compliance with applicable laws, regulations, standards, policies, and procedures.

The Program identifies those organizational imperatives necessary to prevent accidental and intentional non-compliance with applicable laws. It is further designed to detect non-compliance should it occur. Additionally, it is designed to promote such steps as are necessary to prevent future non-compliance, including education and corrective action.

Northern Inyo Healthcare District is committed to maintaining in the community a positive reputation for conduct in accordance with the highest levels of business ethics. This Program supports that objective. The Program fully supports the NIHD mission: Improving our communities, one life at a time. One team. One goal. Your health!

SECTION 1 — COMPLIANCE PROGRAM SUMMARY

Definitions of Commonly Used Terms

A list of words that are commonly used in this Compliance Program and their meanings follows:

- **"Affiliate"** means any person or entity controlled by, or under common control with, Northern Inyo Healthcare District.
- **"District"** means Northern Inyo Healthcare District, and all of its subsidiaries and affiliates that are covered by this Compliance Program.
- **"Personnel"** means all members of the governing board, medical staff, employees of the District, and all contractors or others who are required to comply with this Compliance Program. Each of these persons must sign an Acknowledgment of Receipt of District Compliance Program and a Conflict of Interest Questionnaire Form.
- **"Board"** means the Board of Directors of the District.

Purpose of this Compliance Program

Northern Inyo Healthcare District is committed to ensuring compliance with all applicable statutes, regulations, and policies governing our daily business activities. To that end, the District will have a Compliance Program. The document is to serve as a practical guidebook that can be used by all Personnel to assist them in performing their job functions in a manner that complies with applicable laws and policies. Additionally this Compliance Program is to serve as a mechanism for preventing violations and for reporting any violation in a manner that protects those that identify and report the lack of compliance with those laws.

While this Compliance Program contains policies regarding the business of Northern Inyo Healthcare District, it does not contain every policy that Personnel are expected to follow. For example, this Compliance Program does not cover payroll, vacation and benefits policies. Northern Inyo Healthcare District maintains other policies with which employees are required to comply. If you have questions about which policies apply to you, please ask your supervisor.

It is the policy of the District that:

- All employees are educated about applicable laws and trained in matters of compliance;
- There is periodic auditing, monitoring and oversight of compliance with those laws;
- An atmosphere exists that encourages and enables the reporting of noncompliance without fear of

retribution; and

- Mechanisms exist to investigate and take corrective actions in the event of noncompliance.

Who is Affected

Everyone employed by Northern Inyo Healthcare District is required to comply with our Compliance Program. Because not all sections will apply to your job function, you will receive training and other materials to explain which portions of this Compliance Program apply to you.

While this is not intended to serve as the compliance program for all of our contractors, it is important that all contractors perform services in a manner that complies with the law. To that end, agreements with contractors may incorporate certain provisions of this Compliance Program.

Please note that compliance requirements are subject to change as a result of new laws and changes to existing laws and regulations. Collectively, we must all keep this Compliance Program current and useful. Therefore, you are encouraged to let the Compliance Officer or your supervisor know when you become aware of changes in law or District policy that might affect this Compliance Program.

How to Use This Compliance Program

The District has organized this Compliance Program to be understandable and easy to navigate. A brief description of how this manual is organized follows.

1. **Section I – Compliance Program Summary**

2. **Section II – Code of Conduct**

This section contains specific policies related to your personal conduct while performing your job function. The primary objective of these policies is to create a work environment that promotes cooperation, professionalism, and compliance with the law. Compliance with the Code of Conduct is a significant factor in employee performance evaluations. All Personnel will receive training on this section.

3. **Section III – Compliance Program Systems and Processes**

This section explains the roles of the Compliance Officer and the Compliance and Business Ethics Committee. It also contains information about Compliance Program education and training, auditing, and corrective action. Most importantly, this section explains how to report violations anonymously, either in writing or by calling the Compliance Confidential Report Line at 1-888-200-9764 or by emailing the Compliance Officer directly. All Personnel will receive training on this section.

4. **Section IV – Compliance Policies**

The District electronic policy management system houses NIHD Compliance Policies. Some of these policies may not apply to your specific job function, but it is still important that you are aware of their existence and importance. All Personnel will receive training regarding the policies that apply to their job.

Here are some tips on how to use this Compliance Program effectively:

- **Refer to Table of Contents.** The Table of Contents contains a thorough list of topics covered in this Compliance Program. Use the Table of Contents to locate the topic you are looking for quickly.
- **Important Reference Tool.** This Compliance Program should be viewed as an important reference manual that you can refer to on a regular basis to answer questions about how to perform your job. Although it may not contain all of the answers, it will contain many and can save you time.
- **Read it in Context.** The District has created this Compliance Program to incorporate numerous compliance policies, many of which may not apply to you. When reviewing this Compliance

Program and the policies contained in it, keep in mind that the policies are to be applied in the context of your job. If you are uncertain about if or how a policy applies to you, ask your supervisor.

- **Keep it Handy.** Keep this Compliance Program information easily accessible and refer to it on a regular basis.
- **Talk to Your Co-Workers.** Regular dialogue among co-workers and supervisors is a great way to ensure that policies are applied uniformly. While this discussion is encouraged, always remember that the provisions of this Compliance Program should guide you on compliance matters.

SECTION II – CODE OF CONDUCT

Our Compliance Mission

The mission of Northern Inyo Healthcare District's Compliance Department is to promote an organizational culture that encourages ethical conduct and a commitment to compliance with the law in order to improve our communities, one life at a time.

Northern Inyo Healthcare District believes that dedication to high ethical standards and compliance with all applicable laws and regulations is essential to its mission. This Code of Conduct is a critical component of the overall District Compliance Program. It guides and assists the District in carrying out daily activities in accordance with appropriate ethical and legal standards. These obligations apply to the District's relationship with patients, affiliated physicians, third-party payers, regulatory agencies, subcontractors, contractors, vendors, consultants, and one another. They require that all program participants comply with all applicable federal, state and local laws and regulations. Participants must also comply with all Northern Inyo Healthcare District Standards of Conduct. The absence of a specific guideline practice or instruction covering a particular situation does not relieve an employee from exercising the highest ethical standards applicable to the circumstances.

Compliance with Laws

It is the policy of the District, its affiliates, contractors, and employees to comply with all applicable laws. When the application of the law is uncertain, the District Chief Executive Officer or Compliance Officer will seek guidance from legal counsel.

Open Communication

The District encourages open lines of communication among Personnel. If you are aware of an unlawful or unethical situation, there are several ways you can bring this to the District's attention. Your supervisor is the best place to start, but you can also contact the District's Compliance Officer or call the Compliance Confidential Report Line (1-888-200-9764) to express your concerns. All reports of unlawful or unethical conduct will be investigated promptly. The District does not tolerate threats or acts of retaliation or retribution against employees for using these communication channels.

Your Personal Conduct

The District's reputation for the highest standards of conduct rests not on periodic audits by lawyers and accountants, but on the high measure of mutual trust and responsibility that exists between Personnel and the District. It is based on you, as an individual, exercising good judgment and acting in accordance with this Code of Conduct and the law.

Ethical behavior on the job essentially comes down to honesty, trust, and fairness in dealing with other Personnel and with patients, vendors, competitors, the government and the public. It is no exaggeration to say

that the District's integrity and reputation are in your hands.

The District's basic belief in the importance of respect for the individual has led to a strict regard for the privacy and dignity of Personnel. When management determines that your personal conduct adversely affects your performance, that of other Personnel, or the legitimate interests of the District, the District may be required to take corrective action.

The Work Environment

The District strives to provide Personnel with a safe and productive work environment. All Personnel must dispose of medical waste, environmentally sensitive materials, and any other hazardous materials correctly. You should immediately address and report to your supervisor any situations that are likely to result in falls, shocks, burns, or other harm to patients, visitors, or Personnel.

The work environment also must be free from discrimination and harassment based on race, color, religion, sex, sexual orientation, age, national origin, disability, veteran status, or other factors that are unrelated to the District's legitimate business interests. The District will not tolerate sexual advances, actions, comments or any other conduct in the workplace that creates an intimidating or otherwise offensive environment. Similarly, the use of racial or religious slurs — or any other remarks, jokes or conduct that encourages or permits an offensive work environment — will not be tolerated.

If you believe that you are subject to such conduct, you should bring such activity to the attention of the District, either by informing your supervisor, the District's Compliance Officer, or by calling the Compliance Confidential Report Line (1-888-200-9764). The District considers all complaints of such conduct to be serious matters, and all complaints will be investigated promptly.

Some other activities that are prohibited because they clearly are not appropriate are:

- Threats;
- Violent behavior;
- The possession of weapons of any type on the premises, except for exempt or authorized Personnel;
- The distribution of offensive jokes or other offensive materials via e-mail or any other manner; and
- The use, distribution, sale, or possession of illegal drugs or any other controlled substances, except to the extent permitted by law for approved medical purposes.

In addition, Personnel may not be on the District premises or in the District work environment if they are under the influence of or affected by illegal drugs, alcohol or controlled substances used other than as prescribed.

Employee Privacy

The District collects and maintains personal information that relates to your employment, including medical and benefit information. Access to personal information is restricted solely to people with a need to know this information. Personal information is released outside the District or to its agents only with employee approval, except in response to appropriate investigatory or legal requirements, or in accordance with other applicable law. Employees who are responsible for maintaining personal information and those who are provided access to such information must ensure that the information is not disclosed in violation of the District's Personnel policies or practices.

Use of District Property

District equipment, systems, facilities, corporate charge cards, and supplies must be used only for conducting

District business or for purposes authorized by management.

Personal items, messages, or information that you consider private should not be placed or kept in telephone systems, computer systems, offices, workspaces, desks, credenzas, or file cabinets. Employees should have no expectation of privacy with regard to items or information stored or maintained on District equipment or premises. Management is permitted to access these areas. Employees should not search for or retrieve articles from another employee's workspace without prior approval from that employee or management.

Since supplies of certain everyday items are readily available at District work locations, the question of making personal use of them frequently arises. The answer is clear: employees may not use District supplies for personal use.

Use of District Computers

The increasing reliance placed on computer systems, internal information, and communications facilities in carrying out District business makes it absolutely essential to ensure their integrity. Like other District assets, these facilities and the information they make available through a wide variety of databases should be used only for conducting District business or for purposes authorized by management. Their unauthorized use, whether or not for personal gain, is a misappropriation of District assets.

While the District conducts audits to help ensure that District systems, networks, and databases are being used properly, it is your responsibility to make sure that each use you make of any District system is authorized and proper.

Personnel are not allowed to load or download software or data onto District computer systems unless it is for business purposes and is approved in advance by the appropriate supervisor. Personnel shall not use District e-mail systems to deliver or forward inappropriate jokes, unauthorized political materials, or any other potentially offensive materials. Personnel are strictly forbidden from using computers to access the Internet for purposes of gambling, viewing pornography or engaging in any illegal activities.

Employees should have no expectation of privacy with regard to items or information stored or maintained on District premises or computer, information, or communication systems.

Use of Proprietary Information

Proprietary Information

Proprietary information is generally confidential information that is developed by the District as part of its business and operations. Such information includes, but is not limited to, the business, financial, marketing and contract arrangements associated with District services and products. It also includes computer access passwords, procedures used in producing computer or data processing records, Personnel and medical records, and payroll data. Other proprietary information includes management know-how and processes; District business and product plans with outside vendors; a variety of internal databases; and copyrighted material, such as software.

The value of this proprietary information is well known to many people in the District industry. Besides competitors, they include industry and security analysts, members of the press, and consultants. The District alone is entitled to determine who may possess its proprietary information and what use may be made of it, except for specific legal requirements such as the publication of certain reports.

Personnel often have access to information that the District considers proprietary. Therefore, it is very important not to use or disclose proprietary information except as authorized by the District.

Inadvertent Disclosure

The unintentional disclosure of proprietary information can be just as harmful as intentional disclosure. To avoid unintentional disclosure, never discuss with any unauthorized person proprietary information that has not been made public by the District. This information includes unannounced products or services, prices, earnings, procurement plans, business volumes, capital requirements, confidential financial information, marketing and service strategies, business plans, and other confidential information. Furthermore, you should not discuss confidential information even with authorized District employees if you are in the presence of others who are not authorized — for example, at a meeting, conference or in a public area. This also applies to discussions with family members or with friends, who might innocently or inadvertently pass the information on to someone else.

Direct Requests for Information

If someone outside the District asks you questions about the District or its business activities, either directly or through another person, do not attempt to answer them unless you are certain you are authorized to do so. If you are not authorized, refer the person to the appropriate source within the District. Under no circumstances should you continue contact without guidance and authorization. If you receive a request for information, or to conduct an interview from an attorney, investigator, or any law enforcement officer, and it concerns the District's business, you should refer the request to your supervisor, the office of the District's Chief Executive Officer, or Compliance Officer. Similarly, unless you have been authorized to talk to reporters, or to anyone else writing about or otherwise covering the District or the industry, direct the person to your supervisor.

Disclosure and Use of District Proprietary Information

Besides your obligation not to disclose any District proprietary information to anyone outside the District, you are also required to use such information only in connection with the District's business. These obligations apply whether or not you developed the information yourself.

Proprietary and Competitive Information about Others

In the normal course of business, it is not unusual to acquire information about many other organizations, including competitors (competitors are other Districts and health facilities). Doing so is a normal business activity and is not unethical in itself. However, there are limits to the ways that information should be acquired and used. Improper solicitation of confidential data about a competitor from a competitor's employees or from District patients is prohibited. The District will not tolerate any form of questionable intelligence gathering.

Recording and Reporting Information

You should record and report all information accurately and honestly. Every employee records information of some kind and submits it to the District (for example, a time card, an expense account record, or a report). To submit a document that contains false information — an expense report for meals not eaten, miles not driven, or for any other expense not incurred — is dishonest reporting and is prohibited.

Dishonest reporting of information to organizations and people outside the District is also strictly prohibited and could lead to civil or even criminal liability for you and the District. This includes not only reporting information inaccurately, but also organizing it in a way that is intended to mislead or misinform those who receive it. Personnel must ensure that they do not make false or misleading statements in oral or written communications provided to organizations outside of the District.

Exception

Nothing contained herein is to be construed as prohibiting conduct legally protected by the National Labor Relations Act or other applicable state or federal law.

Gifts and Entertainment

The District understands that vendors and others doing business with the District may wish to provide gifts,

promotional items, or entertainment to District Personnel as part of such vendors' own marketing activities. The District also understands that there may be occasions where the District may wish to provide reasonable business gifts to promote the District's services. However, the giving and receipt of such items can easily be abused and have unintended consequences; giving and receiving gifts, particularly in the health care industry, can create substantial legal risks.

General Policy

It is the general policy of the District that neither you nor any member of your family may solicit, receive, offer or pay any money or gift that is, or could be reasonably construed to be, an inducement in exchange for influence or assistance in conducting District business. It is the intent of the District that this policy be construed broadly such that all business transactions with vendors, contractors, and other third parties are transacted to avoid even the appearance of improper activity. Pharmaceutical samples provided to physicians by manufacturers for patient use are generally allowed. Please discuss any concerns with your supervisor or the Compliance Officer.

Spending Limits — Gifts, Dining and Entertainment

The District has developed policies that clearly define the spending limits permitted for items such as gifts, dining, and entertainment. Occasional gifts from vendors, of nominal value (less than $10), that do not influence or appear to influence the objective judgment of personnel, such as sales promotional items (an inexpensive pen), or business related meal or snack for a department are permitted with approval. All Personnel are strictly prohibited from making any expenditure of District or personal funds for gifts, dining or entertainment in any way related to District business, unless such expenditures are made in strict accordance with District policies.

Marketing and Promotions in Health Care

As a provider of health care services, the marketing and promotional activities of the District may be subject to anti-kickback and other laws that specifically apply to the health care industry. The District has adopted policies elsewhere in this Compliance Program to specifically address the requirements of such laws.

It is the policy of the District that Personnel are not allowed to solicit, offer or receive any payment, compensation or benefit of any kind (regardless of the value) in exchange for referring, or recommending the referral of, patients or customers to the District.

Marketing

The District has expended significant efforts and resources in developing its services and reputation for providing high-quality patient care. Parts of those efforts involve advertising, marketing, and other promotional activities. While such activities are important to the success of the District, they are also potential sources of legal liability as a result of health care laws (such as the anti-kickback laws) that regulate the marketing of health care services. Therefore, it is important that the District closely monitor and regulate advertising, marketing and other promotional activities to ensure that all such activities are performed in accordance with District objectives and applicable law.

This Compliance Program contains various policies applicable to specific business activities of the District. In addition to those policies, it is the general policy of the District that no Personnel engage in any advertising, marketing, or other promotional activities on behalf of the District unless such activities are approved in advance by the appropriate District representative. You should ask your supervisor to determine the appropriate District representative to contact. In addition, no advertising, marketing, or other promotional activities targeted at health care providers or potential patients may be conducted unless approved in advance by the District's Chief Executive Officer or Compliance Officer.

All content posted on Internet websites maintained by the District must be approved in advance by the District's Compliance Officer or designee.

Conflicts of Interest

A conflict of interest is any situation in which financial or other personal considerations may compromise or appear to compromise any Personnel's business judgment, delivery of patient care, or ability of any Personnel to do his or her job or perform his or her responsibilities. A conflict of interest may arise if you engage in any activities or advance any personal interests at the expense of the District's interests.

An actual or potential conflict of interest occurs when any Personnel is in a position to influence a decision that may result in personal gain for that Personnel, a relative or a friend as a result of the District's business dealings. A relative is any person who is related by blood or marriage, or whose relationship with the Personnel is similar to that of persons who are related by blood or marriage, including a domestic partner, and any person residing in the Personnel's household. You must avoid situations in which your loyalty may become divided.

An obvious conflict of interest is providing assistance to an organization that provides services and products in competition with the District's current or potential services or products. You may not, without prior consent, work for such an organization as an employee (including working through a registry or "moonlighting" and picking up shifts at other health care facilities), independent contractor, a consultant, or a member of its Governing Board. Such activities may be prohibited because they divide your loyalty between the District and that organization. While many of these activities are approved with a management plan or Non-Disclosure agreement, failure to obtain prior consent in advance from the District's Compliance Officer may be grounds for corrective action, up to and including termination.

Outside Employment and Business Interests

You are not permitted to work on any personal business venture on the District premises or while working on District time. In addition, you are not permitted to use District equipment, telephones, computers, materials, resources, or proprietary information for any business unrelated to District business. You must abstain from any decision or discussion affecting the District when serving as a member of an outside organization or board or in public office, except when specific permission to participate has been granted by the District's Compliance Officer or Chief Executive Officer.

Contracting with the District

You may not contract with the District to be a supplier, to represent a supplier to the District, or to work for a supplier to the District while you are an employee of the District. In addition, you may not accept money or benefits, of any kind, for any advice or services you may provide to a supplier in connection with its business with the District.

Required Standards

All decisions and transactions undertaken by Personnel in the conduct of the District's business must be made in a manner that promotes the best interests of the District, free from the possible influence of any conflict of interest of such Personnel or the Personnel's family or friends. Personnel have an obligation to address both actual conflicts of interest and the appearance of a conflict of interest. You must always disclose and seek resolution of any actual or potential conflict of interest — whether or not you consider it an actual conflict — before taking a potentially improper action.

No set of principles or standards can cover every type of conflict of interest. The following standards address conduct required of all Personnel and provide some examples of potential conflict of interest situations in addition to those discussed elsewhere in the Compliance Program.

1. Personnel may not make or influence business decisions, including executing purchasing agreements (including but not limited to agreements to purchase or rent equipment, materials, supplies or space) or other types of contracts (including contracts for personal services), from which they, a family member, or a friend may benefit.

2. Personnel must disclose their "significant" (defined below) financial interests in any entity that they know to have current or prospective business, directly or indirectly, with the District. There are two types of significant financial interests:
    a. Receipt of anything of monetary value from a single source. Examples include salary, royalties, gifts and payments for services including consulting fees and honoraria; and
    b. Ownership of an equity interest exceeding 5 percent in any single entity, excluding stocks, bonds and other securities sold on a national exchange; certificates of deposit; mutual funds; and brokerage accounts managed by third parties.
3. Personnel must disclose any activity, relationship, or interest that may be perceived to be a conflict of interest so that these activities, relationships, and interests can be evaluated and managed properly.
4. Personnel must disclose any outside activities that interfere, or may be perceived to interfere, with the individual's capacity to satisfy his or her job or responsibilities at the District. Such outside activities include leadership participation (such as serving as an officer or member of the board of directors) in professional, community, or charitable activities; self-employment; participation in business partnerships; and employment or consulting arrangements with entities other than the District.
5. Personnel may not solicit personal gifts or favors from vendors, contractors, or other third parties that have current or prospective business with the District. Personnel may not accept cash gifts and may not accept non-monetary gifts including meals, transportation, or entertainment from vendors, contractors, or other third parties that have current or prospective business with the District. Questions regarding the gifts should be directed to the District's Compliance Officer.
6. Any involvement by Personnel in a personal business venture shall be conducted outside the District work environment and shall be kept separate and distinct from the District's business in every respect.
7. Personnel should not accept employment or engage in a business that involves, even nominally, any activity during hours of employment with the District, the use of any of the District's equipment, supplies, or property, or any direct relationship with the District's business or operation. Certain emergency situations may require collaboration with suppliers, vendors, or other healthcare organizations. Disclosure and approval by Chief Executive Officer or Compliance Officer at an appropriate time would further clarify compliance; however, nothing in this Program should be interpreted as interfering with the provision of high quality, efficient patient care in a legally compliant manner. Questions should be directed to the District's Compliance Officer.
8. Personnel must guard patient and District information against improper access, disclosure, or use by unauthorized individuals.
9. The District's materials, products, designs, plans, ideas, and data are the property of the District and should never be given to an outside firm or individual, except through normal channels with appropriate prior authorization.
10. Personnel must avoid even the appearance of impropriety when dealing with clinicians and referral sources.
11. All vendors and contractors who have or desire business relationships with the District must abide by this Code of Conduct. Personnel having knowledge of vendors or contractors who violate these standards in their relationship with the District must report these to their supervisor, manager, the District Compliance Officer, or by using the Confidential Compliance Report Line (1-888-200-9764).
12. Personnel shall not sell any merchandise on District premises and shall not sell any merchandise of a medical nature that is of a type or similar to what is sold or furnished by the District, whether on or off District premises, unless prior approval is obtained from the District's Compliance Officer.

13. Personnel shall not request donations for any purpose from other Personnel, patients, vendors, contractors or other third parties, unless prior approval is obtained from the District's Compliance Officer.
14. Personnel may not endorse any product or service without explicit prior approval to do so by the District's Compliance Officer.

Disclosure of Potential Conflict Situations

You must disclose any activity, relationship, or interest that is or may be perceived to be a conflict of interest and complete the attached Conflict of Interest Questionnaire Form within 90 days of being subject to this Compliance Program (that is, being hired by the District, beginning to volunteer at the District, or assuming any responsibilities at the District). At least annually thereafter, you must review this Compliance Program and Conflict of Interest Questionnaire. You are required to file a Conflict of Interest Questionnaire Form annually, and when there is a change in your circumstances that you have not previously reported. At any time during the year, when an actual, potential, or perceived conflict of interest arises, you must revise your questionnaire form and contact the District's Compliance Officer. It is your responsibility to report promptly any actual or potential conflicts.

All questionnaire forms must be sent to the District's Compliance Officer. The Compliance Officer will review all disclosures and determine which disclosures require further action. The Compliance Officer will consult with the Business Compliance Team if an actual or perceived conflict of interest may exist. The District's Chief Executive Officer or legal counsel may be consulted by the Compliance Officer as needed to determine if further action is required. The outcome of these consultations will result in a written determination stating whether or not an actual conflict of interest exists. If a conflict of interest is determined to exist, the written determination shall set forth a plan to manage the conflict of interest, which may include that:

1. The conflict of interest is not significant and is generally permissible;
2. The activity may represent a potential or perceived conflict of interest, but in many cases would be permitted to go forward after disclosure with a Management Plan or Non-Disclosure Agreement;
3. The conflict of interest will require the Personnel to abstain from participating in certain governance, management or purchasing activities related to the conflict of interest;
4. The activity represents an actual conflict of interest which may be permitted to go forward after disclosure with an appropriate Management Plan or Non-Disclosure Agreement to eliminate the conflict, safeguard against prejudice toward Northern Inyo Healthcare District activities, and provide continuing oversight; or
5. The conflict of interest must be eliminated or, if it involves a proposed role in another organization or entity, must not be undertaken.

The Compliance Officer, or designee, will review any written determination with you and discuss any necessary action you are to take.

Anti-Competitive Activities

If you work in community relations, sales, or marketing, the District asks you to perform your job not just vigorously and effectively, but fairly, as well. False or misleading statements about a competitor are inappropriate, invite disrespect and complaints, and may violate the law. Be sure that any comparisons you make about competitors' products and services are fair and accurate. (Competitors are other Districts, hospitals, and health facilities.)

Reporting Violations

The District supports and encourages each employee and contractor to maintain individual responsibility for monitoring and reporting any activity that violates or appears to violate any applicable statutes, regulations, policies, or this Code of Conduct.

The District has established a reporting mechanism that permits anonymous reporting, if the person making the report desires anonymity. Employees who become aware of a violation of the District Compliance Program, including this Code of Conduct, must report the improper conduct to the District's Compliance Officer. That officer, or a designee, will then investigate all reports and ensure that appropriate follow-up actions are taken.

District policy prohibits retaliation against an employee who makes such a report in good faith. In addition, it is the policy of the District that no employee will be punished on the basis that he/she reported what he/she reasonably believed to be improper activity or a violation of this Program.

However, employees are subject to corrective action, if after an investigation the District reasonably concludes that the reporting employee knowingly fabricated, or knowingly distorted, exaggerated or minimized the facts either to cause harm to someone else or to protect or benefit himself or herself.

Additional, detailed information may be found in the NIHD Code of Business Ethics and Conduct.

SECTION III — COMPLIANCE PROGRAM SYSTEMS AND PROCESSES

This Compliance Program contains a comprehensive set of policies. In order to effectively implement and maintain these policies, the District has developed various systems and processes. The purpose of this section of the Compliance Program is to explain the various systems and processes that the District has established for the purpose of providing structure and support to the Compliance Program.

Compliance Officers and Committee

Compliance Officer

The District has a Compliance Officer who serves as the primary supervisor of this Compliance Program. The District's Compliance Officer occupies a high-level position within the organization and has authority to carry out all compliance responsibilities described in this Compliance Program. The Compliance Officer is responsible for assuring that the Compliance Program is implemented to ensure that the District at all times maintains business integrity and that all applicable statutes, regulations and policies are followed.

The Compliance Officer provides frequent reports to the Governing Board about the Compliance Program and compliance issues. The Governing Board is ultimately responsible for oversight of the work of the Compliance Officer, and maintaining the standards of conduct set forth in the Compliance Program. The Governing Board oversees all of the District's compliance efforts and takes any appropriate and necessary actions to ensure that the District conducts its activities in compliance with the law and sound business ethics.

The Compliance Officer and Governing Board shall consult with legal counsel as necessary on compliance issues raised by the ongoing compliance review.

Responsibilities of the Compliance Officer

The Compliance Officer's responsibilities include the following:

- Overseeing and monitoring the implementation and maintenance of the Compliance Program.
- Reporting on a regular basis to the Governing Board (no less than quarterly) on the progress of implementation and operation of the Compliance Program and assisting the Governing Board in establishing methods to reduce the District's risk of fraud, waste, and abuse.
- Periodically revising the Compliance Program in light of changes in the needs of the District and changes in applicable statutes, regulations, and government policies.

- Reviewing at least annually the implementation and execution of the elements of this Compliance Program. The review includes an assessment of each of the basic elements individually and the overall success of the Program, and a comprehensive review of the compliance department.
- Developing, coordinating and participating in educational and training programs that focus on elements of the Compliance Program with the goal of ensuring that all appropriate Personnel are knowledgeable about, and act in accordance with, this Compliance Program and all pertinent federal and state requirements.
- Ensuring that independent contractors and agents of the District are aware of the requirements of this Compliance Program as they affect the services provided by such contractors and agents.
- Ensuring that employees, independent contractors, and agents of the District have not been excluded from participating in Medicare, Medicaid (Medi-Cal) or any other federal or state heath care program.
- Ensuring that the District does not employ or contract with any individual who has been convicted of a criminal offense related to health care within the previous five years, or who is listed by a federal or state agency as debarred, excluded, or otherwise ineligible for participation in Medicare, Medicaid (Medi-Cal), or any other federal or state health care program.
- Coordinating internal compliance review and monitoring activities.
- Independently investigating and acting on matters related to compliance, including design and coordination of internal investigations and implementation of any corrective action.
- Maintaining a good working relationship with other key operational areas, such as quality improvement, coding, billing and clinical departments.
- Designating work groups or task forces needed to carry out specific missions, such as conducting an investigation or evaluating a proposed enhancement to the Compliance Program.

The Compliance Officer has the authority to review all documents and other information relevant to compliance activities, including, but not limited to, patient records, billing records, records concerning marketing efforts and all arrangements with third parties, including without limitation employees, independent contractors, suppliers, agents and physicians.

The Compliance Officer has direct access to the Governing Board, Chief Executive Officer and other senior management, and to legal counsel.

Compliance and Business Ethics Committee

The District has established a Compliance and Business Ethics Committee to advise the Compliance Officer and assist in monitoring this Compliance Program. The Compliance and Business Ethics Committee (CBEC) provides the perspectives of individuals with diverse knowledge and responsibilities within the District.

Members of the Compliance and Business Ethics Committee

The Compliance and Business Ethics Committee consists of multiple representatives. The members of the CBEC include those individuals designated below and other members as requested, including representatives of senior management, chosen by the District's Chief Executive Officer in consultation with the Compliance Officer:

- Compliance Officer
- Chief Financial Officer
- Cybersecurity Officer

- Chief Medical Officer
- Chief Nursing Officer
- Chief Executive Officer
- Chief Human Resource Officer
- Board of Directors' Representative
- As appropriate, Health Information Management Manager, Revenue Cycle Director, or department designee from Emergency, Human Resources Director Laboratory, Pharmacy, Imaging, Purchasing, and other areas

The Compliance Officer serves as the chairperson of the Compliance and Business Ethics Committee. The CBEC serves in an advisory role and has authority to adopt or implement policies following Board approval. The Compliance Officer will consult with members of the CBEC on a regular basis and may call meetings of all or some members of the CBEC.

The Board of Directors' representative to the CBEC shall be appointed by the full Board of Directors. The Board of Directors' representative shall meet the following qualifications prior to consideration for appointment:

- Completion of ethics and governance training as required by AB1234; and,
- Attended an Association of California Healthcare District (ACHD) Annual Conference within past two years; and,
- Has completed and filed CA Form 700; and,
- NIHD Conflict of Interest for Members of the Board of Directors has been completed, returned, and reviewed by the Business Compliance Team.

Each member of the CBEC shall sign a Non-Disclosure Agreement (NDA).

Functions of the Compliance and Business Ethics Committee
The Compliance and Business Ethics Committee's functions include the following:

- Assessing existing and proposed compliance policies for modification or possible incorporation into the Compliance Program.
- Working with the Compliance Officer to develop standards of conduct and policies to promote compliance.
- Development on Annual Compliance Department Work Plan and Audit Plan, including review and re-prioritizing as necessary
- Recommending and monitoring, in conjunction with the Compliance Officer, the development of internal systems and controls to carry out the standards and policies of this Compliance Program.
- Reviewing and proposing strategies to promote compliance and detection of potential violations.
- Assisting the Compliance Officer in the development and ongoing monitoring of systems to solicit, evaluate, and respond to complaints and problems related to compliance.
- Assisting the Compliance Officer in coordinating compliance training, education and other compliance-related activities in the departments and business units in which the members of the Compliance and Business Ethics Committee work.
- Consulting with vendors of the District on a periodic basis to promote adherence to this

Compliance Program as it applies to those vendors and to promote their development of formal Compliance Programs.

The tasks listed above are not intended to be exhaustive. The CBEC may also address other compliance-related matters as determined by the Compliance Officer.

The CBEC may, from time to time, create one or more sub-committees which shall have that authority specifically designated thereto. Each sub-committee shall answer directly to the respective Compliance and Business Ethics Committee.

The District has established a Billing, Coding, and Compliance Committee (BCCC), which is a sub-committee of the Compliance and Business Ethics Committee, to advise the Compliance Officer and assist in monitoring of billing, coding, and revenue cycle management. The Billing, Coding, and Compliance Committee shall be renamed the Billing and Coding Compliance Subcommittee (BCCS).

The District has established a Business Compliance Team (BCT) to assist the Compliance Officer in appropriate determinations and plans of action for reported, actual, or perceived conflicts of interest. The Business Compliance Team is a subcommittee of the CBEC.

Compliance as an Element of Performance

The promotion of, and adherence to, the elements of this Compliance Program is a factor in evaluating the performance of all District employees. Personnel will be trained periodically regarding the Compliance Program, and new compliance policies that are adopted. In particular, all managers and supervisors involved in any processes related to the evaluation, preparation, or submission of medical claims must do the following:

- Discuss, as applicable, the compliance policies and legal requirements described in this Compliance Program with all supervised Personnel.
- Inform all supervised Personnel that strict compliance with this Compliance Program is a condition of continued employment.
- Inform all supervised Personnel that disciplinary action will be taken, up to and including termination of employment or contractor status, for violation of this Compliance Program.

Managers and supervisors will be subject to discipline for failure to adequately instruct their subordinates on matters covered by the Compliance Program. Managers and supervisors will also be subject to discipline for failing to detect violations of the Compliance Program where reasonable diligence on the part of the manager or supervisor would have led to the discovery of a problem or violation and thus would have provided the District with the opportunity to take corrective action.

Training and Education

The District acknowledges that this Compliance Program will be effective only if it is communicated and explained to Personnel on a routine basis and in a manner that clearly explains its requirements. For this reason, the District requires all Personnel to attend specific training programs on a periodic basis. Training requirements and scheduling are established by the District for its departments and affiliates based on the needs and requirements of each department and affiliate. Training programs include appropriate training in federal and state statutes, regulations, guidelines, the policies described in this Compliance Program, and corporate ethics. Training will be conducted by qualified internal or external personnel. New employees are trained early in their employment. Training programs may include sessions highlighting this Compliance Program, summarizing fraud and abuse laws, physician self-referral laws, claims development and submission processes, and related business practices that reflect current legal standards.

All formal training undertaken as part of the Compliance Program is documented. Documentation includes at

a minimum the identification of the Personnel participating in the training, the subject matter of the training, the time and date of the training, the training materials used, and any other relevant information.

The Compliance Officer evaluates the content of the training program at least annually to ensure that the subject content is appropriate and sufficient to cover the range of issues confronting the District's employees. The training program is modified as necessary to keep up-to-date with any changes in federal and state health care program requirements, and to address results of the District's audits and investigations; results from previous training and education programs; trends in Hotline reports; and guidance from applicable federal and state agencies. The appropriateness of the training format is evaluated by reviewing the length of the training sessions; whether training is delivered via live instructors or via computer-based training programs; the frequency of training sessions; and the need for general and specific training sessions.

The Compliance Officer seeks feedback to identify shortcomings in the training program, and administers post-training tests as appropriate to ensure attendees understand and retain the subject matter delivered.

Specific training for appropriate corporate officers, managers, and other employees may include areas such as:

- Restrictions on marketing activities.
- General prohibitions on paying or receiving remuneration to induce referrals.
- Proper claims processing techniques.
- Monitoring of compliance with this Compliance Program.
- Methods for educating and training employees.
- Duty to report misconduct.

The members of the District's Governing Board will be provided with periodic training, not less than annually, on fraud and abuse laws and other compliance matters.

Attendance and participation in compliance training programs is a condition of continued employment. Failure to comply with training requirements will result in disciplinary action, including possible termination.

Adherence with the provisions of this Compliance Program, including training requirements, is a factor in the annual evaluation of each District employee. Where feasible, outside contractors will be afforded the opportunity to participate in, or be encouraged to develop their own, compliance training and educational programs to complement the District's standards of conduct and compliance policies. The Compliance Officer will ensure that records of compliance training, including attendance logs and copies of materials distributed at training sessions, are maintained.

The compliance training described in this program is in addition to any periodic professional education courses that may be required by statute or regulation for certain Personnel. The District expects its employees to comply with applicable education requirements; failure to do so may result in disciplinary action.

Lines of Communicating and Reporting

Open Door Policy

The District recognizes that clear and open lines of communication between the Compliance Officer and District Personnel are important to the success of this Compliance Program. The District maintains an open door policy in regards to all Compliance Program related matters. District Personnel are encouraged to seek clarification from the Compliance Officer in the event of any confusion or question about a statute, regulation, or policy discussed in this Compliance Program.

Submitting Questions or Complaints

The District has established a telephone hotline for use by District Personnel to report concerns or possible

wrongdoing regarding compliance issues. We refer to this telephone line as our "Compliance Confidential Report Line."

The Compliance Confidential Report Line contact number is:

Phone: 1-888-200-9764

Personnel may also submit compliance-related questions or complaints in writing. Letters may be sent anonymously. All such letters should be sent to the Compliance Officer at the following address:

Compliance Officer
Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, CA 93514

The Compliance Confidential Report Line number and the Compliance Officer's contact information are posted in conspicuous locations throughout the District's facilities.

All calls to the Compliance Confidential Report Line are treated confidentially and are not traced. The caller need not provide his or her name. The District's Compliance Officer or designee investigates all calls and letters and initiates follow-up actions as appropriate.

Communications via the Compliance Confidential Report Line and letters mailed to the Compliance Officer are treated as privileged to the extent permitted by applicable law; however, it is possible that the identity of a person making a report may become known, or that governmental authorities or a court may compel disclosure of the name of the reporting person.

Matters reported through the Compliance Confidential Report Line or in writing that suggest violations of compliance policies, statutes, or regulations are documented and investigated promptly. A log is maintained by the Compliance Officer of calls or communications, including the nature of any investigation and subsequent results. A summary of this information is included in reports by the Compliance Officer to the District's Governing Board and Chief Executive Officer.

Non-Retaliation Policy
It is the District's policy to prohibit retaliatory action against any person for making a report, anonymous or otherwise, regarding compliance. However, District Personnel cannot use complaints to the Compliance Officer to insulate themselves from the consequences of their own wrongdoing or misconduct. False or deceptive reports may be grounds for termination. It will be considered a mitigating factor if a person makes a forthright disclosure of an error or violation of this Compliance Program, or the governing statutes and regulations.

Enforcing Standards and Policies

Policies
It is the policy of the District to use appropriate corrective action with District Personnel who fail to comply with the Code of Conduct or the policies set forth in, or adopted pursuant to, this Compliance Program or any federal or state statutes or regulations.

The guiding principles underlying this policy include the following:

- Intentional or reckless noncompliance will subject Personnel to significant sanctions, which may include oral warnings, suspension, or termination of employment, depending upon the nature and extent of the noncompliance.
- Negligent failure to comply with the policies set forth in this Compliance Program, or with

applicable laws, will also result in sanctions.

- Corrective action will be taken where a responsible employee fails to detect a violation, if this failure is attributable to his or her negligence or reckless conduct.
- Internal audit or review may lead to discovering violations and result in corrective action.

Because the District takes compliance seriously, the District will respond to Personnel misconduct.

Corrective Action Procedures

Employees found to have violated any provision of this Compliance Program are subject to discipline consistent with the policies set forth herein, including termination of employment if deemed appropriate by the District. Any such discipline is within the sole discretion of the District. Each instance involving disciplinary action shall be thoroughly documented by the employee's supervisor and the Compliance Officer.

Upon determining that an employee of the District or any of its affiliates has committed a violation of this Compliance Program, such employee shall meet with his or her supervisor to review the conduct that resulted in violation of the Compliance Program. The employee and supervisor will contact the Compliance Officer to discuss any actions that may be taken to remedy such violation. All employees are expected to cooperate fully with the Compliance Officer during the investigation of the violation. The Chief of Human Resources, Compliance Officer, or Chief Executive Officer may consult legal counsel prior to final actions or disciplinary measures, as appropriate.

Auditing and Monitoring

The District conducts periodic monitoring of this Compliance Program. Compliance reports created by this monitoring, including reports of suspected noncompliance, will be reviewed and maintained by the Compliance Officer.

The Compliance Officer will develop and implement an audit plan. The plan will be reviewed at least annually to determine whether it addresses the proper areas of concern, considering, for example, findings from previous years' audits, risk areas identified as part of the annual risk assessment, and high volume services.

Periodic compliance audits are used to promote and ensure compliance. These audits are performed by internal or external auditors who have the appropriate qualifications and expertise in federal and state health care statutes and regulations and federal health care program requirements. The audits will focus on specific programs or departments of the District, including external relationships with third-party contractors. These audits are designed to address, at a minimum, compliance with laws governing kickback arrangements, physician self-referrals, claims development and submission (including an assessment of the District's billing system), reimbursement, and marketing. All Personnel are expected to cooperate fully with auditors during this process by providing information, answering questions, etc. If any employee has concerns regarding the scope or manner of an audit, the employee should discuss this with his or her immediate supervisor.

The District shall conduct periodic reviews, including unscheduled reviews, to determine whether the elements of this Compliance Program have been satisfied. Appropriate modifications to the Compliance Program will be implemented when monitoring discloses that compliance issues have not been detected in a timely manner due to Compliance Program deficiencies.

The periodic review process may include the following techniques:

- Interviews with Personnel involved in management, operations, claim development and submission, and other related activities.
- Questionnaires developed to solicit impressions of the District Personnel.

- Reviews of all billing documentation, including medical and financial records and other source documents, that support claims for reimbursement and claims submissions.
- Presentations of a written report on compliance activities to the Compliance Officer. The report shall specifically identify areas, if any, where corrective actions are needed. In certain cases, subsequent reviews or studies may be conducted to ensure that recommended corrective actions have been successfully implemented.

Error rates shall be evaluated and compared to error rates for prior periods as well as available norms. If the error rates are not decreasing, the District shall conduct a further investigation into other aspects of the Compliance Program in an effort to determine hidden weaknesses and deficiencies.

Corrective Action

Violations and Investigations

Violations of this Compliance Program, failure to comply with applicable federal or state laws, and other types of misconduct threaten the District's status as a reliable and honest provider of health care services. Detected but uncorrected misconduct can seriously endanger the District's business and reputation, and can lead to serious sanctions against the District. Consequently, upon reports or reasonable indications of suspected noncompliance, prompt steps to investigate the conduct in question will be initiated under the direction and control of the Compliance Officer to determine whether a material violation of applicable law or the requirements of the Compliance Program has occurred. The Compliance Officer may create a response team to review suspected noncompliance including representatives from the compliance, audit and other relevant departments.

If such a violation has occurred, prompt steps will be taken to correct the problem, taking into account the root cause of the problem. As appropriate, such steps may include an immediate referral to criminal and/or civil law enforcement authorities, a corrective action plan, a report to the Office of Inspector General (OIG) or any other appropriate government organization, and/or submission of any overpayments. The specific steps that are appropriate in any given case will be determined after consultation between the Chief Executive Officer or Compliance Officer and legal counsel.

Depending upon the nature of the alleged violations, the Compliance Officer's internal investigation could include interviews with relevant Personnel and a review of relevant documents. Legal counsel, auditors or health care experts may be engaged by the Compliance Officer to assist in an investigation where the Compliance Officer deems such assistance appropriate. Complete records of all investigations will be maintained which contain documentation of the alleged violations, a description of the investigative process, copies of interview notes and key documents, a log of the witnesses interviewed and the documents reviewed, results of the investigation (e.g., any disciplinary action taken), and corrective actions implemented.

If an investigation of an alleged violation is undertaken and the Compliance Officer believes the integrity of the investigation may be at stake because of the presence of employees under investigation, those employees will be removed from their current work activity until the investigation is completed. Where necessary, the Compliance Officer will take appropriate steps to secure or prevent the destruction of documents or other evidence relevant to the investigation.

Reporting

If the Compliance Officer or a management official discovers credible evidence of misconduct from any source and, after reasonable inquiry, has reason to believe that the misconduct may violate criminal, civil, or administrative law, then the misconduct will promptly be reported as appropriate to the OIG or any other appropriate governmental authority or federal and/or state law enforcement agency having jurisdiction over such matter. Such reports will be made by the Compliance Officer on a timely basis.

All overpayments identified by the District shall be promptly disclosed and/or refunded to the appropriate

public or private payer or other entity.

SECTION IV – COMPLIANCE POLICIES

The District electronic policy management system houses NIHD Compliance Policies. Some of these policies may not apply to your specific job function, but it is still important that you are aware of their existence and importance. All Personnel will receive training regarding the policies that apply to their job.

REFERENCES:

1. Supplemental Compliance Program Guidance for Hospitals (70 Fed. Reg. 4858; January 31, 2005)
2. Compliance Program Guidance for Hospitals (63 Fed. Reg. 8987; February 23, 1998)

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Authority of the Chief Executive Officer for Contracts and Bidding
2. Business Associate Agreements Execution and Management
3. California Public Records Act – Information Requests
4. Communicating Protected Health Information via Electronic Mail (Email)
5. Disclosures of Protected Health Information Over the Telephone
6. Disposal of Equipment
7. Electronic Communication (Email) Acceptable Use Policy
8. False Claims Act Employee Training and Prevention Policy
9. Family Member and Relatives in the Workplace
10. Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information
11. Language Access Services Policy
12. NIHD Code of Business Ethics and Conduct
13. Non-Retaliation Policy
14. Nondiscrimination Policy
15. Patient Rights
16. Pricing Transparency Policy
17. Purchasing Signature Authority
18. Equal Employment Opportunity
19. Sanctions for Breach of Patient Privacy Policies
20. Sending Protected Health Information via Fax
21. Using and Disclosing Protected Health Information for Treatment, Payment and HealthCare Operations
22. Vendor Credentialing
23. Workforce Access to His or Her Own Protected Health Information
24. Workforce Investigations
25. InQuiseek – #100 Regulatory Compliance Policy
26. InQuiseek - #105 Formal Corporate or Organization Compliance Plan Policy