Northern Inyo Healthcare District

Board Meetings

September 18, 2024 Regular Board Meeting

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AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OOF DIRECTORS REGULAR MEETING

September 18, 2024 at 5:30 p.m.
Northern Inyo Healthcare District invites you to join this meeting:

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

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

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

Board Member, David Barrett McCoy, 77 Box Street Brooklyn, NY 11222

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

c. Resolutions
    i. 24 -04 Resolution for appropriations *(Action Item)*
    ii. 24-05 Authorization of Operations Accounts *(Action Item)*
    iii. 24-06 Resolution Approving Certain Deposits and Investments *(Action Item)*
    iv. 24-07 New Named Fiduciaries for the NICLHD plans *(Action Item)*
d. Chief Executive Officer Report *(Board will receive this report)*
    i. Position Recruitment *(Information Item)*
    ii. Strategic Plan *(Information Item)*
e. Chief Financial Officer Report
    i. Financial & Statistical Reports *(Board will consider the approval of these reports)*
    ii. Recruitment for Revenue Cycle Director *(Information Item)*
    iii. Preparations for audit and cost report *(Information Item)*
f. Chief Medical Officer Report
g. Chief of Staff Report, Sierra Bourne MD
    i. Medical Executive Committee Meeting Report *(information item)*

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4. Consent Agenda – All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.
    a. Approval of minutes of the August 21, 2024 Regular Board Meeting
    b. Approval of minutes of the August 28, 2024 Special Board Meeting
    c. CEO Credit Card Statements
    d. Department Leader Updates
    e. Approval of Policies and Procedures
        i. Designated areas for food and drink near patient care areas
        ii. Final payroll check
        iii. Guarantor verification procedure
        iv. Infection control risk assessment
        v. Infection prevention pan
        vi. Learning Internships Clinical or Academic Rotations and Career Shadowing Opportunities
        vii. License employees and continuing education

viii. Musculoskeletal injury prevention plan
ix. NIHD recruitment and selection
x. NIHD dress code
xi. Provider preformed microscopy competency
xii. Temporary telecommuting assignment policy
xiii. Wages – pay scale and pay adjustments
xiv. Waste anesthetic gases-trace gas testing

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5. General Information from Board Members *(Board will provide this information)*
6. Public comments on closed session items
7. Adjournment to closed session to/for:
    a. Public Employee Performance Evaluation pursuant to Government Code Section 54957(b)(1).
        Title: CEO Evaluation
8. Return to open session and report on any actions taken in closed session
9. Adjournment

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

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

Date: September 6, 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 with insight into NIHD's compliance with the NIHD Compliance Program.

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 HIGHLIGHTS

- June-July: approximately 450 audits were completed to ensure appropriate access to patient records (work-related, minimum necessary, need-to-know), five audits required additional follow up, and only one access was inappropriate. Investigation, education, and disciplinary action were completed, as appropriate.

- NIHD has reported five privacy breaches to California Department of Public Health (CDPH) through the end of August 2024.

- CDPH Medical Breach Enforcement Section has assigned a $45,000 administrative penalty to NIHD. We are appealing the penalty.

- Centers for Medicare and Medicaid Services has notified NIHD that our price transparency website is out of compliance with the Price Transparency Rules. We are in the process of creating a corrective action plan.

- An unusual occurrence is an event that is not within our "usual" actions or outcomes. Those are reported through the unusual occurrence reporting system. The Compliance team processed 347 unusual occurrence reports (UORs) through August CY2024. Some of the "take-away" points for NIHD and the patients we serve:

    - We provide responses to patient complaints and concerns within 7 days 100% of the time.
    - 100% of alleged privacy breaches were reported to California Department of Public Health, Office of Civil Rights, and the affected patient(s) within 15 days of discovery.

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

- The Compliance team provided additional privacy education and training to the Rural Health Clinic 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.

- NIHD clinical teams have moved to using Cyracom Interpreter Services as a first choice, saving the District approximately $8,000, since the beginning of July 2024, with no change in service. NIHD has provided 60,059 minutes of interpretation services (via phone or video unit) for $67,791. This service is a federal requirement and is one of many required services for which there is no reimbursement from patients, insurances, or state and federal governments.

- With the help of Lynda Vance, Compliance has completely updated the process of collecting conflict of interest data from the workforce. The time to complete the form has dropped to under a minute for all District workforce. Additionally, the streamlined workflow has cut the time the Compliance department spends on this mandatory data collection by about 85%, saving the District of $25,000.

- The SAFER electronic health record annual assessment has been completed for 2024. This is required for the Quality Department to submit the MIPS data that improves public health and will garner several million dollars for NIHD.

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Quarterly Compliance Report –Q3 2024
Sept 6, 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 April through July activity
      a. New Employee Audits: 53
         I. Flags: 1
         II. Flags resulting in policy violations: 0
      b. For Cause Audits: 5
         I. Flags: 0
         II. Flags resulting in policy violations: 0
         III. Flags resulting in disciplinary action: 0
      c. In "own" chart flags: 13
         I. Flags resulting in policy violations: 4
            i. Provided education and training: 4

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ii. Repeat violations: 0

d. Same Last Name Search Flags: 313
   I. Resulted in follow up with employee: 0
   II. Flags resulting in policy violations: 0

e. 3rd Party Vendors (ex. Our billing or coding company): 68
   I. Flags: 0
   II. Flags resulting in policy violations: 0

f. High Profile Persons: 1
   I. Flags: 0
   II. Flags resulting in policy violations: 0

B. Business Associates Agreements (BAA) audit
   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.
   ii. NIHD BAAs need to be reviewed for current regulatory terms. Some BAAs are many years old, and need to be renegotiated in the current cybersecurity risk environment.

C. Compliance Department Contract and Agreement reviews/audit
   i. Documents processed for CY 24 (through August)
      a. 143 Agreements, Amendments or Termination Notices have been completed.
      b. ~35 are currently in progress

D. HIMs (Health Information Management) scanning audit
   i. To be conducted by HIMS and summary reports will be sent to Compliance
   ii. No reports received in June/July

E. Email security audit/reviews
   i. Reviewed at least once a month
   ii. Review email security systems for violations of data loss prevention rules

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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.

F. Language Access Services Audit
   i. Interpretive (spoken word) services are provided via telephone and video interpreting units from third parties, CyraCom and Language Line.
      a. Q3 - NIHD has provided a total of 60,059 minutes of interpreting services to our patients at a cost to the District of $67,791.48. (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 (July/Aug) – 0.94
         II. CY24 Q2 average price per minute - $1.197
         III. CY24 Q1 average price per minute – $1.197
      d. Actual Savings since June - $7,950.58
   ii. Translation services (written word) services are provided via Language Line Translation Services.
   iii. NIHD provided services in the following languages in 2024
      a. Spanish (21 countries claim Spanish as an official language),
      b. American Sign Language,
      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

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iv. Laws require providing language access services to all limited English proficiency patients at no cost to the patient.
v. 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 completed 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
   i. More than 350 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

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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 quarterly.
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.
iii. Collectively in 2024, NIHD employees have read 98.2% of assigned Compliance and Privacy policies.
iv. Information Technology, Human Resources, and Compliance are currently (June 2024) conducting a review of job roles, assigned titles and groups in Policy Manager to ensure all employees receive all policies that should be assigned to them. We are also ensuring that we are not assigning policies that are not relevant to the role with the District.
   a. This helps lower costs for the District.

2. **HIPAA Security Risk Assessment (SRA)** – Due in October 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 June 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 via Smartsheet, unless there is disagreement. Once a determination is made for a

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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 340 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 August 31, 2024

i. Reported to Compliance – 22
ii. Reported to CDPH/OCR – 5
iii. Investigations still active in the Compliance Department - 2
iv. Investigations closed by the Compliance Department with no reporting required - 17

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

I. Reported – 10

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i. 4 are closed

b. Privacy investigations from 2022
   I. Reported – 6
      i. 2 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. The fine is assessed to NIHD for "failure to prevent unauthorized access" and "failure to notify CDPH and the patients in a timely manner."
         3. Compliance is working with legal counsel to appeal the decision. We believe that CDPH and the patients were notified in a timely manner in compliance with California state laws.

c. Privacy investigations from 2021
   I. Reported – 4
      i. 3 are closed
   II. CDPH changed their reporting requirements to more closely mirror federal regulations, which explains the significant drop in the number of reportable cases.

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

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ii. We received notification on September 6, 2024 that one of the two outstanding cases is closed. The findings were substantiated with no deficiency.

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.
   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 30 investigations through August 2024 including, but not limited to, the following:
   i. California Department of Labor, Department of Industrial Relations

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a. Response to investigation regarding California Labor Code, Division 2, Part 7 relating to a contractor participating in the Pharmacy/Infusion Construction Project.
b. In progress

ii. Health and Human Services Office of Inspector General
a. Compliance and legal counsel (Best Best & Kreiger) submitted a nearly 700-page document containing all NIHD responses and associated documentation for the breach by our Business Associate, 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 ~$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. 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 48 subpoenas for records or appearances through 05/31/2024.

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.

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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.

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.

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. All forms and public information documents used at the District for patient care, regulatory requirements, orders, down-time documentation, standardized workflows, and process improvement are submitted to the Forms Committee. Once approved they are maintained in a location on the NIHD Intranet (a quick link named "Approved Forms") for access by NIHD workforce.
   iii. The team will begin requesting postings and signage to be approved through the Forms Committee, as there is problem with "signage fatigue," inconsistency, failure to meet Affordable Care Act Section 1557 standards, failure to use consistent District branding, and failure to obtain appropriate translations.
   iv. 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.
   v. One meeting has been held in 2024. District reorganization has slowed the Forms development and approval process.

9. Issues and Prevention

A. Compliance researched over 65 issues for the District in 2024. They include adolescent privacy regulations; billing issues, sentinel event reporting, Substance Abuse and Mental Health Services Administration (SAMHSA) regulations, confidentiality issues, release of information and information blocking regulations, regulatory updates, mandatory reporting, regulatory issues, and many other areas of

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interest and concern. The compliance team takes a proactive approach for all issues brought to our attention.

B. NIHD has been notified by CMS (Centers for Medicare/Medicaid Services) that we are out of compliance with Price Transparency regulations. Compliance and the Executive team are supporting the Business Office Manager with the corrective action plan, which will need to be submitted in September, and completed by mid-November. If these deadlines are not met, there is potential for administrative penalties.

10. CPRA (California Public Records Act) Requests

A. Compliance has received nine (9) CPRA thus far in CY 2024.
   i. Seven completed timely.
   ii. Two in progress

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:
   i. NIHD has approximately 1155 policies and procedures.
   ii. 619 documents are due for review.
      a. 235 are in the rewriting/review/approval workflow.
      b. 382 are waiting to be reviewed.
   iii. 330 policies and procedures had not been reviewed in over 3 years on June 5, 2024. This number has now dropped to 87 policies more than 3 years overdue.
   iv. 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.

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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 August 31, 2024, see attached
   i. Notable trends out of 225 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 85 of the 225 UORs (~25%).
         I. We are addressing some trending issues:
            i. Billing complaints – particularly wellness/annual visits
            ii. Specimen issues
      b. 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.
      c. Multiple systemic changes have been put into place based on action plans developed during UOR review and investigation.

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.
      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	Total
Language Line - Phone minutes provided	1,221	1,453	1,626	1,705	1,630	999	345	273	
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	
Language Line - Video - minutes provided	3,689	2,952	4,247	4,948	5,861	2,547	2,097	2,288	
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	
Cyracom - Phone - minutes provided	1,415	1,201	1,754	959	719	2,294	3,186	4,577	
Cyracom - Phone - Cost	$1,035.03	$855.15	$1,315.50	$616.65	$469.14	$1,720.50	$2,297.73	$3,183.48	
Cyracom - Video - minutes provided	154	142	232	77	243	1,692	1,689	1,844	
Cyracom - Video - Cost	$115.50	$106.50	$174.00	$57.75	$182.25	$1,269.00	$1,267.75	$1,389.50	
Total Minutes of interpretive services provided	**6479**	**5748**	**7859**	**7689**	**8453**	**7532**	**7317**	**8982**	**60059**
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**	**$67,791.48**
Translation									
Language Line Translation Services - Cost	$713.82	$0.00	$107.55	$210.23	$1,161.60		$99.00		**$2,292.20**
									$70,083.68

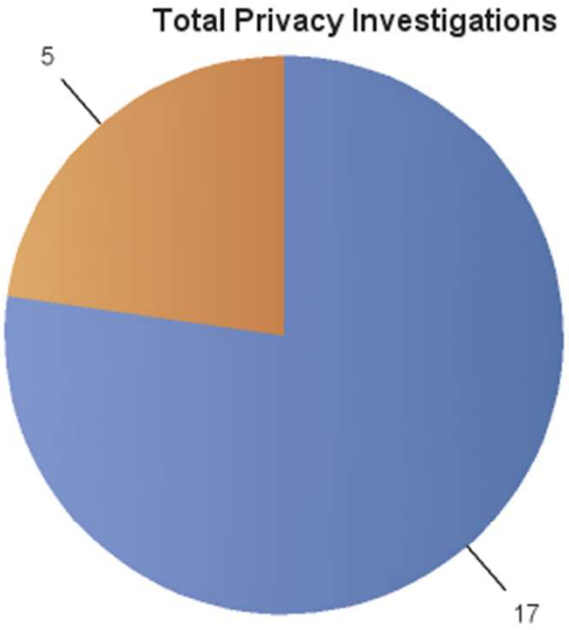
COMPLIANCE ANNUAL WORKPLAN - 2024

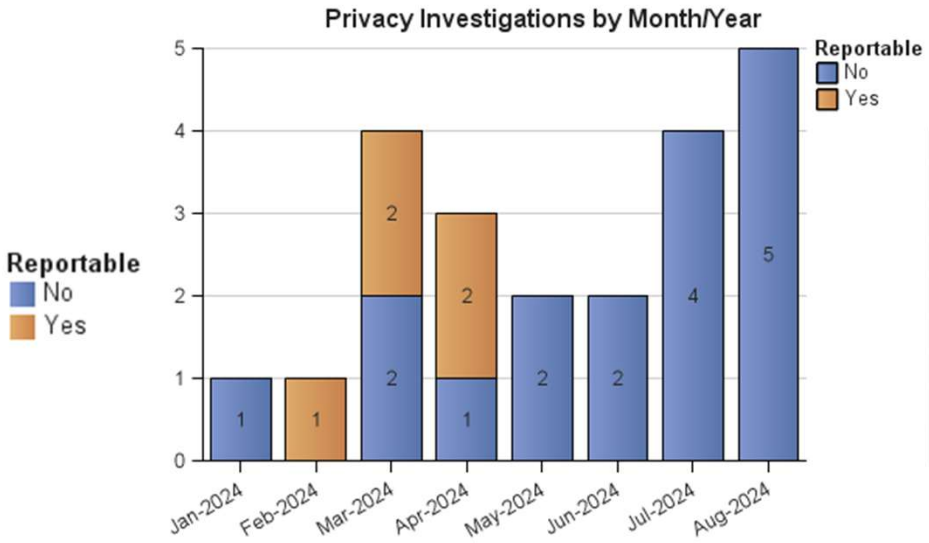
No.	Item	Reference	Comments
Compliance Oversight and Management			
1.	Review and update charters and policies related to the duties and responsibilities of the Compliance Committees.	NIHD Compliance Program (p.17)	Due Quarter 3 CY 2024
2.	Develop and deliver the annual briefing and training for the Board 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

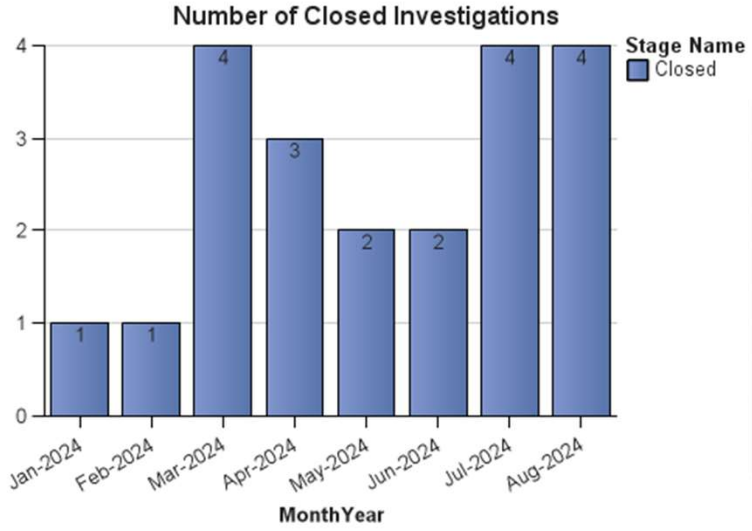
	c. Financial Audits	FY 2024	CLA Audit completed. Cost Report and audit completed.
	d. Payment patterns		Due quarter Q3 CY 2024
	e. Bad debt/ credit balances, AR days		Monitored weekly by Revenue Cycle and Business Office
	f. DME (Durable Medical Equipment)	HHS OIG target	NIHD may provide and charge for "off-the-shelf, non-customized" medical equipment. Chargemaster being updated. Review Q3 2024
	g. Lab services	MAC target	Deferred
	h. Imaging services (high cost/high usuage)	MAC target	Deferred
	i. Rehab services	HHS OIG workplan	Deferred
	j. 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
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		May 2024
	II. Workplace Violence		May 2024
	III. Falls		May 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 starting completing reported breach investigations from before 2021.

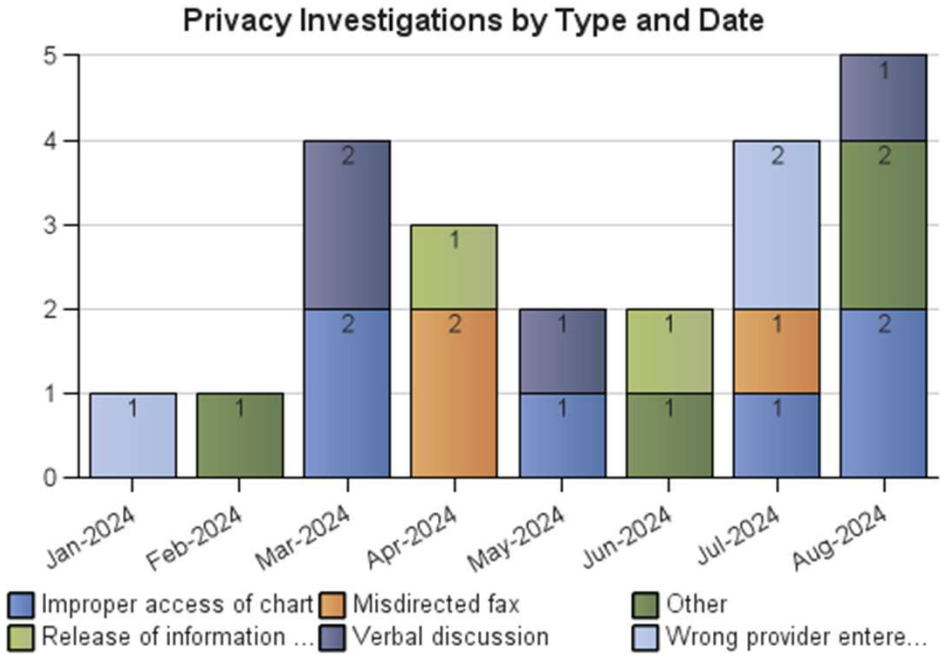




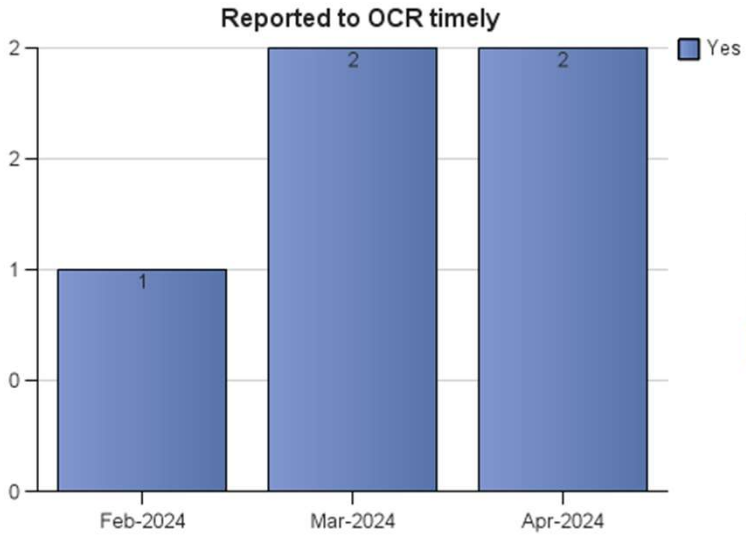
	No	Yes	Total
Jan-2024	1		1
Feb-2024		1	1
Mar-2024	2	2	4
Apr-2024	1	2	3
May-2024	2		2
Jun-2024	2		2
Jul-2024	4		4
Aug-2024	5		5
Total	**17**	**5**	**22**



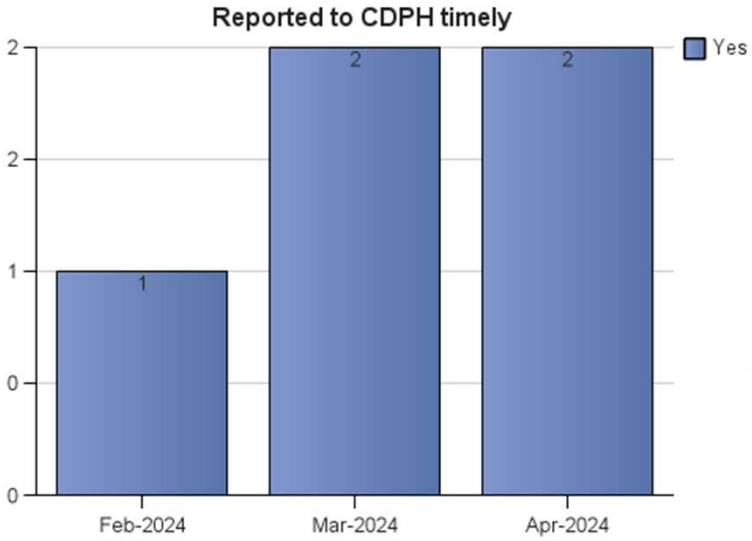
	Closed	Total
May-2024	2	2
Mar-2024	4	4
Jun-2024	2	2
Jul-2024	4	4
Jan-2024	1	1
Feb-2024	1	1
Aug-2024	4	4
Apr-2024	3	3
Total	**21**	**21**
Total	**21**	**21**



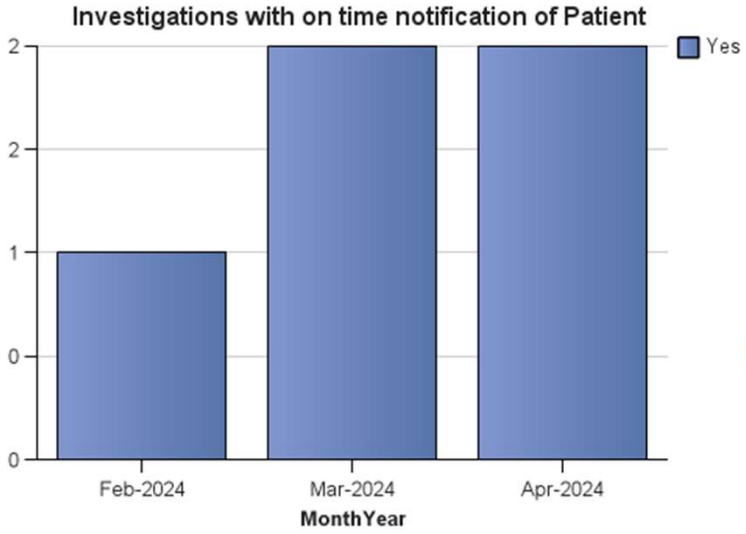
	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
Improper access of chart			2		1		1	2	**6**
Misdirected fax				2			1		**3**
Other		1				1		2	**4**
Release of information concern				1		1			**2**
Verbal discussion			2		1			1	**4**
Wrong provider entered/selected	1						2		**3**
Total	**1**	**1**	**4**	**3**	**2**	**2**	**4**	**5**	**22**



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

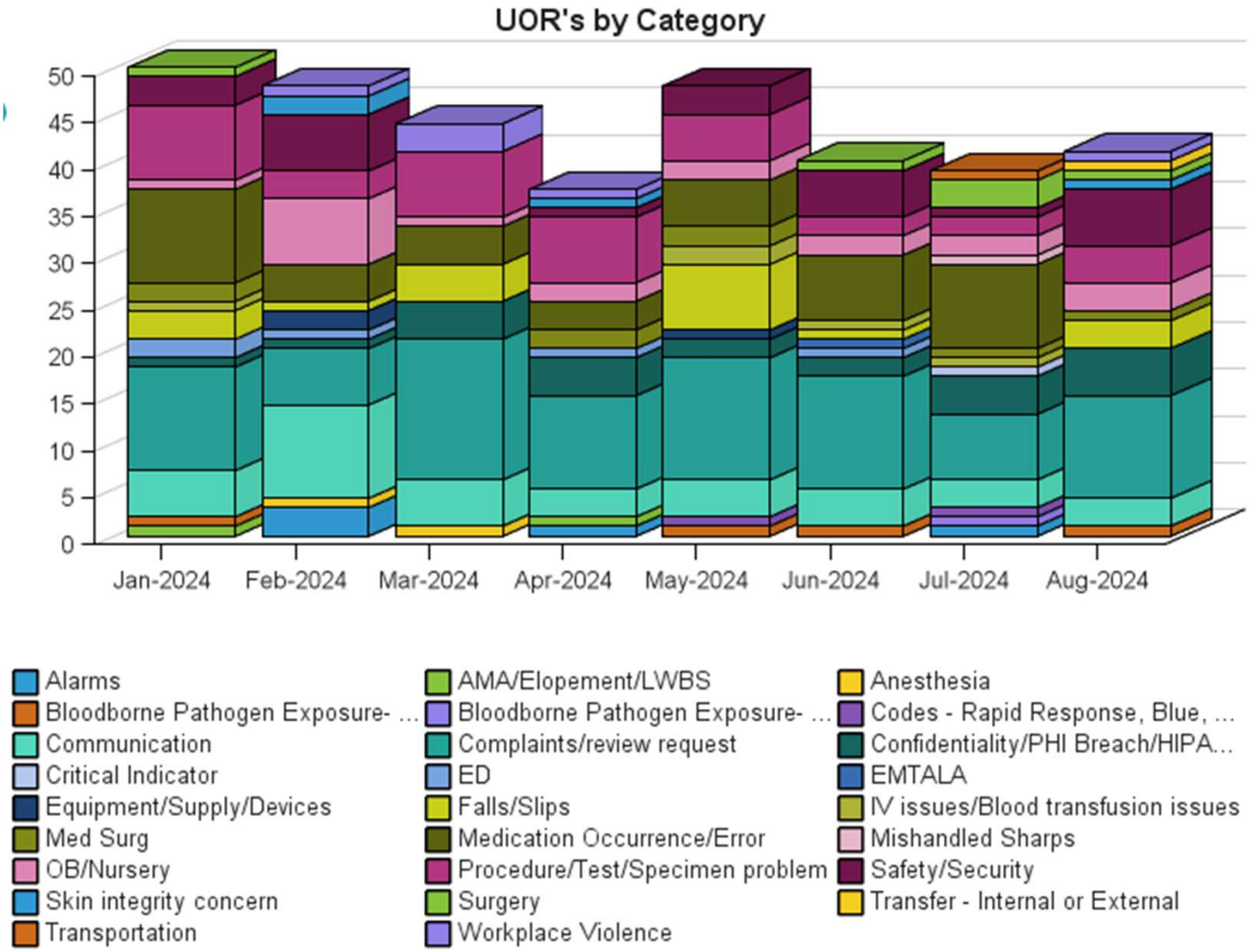


	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	2	2
Total	5	5



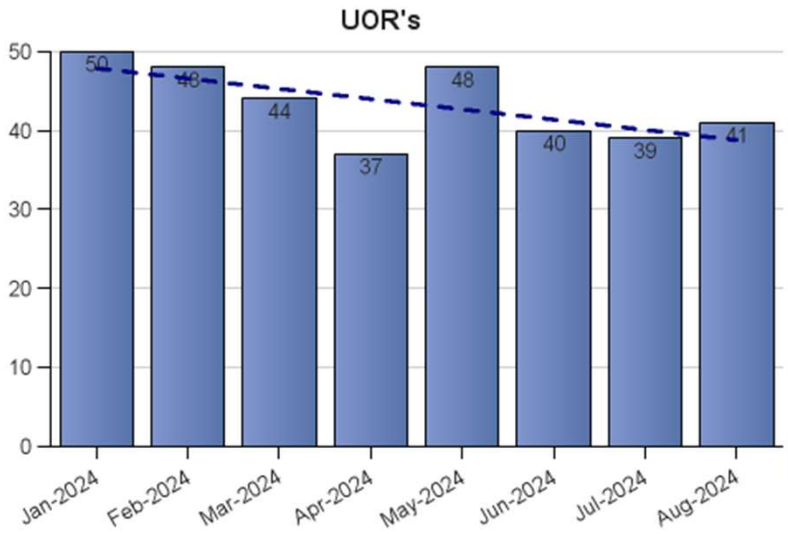
	Yes	Total
Feb-2024	1	1
Mar-2024	2	2
Apr-2024	2	2
Total	5	5

Calendar Year 2024
Unusual Occurrence Report (UOR) Data

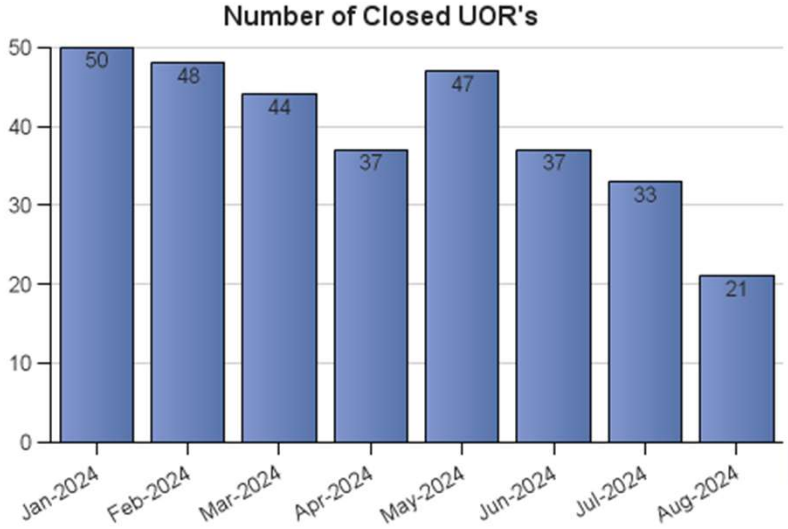

UOR's by Category
50
45
40
35
30
25
20
15
10
5
0
Jan-2024
Feb-2024
Mar-2024
Apr-2024
May-2024
Jun-2024
Jul-2024
Aug-2024
Alarms
AMA/Elopement/LWBS
Anesthesia
Bloodborne Pathogen Exposure- ...
Bloodborne Pathogen Exposure- ...
Codes - Rapid Response, Blue, ...
Communication
Complaints/review request
Confidentiality/PHI 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

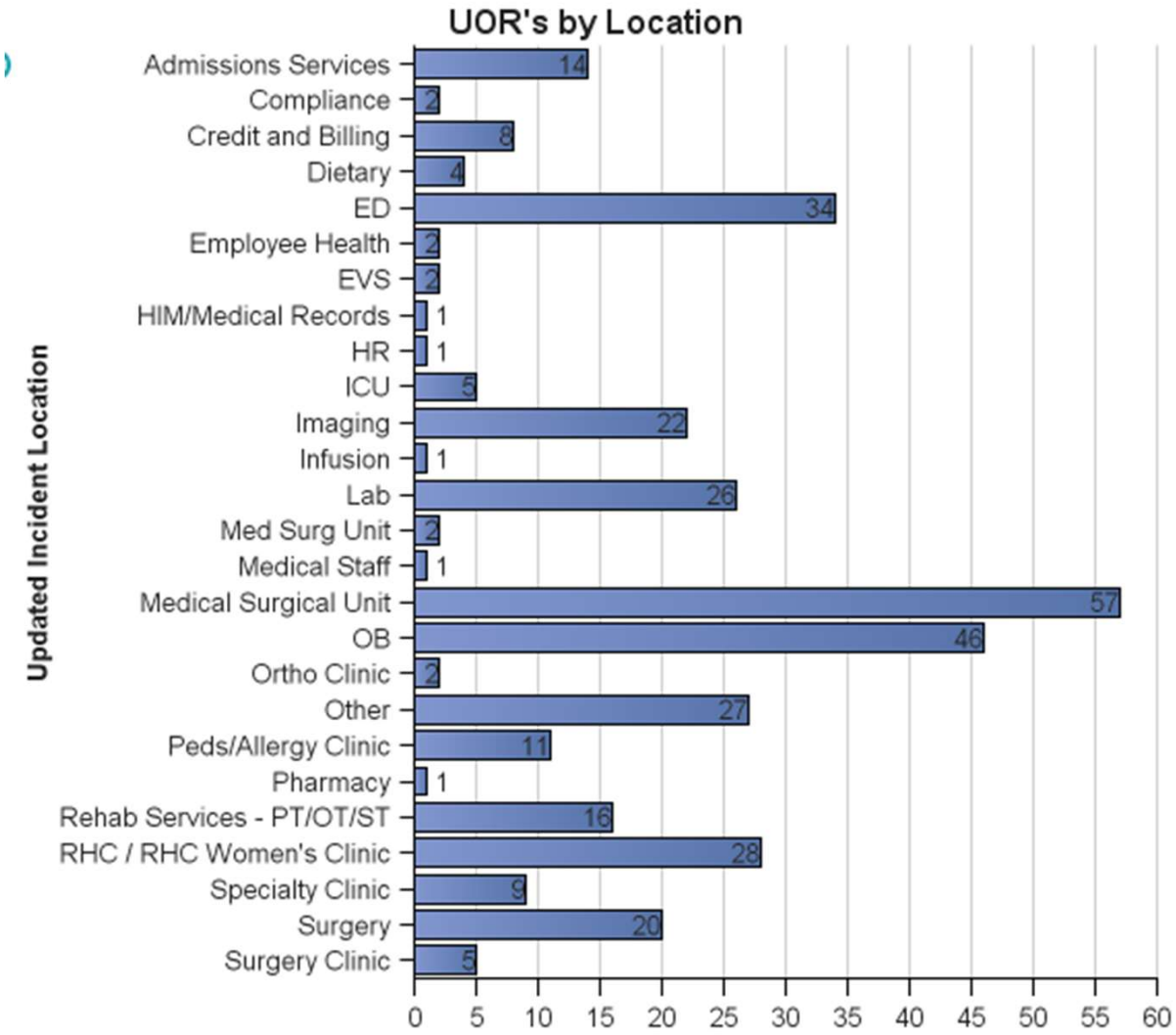
	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
Alarms		3		1			1		5
AMA/Elopement/LWBS	1			1					2
Anesthesia		1	1						2
Bloodborne Pathogen Exposure- Sharps Injury	1				1	1		1	4
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane							1		1
Codes - Rapid Response, Blue, Deescalation					1		1		2
Communication	5	10	5	3	4	4	3	3	37
Complaints/review request	11	6	15	10	13	12	7	11	85
Confidentiality/PHI Breach/HIPAA violation	1	1	4	4	2	2	4	5	23
Critical Indicator							1		1
ED	2	1		1		1			5
EMTALA						1			1
Equipment/Supply/Devices		2			1				3
Falls/Slips	3	1	4		7	1		3	19
IV issues/Blood transfusion issues	1				2	1	1		5
Med Surg	2			2	2		1	1	8
Medication Occurrence/Error	10	4	4	3	5	7	9		42
Mishandled Sharps							1		1
OB/Nursery	1	7	1	2	2	2	2	3	20
Procedure/Test/Specimen problem	8	3	7	7	5	2	2	4	38
Safety/Security	3	6		1	3	5	1	6	25
Skin integrity concern		2		1				1	4
Surgery	1					1	3	1	6
Transfer - Internal or External								1	1
Transportation							1		1
Workplace Violence		1	3	1				1	6
Total	**50**	**48**	**44**	**37**	**48**	**40**	**39**	**41**	**347**



Jan-2024	50
Feb-2024	48
Mar-2024	44
Apr-2024	37
May-2024	48
Jun-2024	40
Jul-2024	39
Aug-2024	41
Total	**347**



	Closed
Jan-2024	50
Feb-2024	48
Mar-2024	44
Apr-2024	37
May-2024	47
Jun-2024	37
Jul-2024	33
Aug-2024	21
Total	**317**

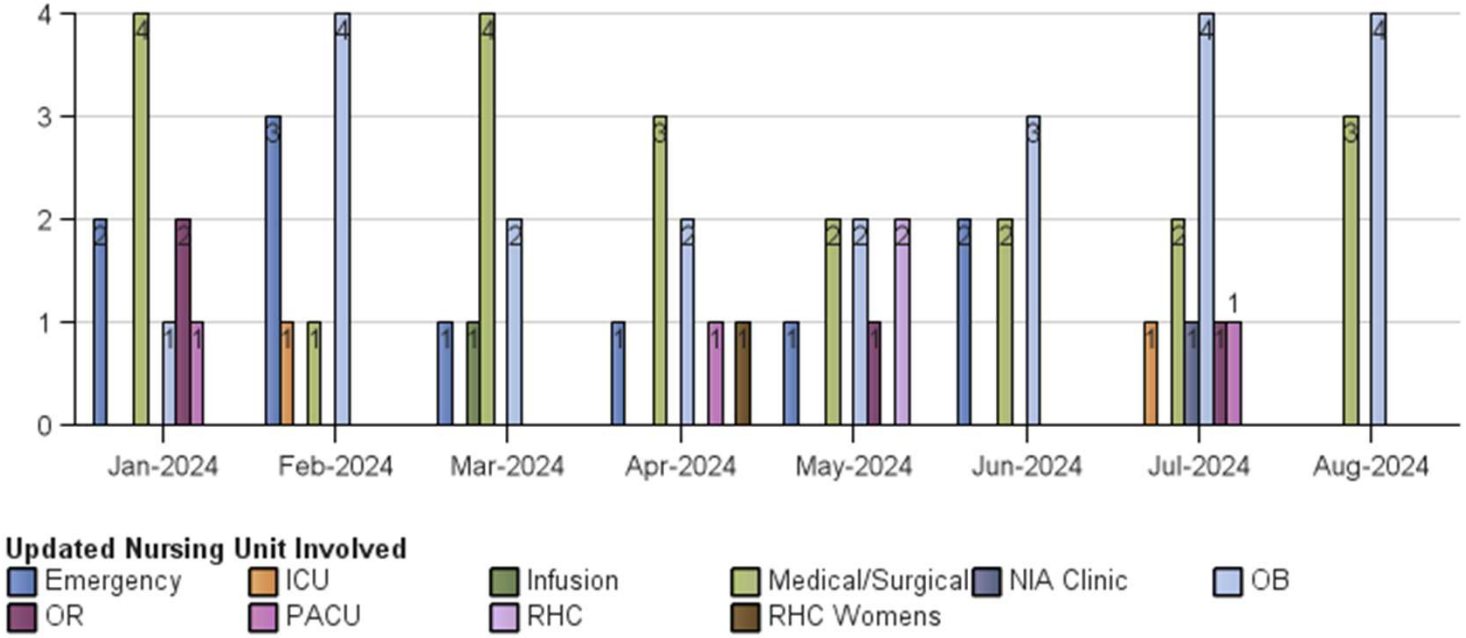

UOR's by Location
Updated Incident Location
Admissions Services 14
Compliance 2
Credit and Billing 8
Dietary 4
ED 34
Employee Health 2
EVS 2
HIM/Medical Records 1
HR 1
ICU 5
Imaging 22
Infusion 1
Lab 26
Med Surg Unit 2
Medical Staff 1
Medical Surgical Unit 57
OB 46
Ortho Clinic 2
Other 27
Peds/Allergy Clinic 11
Pharmacy 1
Rehab Services - PT/OT/ST 16
RHC / RHC Women's Clinic 28
Specialty Clinic 9
Surgery 20
Surgery Clinic 5
0 5 10 15 20 25 30 35 40 45 50 55 60

Data for previous slide

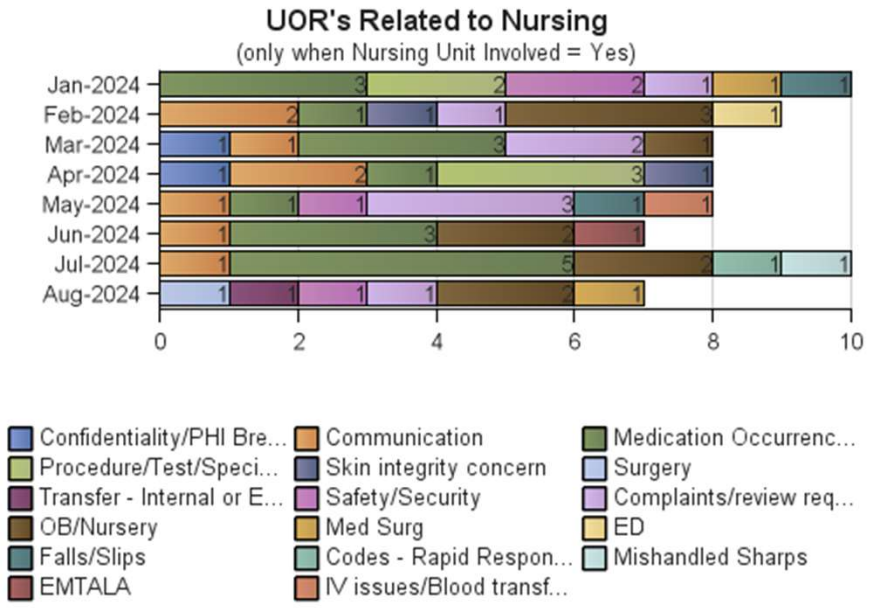
Admissions Services	14
Compliance	2
Credit and Billing	8
Dietary	4
ED	34
Employee Health	2
EVS	2
HIM/Medical Records	1
HR	1
ICU	5
Imaging	22
Infusion	1
Lab	26
Med Surg Unit	2
Medical Staff	1
Medical Surgical Unit	57
OB	46
Ortho Clinic	2
Other	27
Peds/Allergy Clinic	11
Pharmacy	1
Rehab Services - PT/OT/ST	16
RHC / RHC Women's Clinic	28
Specialty Clinic	9
Surgery	20
Surgery Clinic	5
Total	**347**

UOR's Related to Nursing by Nursing Unit Involved

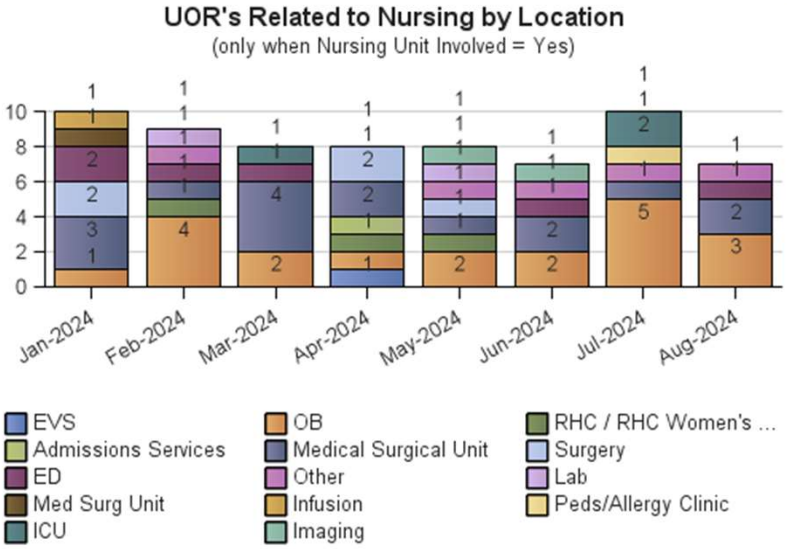
(only when Nursing Unit Involved = Yes)



	Yes
Emergency	10
ICU	2
Infusion	1
Medical/Surgical	21
NIA Clinic	1
OB	22
OR	4
PACU	3
RHC	2
RHC Womens	1
Total	**67**

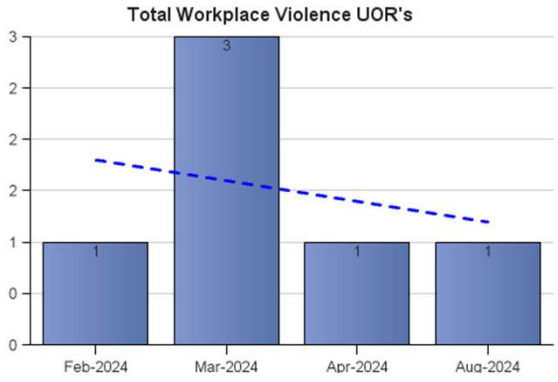


	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
Confidentiality/PHI Breach/HIPAA violation			1	1					**2**
Communication		2	1	2	1	1	1		**8**
Medication Occurrence/Error	3	1	3	1	1	3	5		**17**
Procedure/Test/Specimen problem	2			3					**5**
Skin integrity concern		1		1					**2**
Surgery								1	**1**
Transfer - Internal or External								1	**1**
Safety/Security	2				1			1	**4**
Complaints/review request	1	1	2		3			1	**8**
OB/Nursery		3	1			2	2	2	**10**
Med Surg	1							1	**2**
ED		1							**1**
Falls/Slips	1				1				**2**
Codes - Rapid Response, Blue, Deescalation							1		**1**
Mishandled Sharps							1		**1**
EMTALA						1			**1**
IV issues/Blood transfusion issues					1				**1**
Total	**10**	**9**	**8**	**8**	**8**	**7**	**10**	**7**	**67**

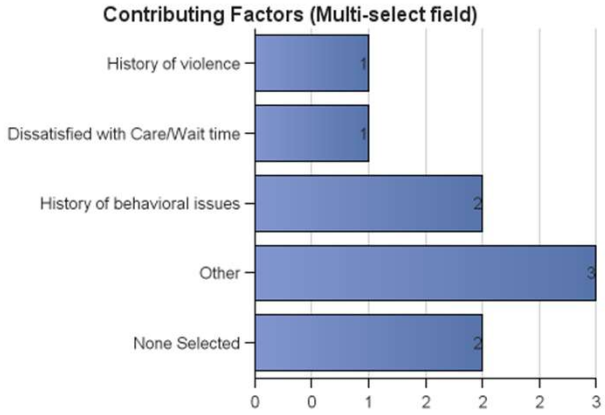


	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
EVS				1					**1**
OB	1	4	2	1	2	2	5	3	**20**
RHC / RHC Women's Clinic		1		1	1				**3**
Admissions Services				1					**1**
Medical Surgical Unit	3	1	4	2	1	2	1	2	**16**
Surgery	2			2	1				**5**
ED	2	1	1			1		1	**6**
Other		1			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**

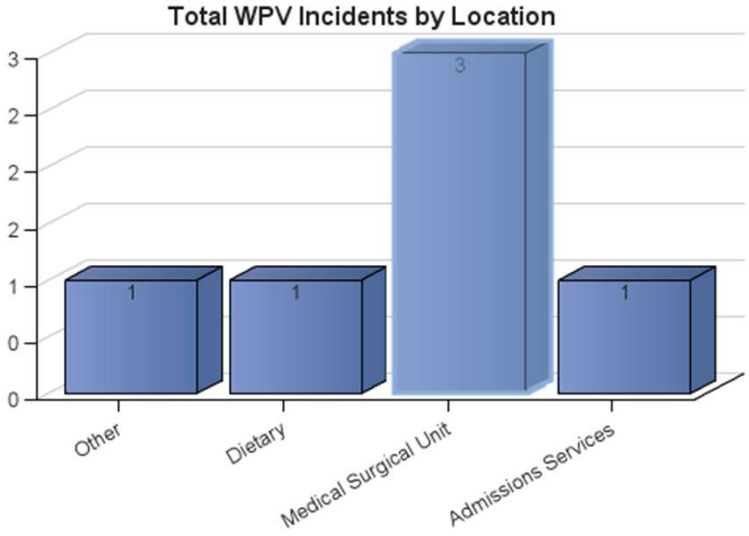
WORKPLACE VIOLENCE



	Feb-2024	Mar-2024	Apr-2024	Aug-2024	Total
Workplace Violence	1	3	1	1	6
Total	**1**	**3**	**1**	**1**	**6**

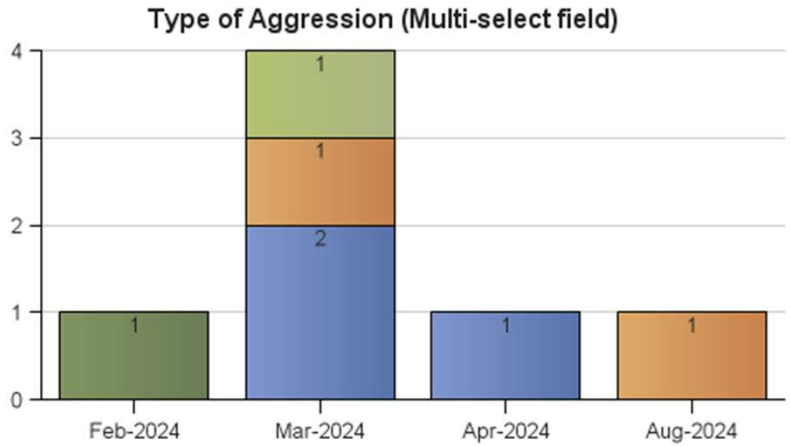


None Selected	2
Dissatisfied with Care/Wait time	1
History of behavioral issues	2
History of violence	1
Other	2
Total	**8**



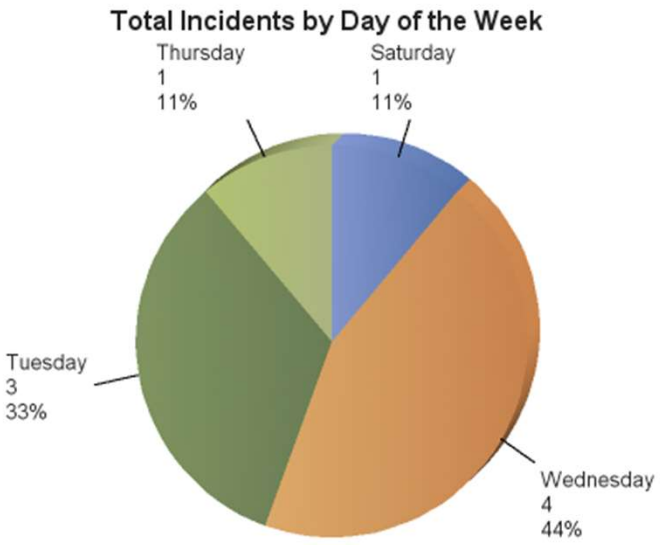
Other	1
Dietary	1
Medical Surgical Unit	3
Admissions Services	1
Total	**6**

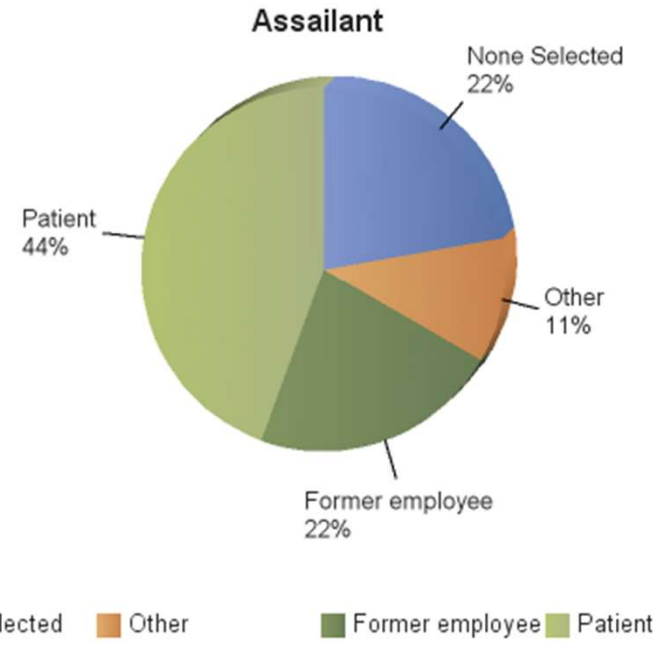
WORKPLACE VIOLENCE

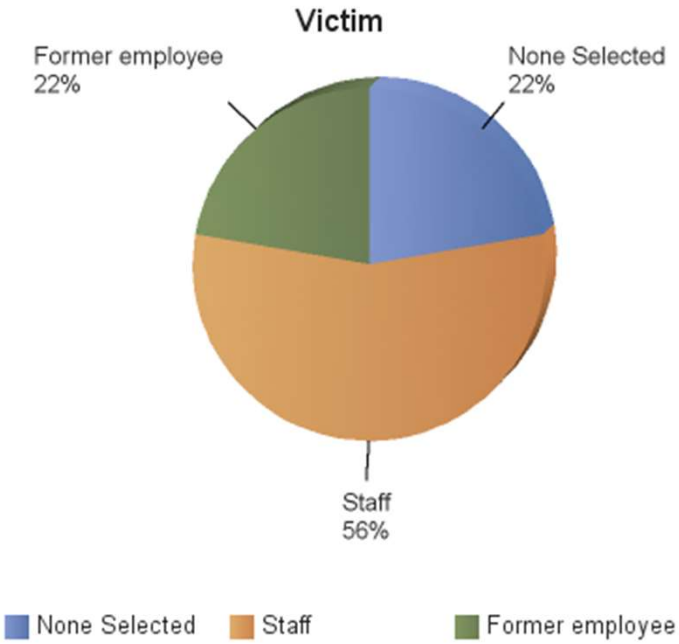


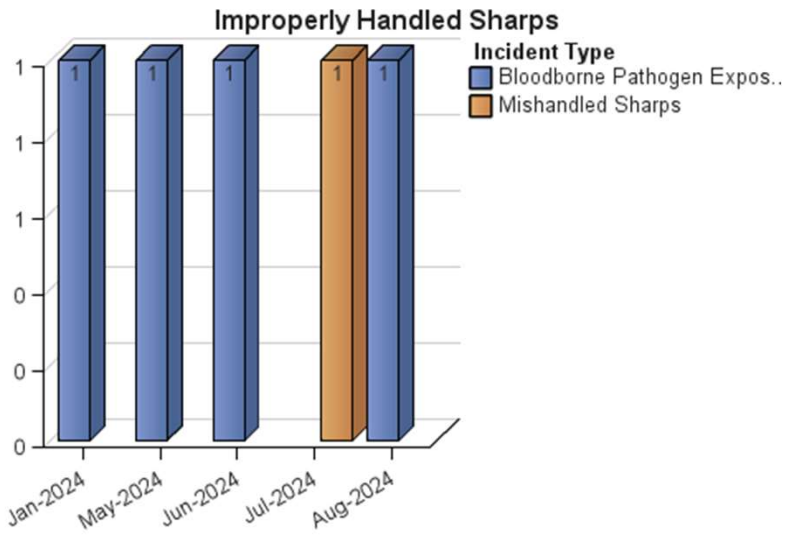
	Feb-2024	Mar-2024	Apr-2024	Aug-2024	Total
Verbal abuse		2	1		3
None Selected		1		1	2
Physical attack (biting, choking, grabbing, hair pulling, kicking, punching/slapping, scratching, spitting, striking, etc)	1				1
Threat or the use or a weapon/object		1			1
Total	**1**	**4**	**1**	**1**	**7**

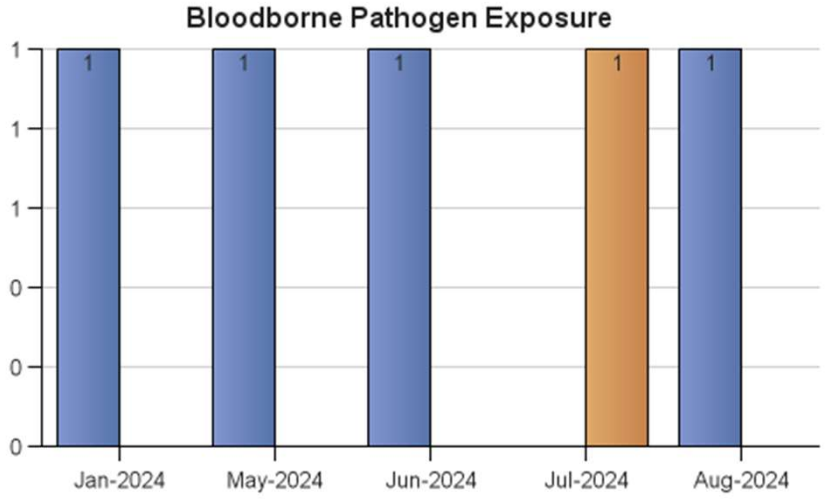
WORKPLACE VIOLENCE





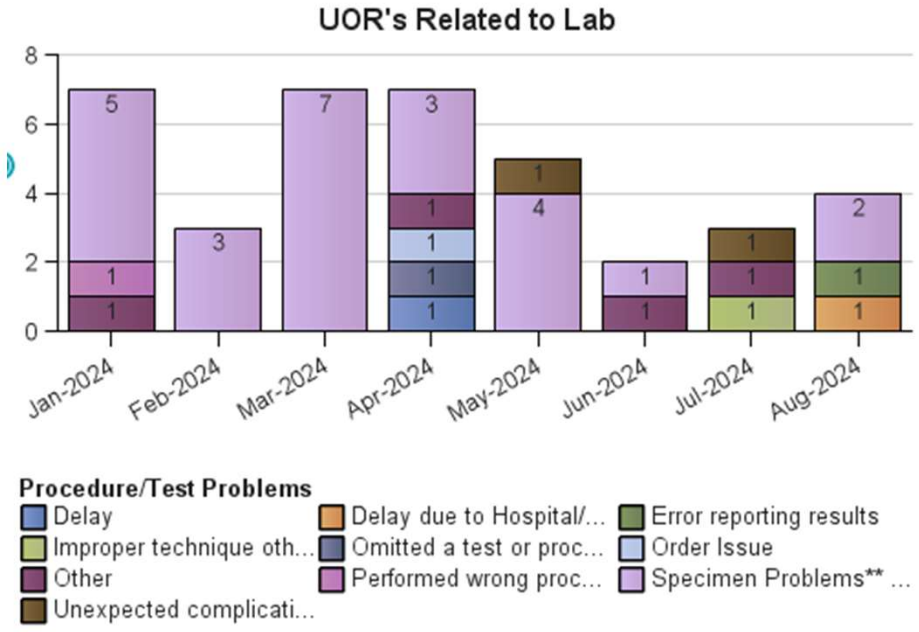






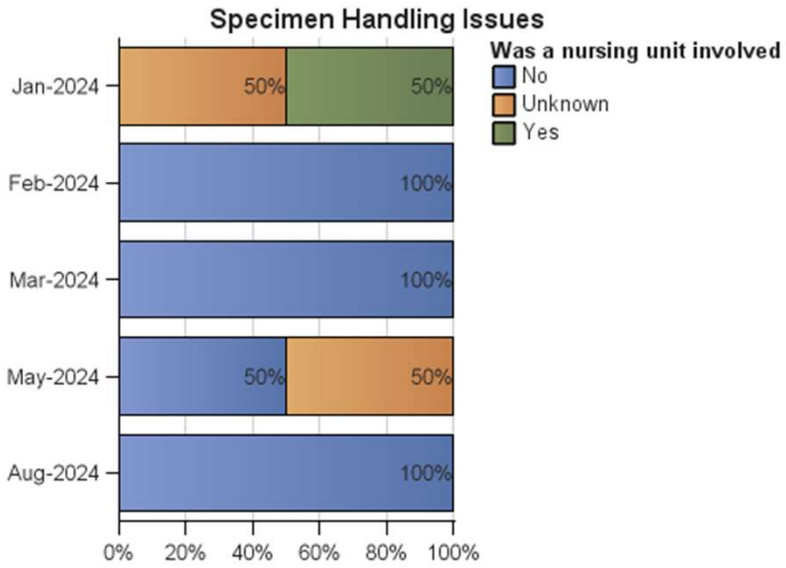
	Jan-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
Bloodborne Pathogen Exposure- Sharps Injury	1	1	1		1	4
Mishandled Sharps				1		1
Total	**1**	**1**	**1**	**1**	**1**	5

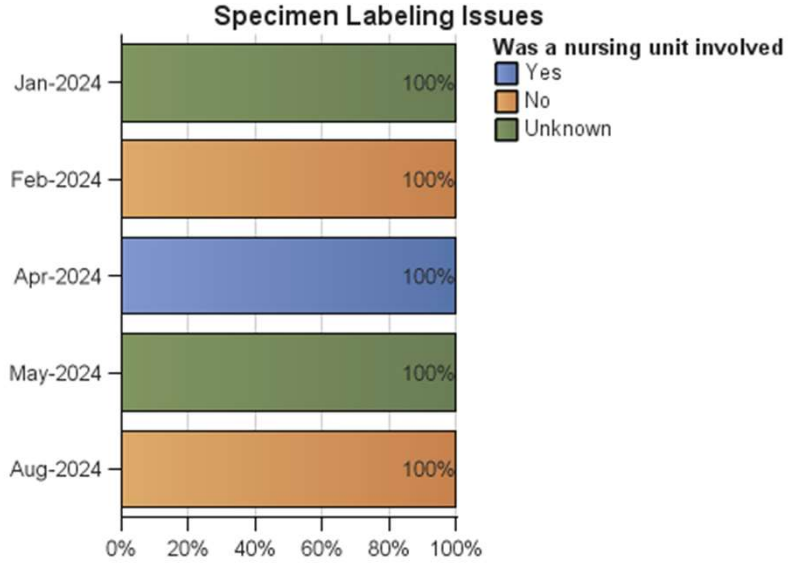
	Jan-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
Bloodborne Pathogen Exposure- Sharps Injury	1	1	1		1	4
Bloodborne Pathogen Exposure- Splash/ Mucous Membrane				1		1
Total	**1**	**1**	**1**	**1**	**1**	5



	Jan-2024	Feb-2024	Mar-2024	Apr-2024	May-2024	Jun-2024	Jul-2024	Aug-2024	Total
Delay				1					1
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
Order Issue				1					1
Other	1			1		1	1		4
Performed wrong procedure	1								1
Specimen Problems** LAB ALWAYS SELECT THIS ONE***	5	3	7	3	4	1		2	25
Unexpected complications					1		1		2
Total	**7**	**3**	**7**	**7**	**5**	**2**	**3**	**4**	**38**

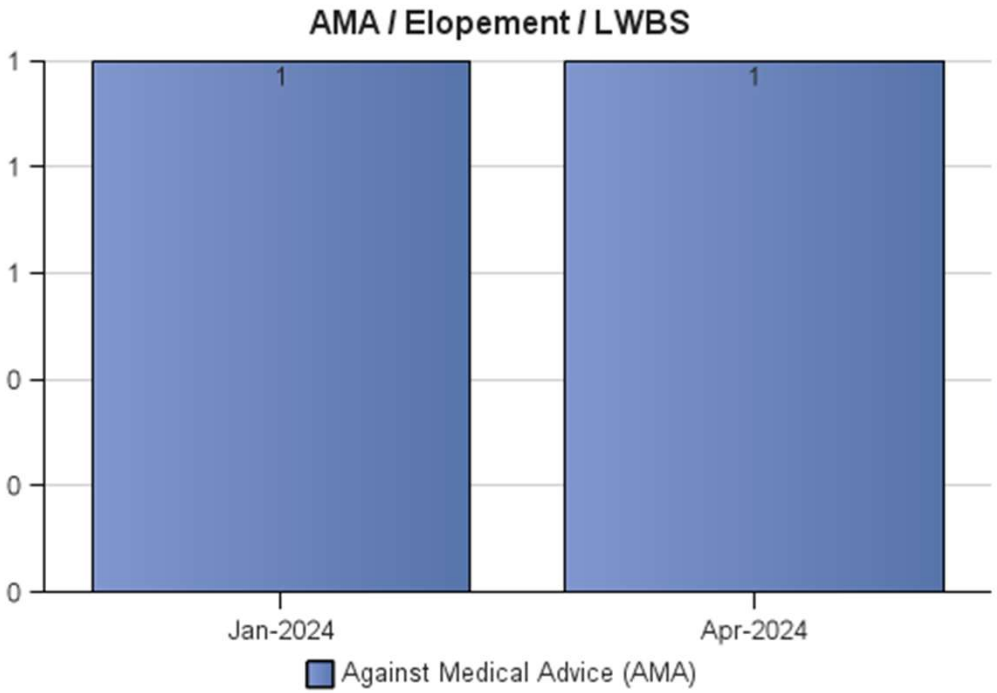
We are working with the vendor to develop additional reporting specific to “Specimen Problems.” We collect much more specific data about the problems that affect the lab team.





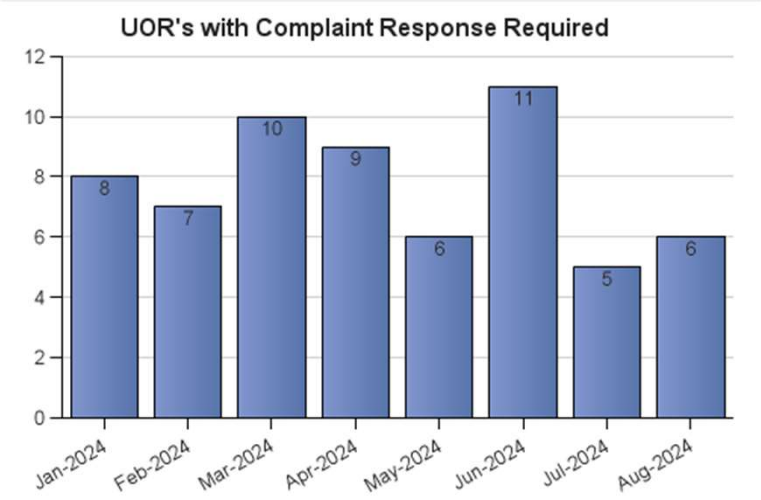
	Jan-2024	Feb-2024	Mar-2024	May-2024	Aug-2024	Total
No		1	7	1	1	**10**
Unknown	1			1		**2**
Yes	1					**1**
Total	**2**	**1**	**7**	**2**	**1**	13

	Jan-2024	Feb-2024	Apr-2024	May-2024	Aug-2024	Total
Yes			2			**2**
No		1			1	**2**
Unknown	1			2		3
Total	**1**	**1**	**2**	**2**	**1**	7

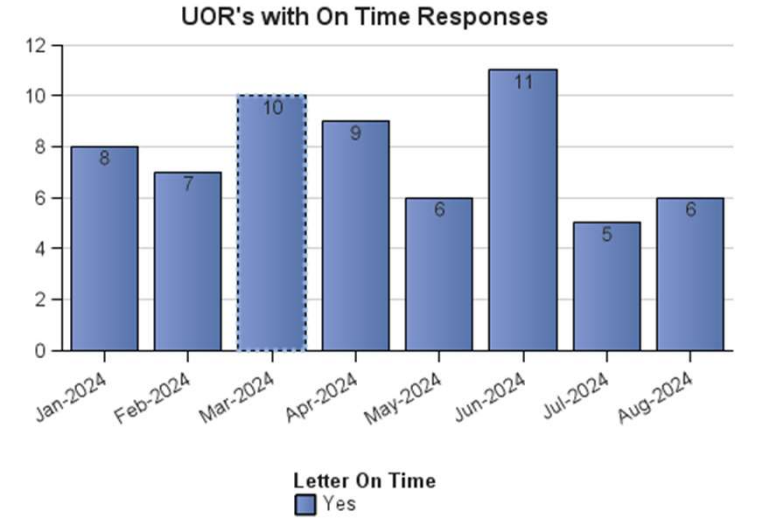


	Jan-2024	Apr-2024	Total
Against Medical Advice (AMA)	1	1	**2**
Total	**1**	**1**	**2**

AMA – Against Medical Advice
LWBS – Left Without Being Seen

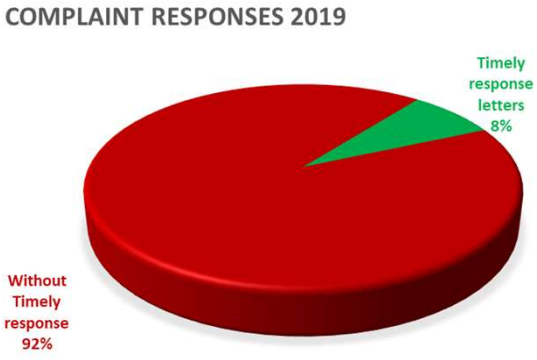


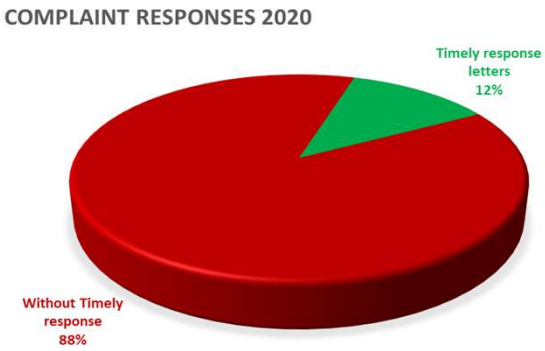
Jan-2024	8
Feb-2024	7
Mar-2024	10
Apr-2024	9
May-2024	6
Jun-2024	11
Jul-2024	5
Aug-2024	6
Total	**62**

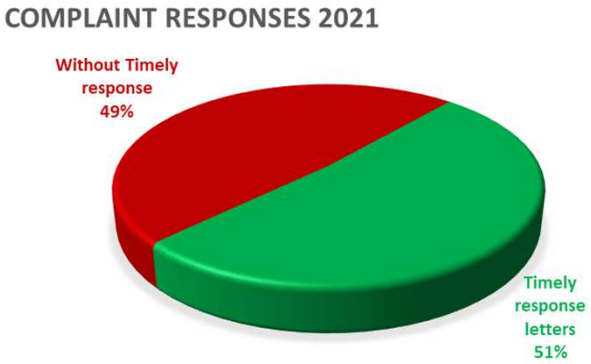


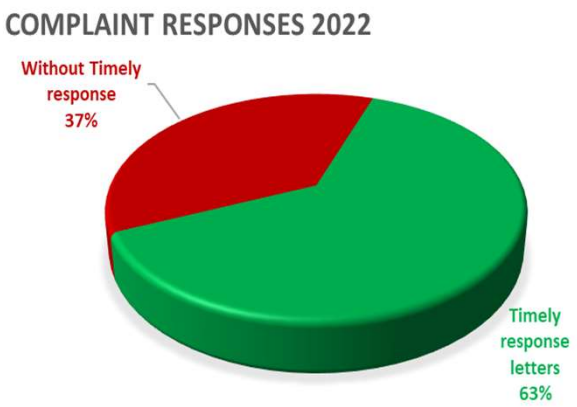
	Yes	Total
Jan-2024	8	**8**
Feb-2024	7	**7**
Mar-2024	10	**10**
Apr-2024	9	**9**
May-2024	6	**6**
Jun-2024	11	**11**
Jul-2024	5	**5**
Aug-2024	6	**6**
Total	**62**	**62**

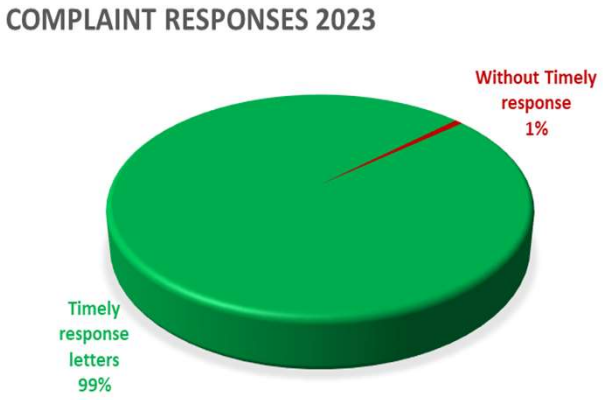
*April 2024 – One letter had previously been marked untimely; however, it was a date calculation error.

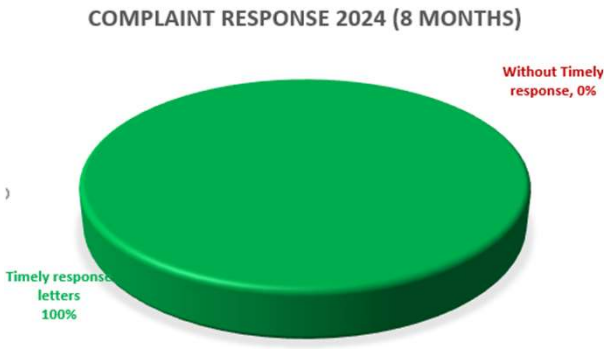






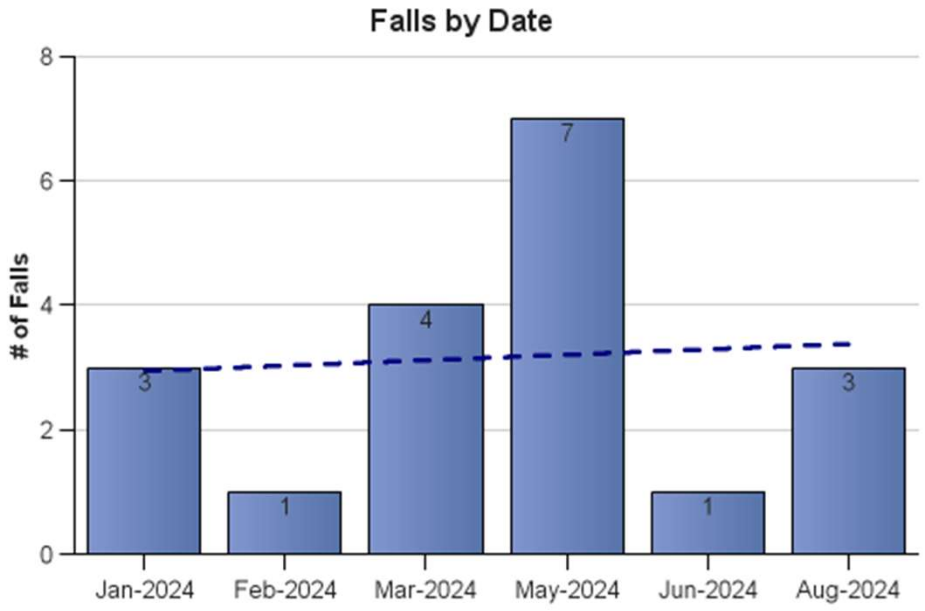






Goal is 100% Green (timely responses)

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	4			4
ED	1		1	2
Inpatient		1	5	6
Outpatient	7			7
Total	**12**	**1**	**6**	**19**

# of Falls	Falls/Slip Problem(s)							Total
	Not Identified	Ambulating	Bathroom	Bed/Crib	Grounds/floor issues	Other	Other Person	
Not Identified	1	3		1	5	1	1	12
Confused		1						1
Oriented		2	3	1				6
Total	**1**	**6**	**3**	**2**	**5**	**1**	**1**	**19**

# of Falls	Falls/Slips	Total
ED	2	2
Imaging	1	1
Medical Surgical Unit	6	6
OB	1	1
Other	2	2
Rehab Services - PT/OT/ST	6	6
Specialty Clinic	1	1
Total	**19**	**19**

# of Falls	Was the Patient Assessed for Fall Risk		
	Not assessed	Yes	Total
Workforce	4		4
Outpatient	7		7
Inpatient		6	6
ED	1	1	2
Total	**12**	**7**	**19**

# of Falls	Was the Patient Assessed for Falls Protocol		
	Not assessed	Yes	Total
Workforce	4		4
Outpatient	7		7
Inpatient		6	6
ED	1	1	2
Total	**12**	**7**	**19**

# of Falls	Received a Sedative w/in the Last 4 Hours			
	Not assessed	Yes	No	Total
Workforce	4			4
Outpatient	7			7
Inpatient		1	5	6
ED	1	1		2
Total	**12**	**2**	**5**	**19**

# of Falls	The Patient Is			
	Not assessed	Oriented	Confused	Total
Workforce	4			4
Outpatient	7			7
ED	1	1		2
Inpatient		5	1	6
Total	**12**	**6**	**1**	**19**

# of Falls	Activity Privileges		
	Not assessed	Ambulatory	Total
Workforce	4		4
ED	1	1	2
Inpatient		6	6
Outpatient	7		7
Total	**12**	**7**	**19**

# of Falls	Siderails			
	Not assessed	Siderails down	Siderails up	Total
Workforce	4			4
Outpatient	7			7
ED	1	1		2
Inpatient		1	5	6
Total	**12**	**2**	**5**	**19**

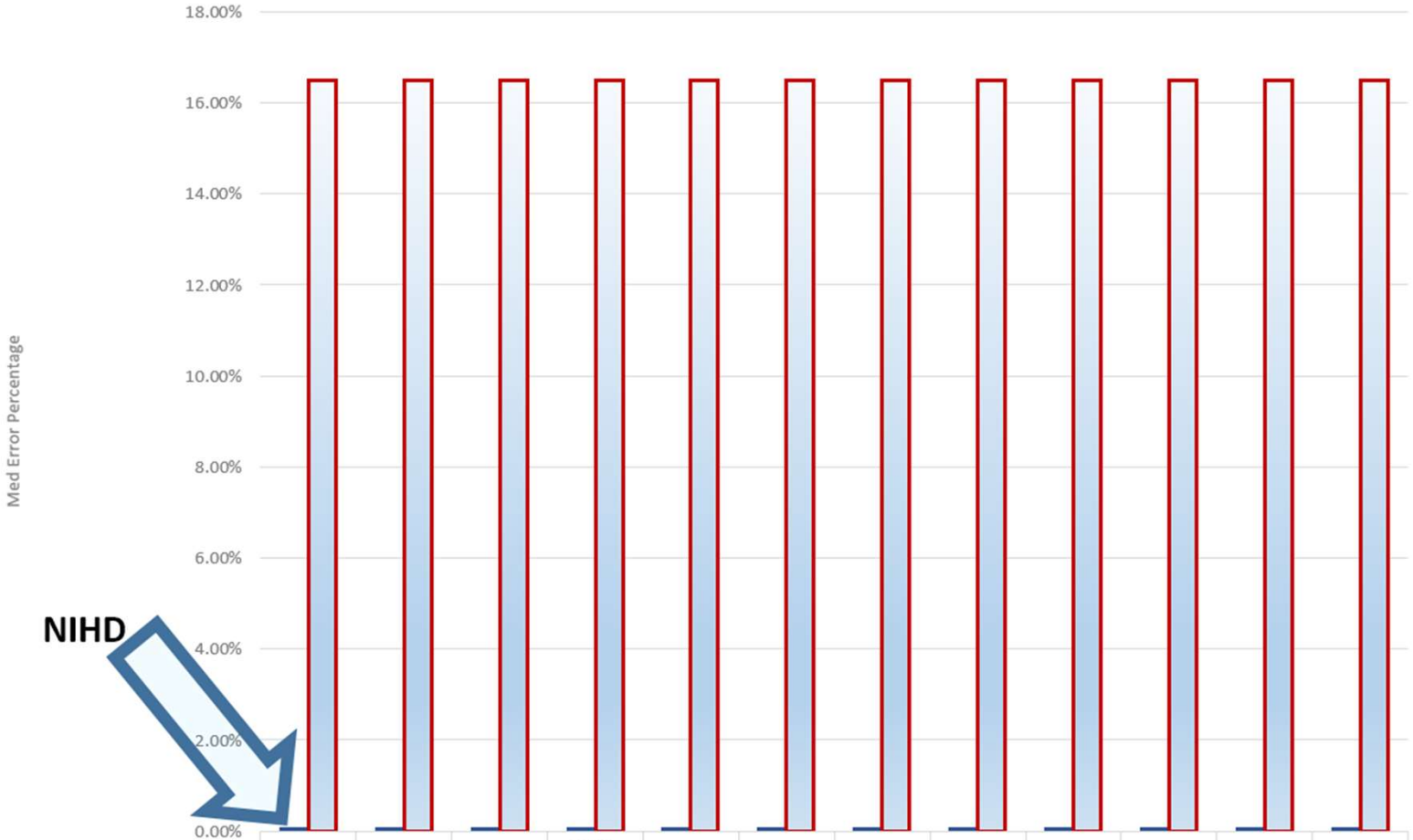
# of Falls	Restraints		
	Not assessed	None	Total
Workforce	4		4
Outpatient	7		7
Inpatient		6	6
ED	1	1	2
Total	**12**	**7**	**19**

# of Falls	Patient Attendent			
	Not assessed	Yes	No	Total
Workforce	4			4
Outpatient	7			7
Inpatient		3	3	6
ED	1	1		2
Total	**12**	**4**	**3**	**19**

# of Falls	Environment			
	Not assessed	No environmental concerns	Other	Total
Workforce	4			4
Outpatient	7			7
Inpatient		5	1	6
ED	1	1		2
Total	**12**	**6**	**1**	**19**

# 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	4			4	4			4	4			4	4			4
ED	1		1	2	1	1		2	1	1		2	1		1	2
Inpatient	1	3	2	6	4		2	6	2	3	1	6	3	1	2	6
Outpatient	7			7	7			7	7			7	7			7
Total	**13**	**3**	**3**	**19**	**16**	**1**	**2**	**19**	**14**	**4**	**1**	**19**	**15**	**1**	**3**	**19**

NIHD Medication Error Rate vs. National Medication Error Rate



	2023 - June	2023 - July	2023 - August	2023 - September	2023 - October	2023 - November	2023 - December	2024 - January	2024 - February	2024 - March	2024 - April	2024 - May
NIHD % error rate	0.03%	0.02%	0.03%	0.02%	0.01%	0.02%	0.03%	0.05%	0.02%	0.04%	0.05%	0.04%
Mean National % Med Error	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%	16.50%

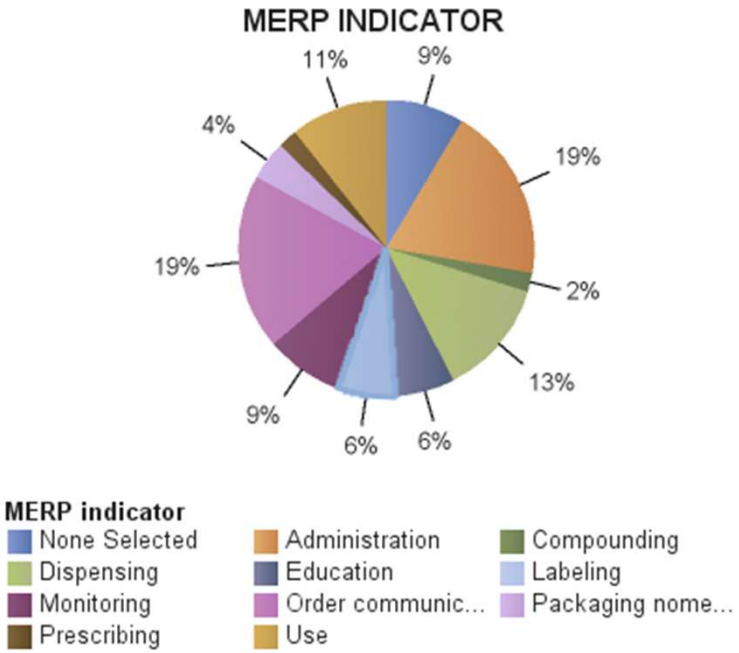
CY2024 Q3 Update not yet available

Data for previous slide

CY2024 Q3
Update not yet available

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
2023 - June	11,375	2	0.02%	8%-25%	16.50%	99.98%	During medication administration, there is about an 8%-25% median medication error rate (Patient Safety Network, March 2021).
2023 - July	14,485	4	0.03%	8%-25%	16.50%	99.97%	
2023 - August	14,263	7	0.05%	8%-25%	16.50%	99.95%	
2023 - September	12,669	2	0.02%	8%-25%	16.50%	99.98%	
2023 - October	16,208	6	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.
2023 - November	13,327	6	0.05%	8%-25%	16.50%	99.95%	
2023 - December	14,162	6	0.04%	8%-25%	16.50%	99.96%	
2024 - January	16,772	7	0.04%	8%-25%	16.50%	99.96%	
2024 - February	12,671	4	0.03%	8%-25%	16.50%	99.97%	reference for above: https://psnet.ahrq.gov/primer/medication-administration-errors#:~:text=In%20a%20review%20of%2091,%E2%80%9325%25%20during%20medication%20administration.
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%	Occurrences not included, as they are not errors that are administered to a patient.
2024 - May	15,273	2	0.01%	8%-25%	16.50%	99.99%	

Medication Error Reduction Plan (MERP)

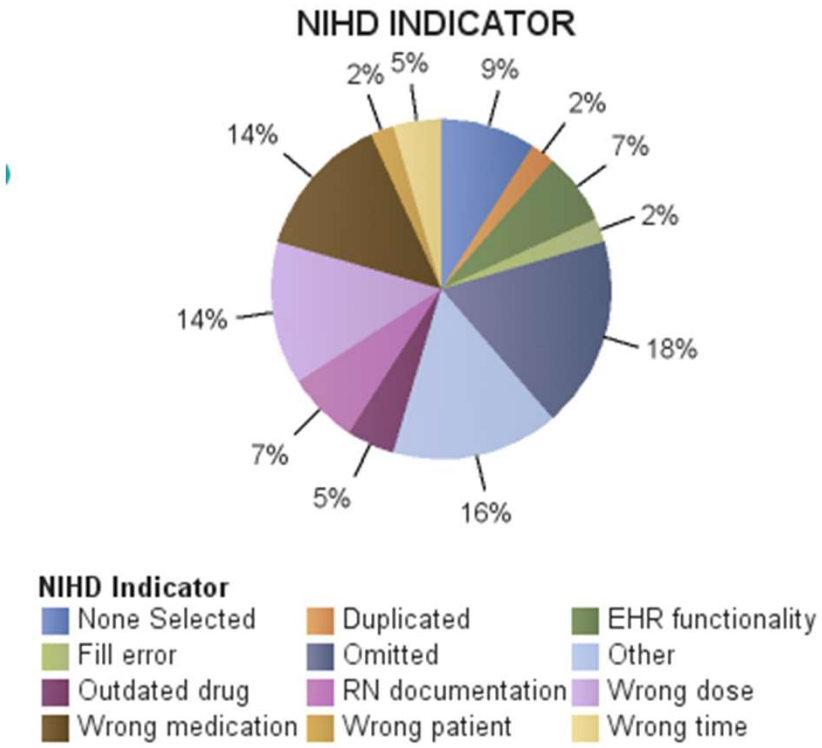


None Selected	4
Administration	9
Compounding	1
Dispensing	6
Education	3
Labeling	3
Monitoring	4
Order communication	9
Packaging nomenclature	2
Prescribing	1
Use	5
Total	**47**

	# 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**
Total	**27**	**12**	**39**

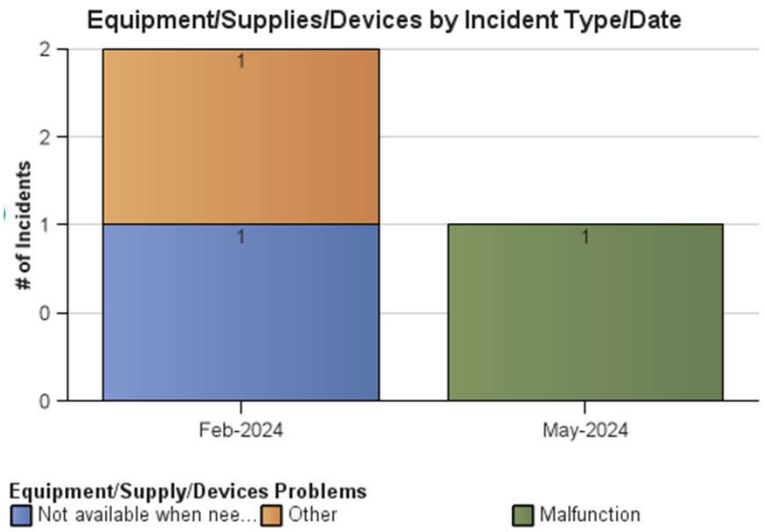
All medication errors and occurrences are reviewed by the Medication Administration Improvement Committee. The MERP and NIHD Indicators (following page) allow NIHD to categorize errors in order to focus on high frequency error reasons to create a plan for reduction.

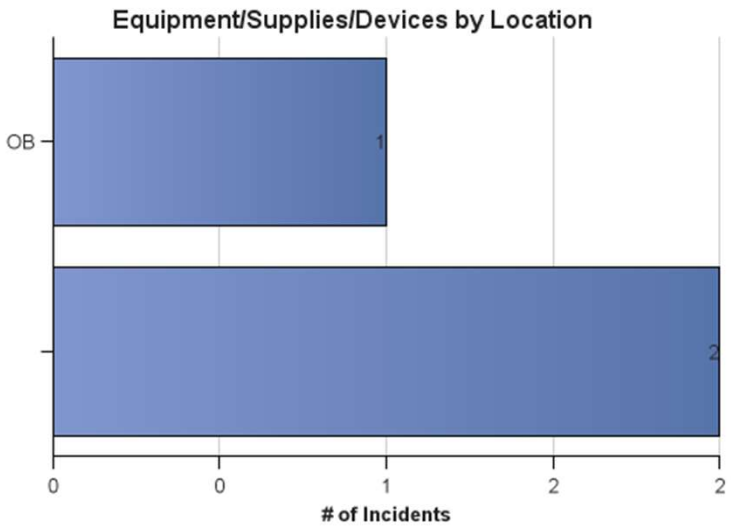
Medication errors are errors that reach the patient. Medication occurrences are errors that are caught before they reach the patient.



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.





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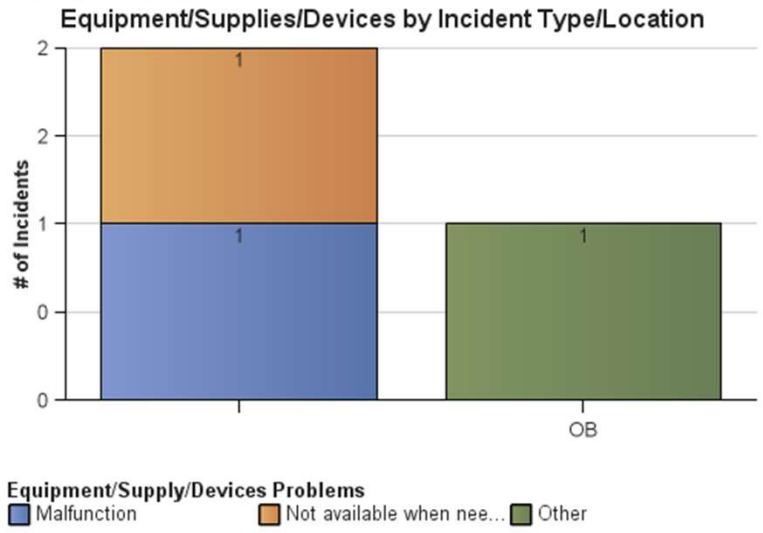


NORTHERN INYO HEALTHCARE DISTRICT
RECOMMENDATION TO THE BOARD OF DIRECTORS
FOR ACTION

Date: September 18, 2024

Title: BOARD RESOLUTION 24-04 APPROVAL OF APPROPRIATIONS LIMIT

Synopsis: It is recommended that the Board of Directors approve and adopt the Resolution to establish an annual appropriations limit in accordance with Article XIIIB of the California Constitution. As a government entity, NIHD is to receive funds from property taxes in the form of State Appropriations. These funds are for operating expenses and are not restricted as to use.

Prepared by: Andrea Mossman 9/12/24
Andrea Mossman
Interim Associate Financial Officer

Approved by: Stephen DelRossi 9/10/24
Stephen DelRossi
CEO/CFO

NORTHERN INYO HEALTHCARE DISTRICT
DISTRICT BOARD RESOLUTION 24-04
Appropriations

WHEREAS, the Northern Inyo Healthcare District is required to establish an annual appropriations limit in accordance with Article XIIIB of the California Constitution; and

WHEREAS, using data provided by the State of California Department of Finance, letter dated July 2023, the Board of Directors of Northern Inyo Healthcare District established an appropriations limit of $803,350.09 for the July l, 2023 to June 30, 2024 fiscal year; and

WHEREAS, using data provided by the State of California Department of Finance and the County of Inyo, an appropriations limit of $837,676.40 has been calculated for the July 1, 2024 to June 30, 2025 fiscal year.

NOW, THEREFORE, BE IT RESOLVED by this Board of Directors of Northern Inyo Healthcare District, meeting in regular session this 18th day of September, 2024 that an appropriations limit of $837,676.40 be established for the Northern Inyo Healthcare District for the 2024-2025 fiscal year; and

BE IT FURTHER RESOLVED BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting; and this Resolution shall take effect immediately after its adoption on the date hereof.

PASSED, APPROVED, AND ADOPTED by the Northern Inyo Healthcare District this 18th day of September 2024 by the following vote:

AYES: _____

NOES: _____

ABSTAIN: _____

ABSENT: _____

By: _____
Melissa Best-Baker, Chair of the Board
Northern Inyo Healthcare District

ATTEST: _____
Clerk of the Board
Northern Inyo Healthcare District

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

Date: September 18, 2024

Title: BOARD RESOLUTION 24-05 Authorization of Operations Accounts

Synopsis: It is recommended that the Board of Directors approve and adopt the Resolution to authorize Andrea Mossman, Interim Associate Financial Officer and Alison Murray, Chief Human Resources Officer, to deposit and withdraw money and create and maintain accounts for the operation of the Health Care District.

Prepared by: Stephen DelRossi 9/10/24
Stephen DelRossi
CEO/CFO

NORTHERN INYO HEALTHCARE DISTRICT
DISTRICT BOARD RESOLUTION 24-05

WHEREAS, California Health and Safety Code, Division 23, Section 32000 et seq. established Healthcare Districts; and

WHEREAS, the Board of Directors of the Northern Inyo Healthcare District does hereby find that the deposit and withdrawal of money, the creation and maintenance of accounts for the operation of the Health Care District and its business entities as outlined in Division 23, Chapter 2, Article 2; and

NOW THEREFORE, BE IT RESOLVED, that the Board of Directors of Northern Inyo Healthcare District does hereby authorize the creation and maintenance of accounts for the deposit of monies and withdrawal of monies of Northern Inyo Healthcare District for the purpose of operating the business entities of the District and,

BE IT FURTHER RESOLVED by the Northern Inyo Healthcare District Board of Directors, meeting in regular session this 18th day of September 2024, that the Chief Executive Officer / Chief Financial Officer, Stephen DelRossi, MBA; Chief Nursing Officer / Chief Operating Officer, Allison Partridge, MSN; Chief Medical Officer J. Adam Hawkins, DO, Chief Human Resources Officer Alison Murray, MBA; and Interim Associate Financial Officer, Andrea Mossman MBA, shall be authorized to operate District approved business accounts, and to create additional accounts as needed to meet the business needs of the Healthcare District in accordance with Division 23, Chapter 2, Article 2.

BE IT FURTHER RESOLVED BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting; and this Resolution shall take effect immediately after its adoption on the date hereof.

PASSED, APPROVED, AND ADOPTED by the Northern Inyo Healthcare District this 18th day of September 2024 by the following vote:

AYES: _____

NOES: _____

ABSTAIN: _____

ABSENT: _____

_____ _____
Melissa Best-Baker, Chair Date
Northern Inyo Healthcare District

Attest: _____ _____

Clerk of the Board Date
Northern Inyo Healthcare District

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

Date: September 18, 2024

Title: BOARD RESOLUTION 24-06 Approving the deposit and investment of funds to eligible certificate of deposit and the local agency investment fund

Synopsis: It is recommended that the Board of Directors approve and adopt the Resolution to include the Interim Chief Financial Officer, to manage and authorize the deposits and investments of funds in eligible certificates of deposit and LAIF.

Prepared by: Stephen D'Rossi 9/10/24
Stephen DelRossi
CEO

NORTHERN INYO HEALTHCARE DISTRICT
DISTRICT BOARD RESOLUTION 24-06
APPROVING THE DEPOSIT AND INVESTMENT OF FUNDS TO ELIGIBLE CERTIFICATES OF DEPOSIT AND THE LOCAL AGENCY INVESTMENT FUND

WHEREAS, the Legislature of the State of California has declared that the deposit and investment of public funds by local officials and local agencies is an issue of statewide concern (California Government Code Sections 53600.6 and 53630.1); and

WHEREAS, the Board of Directors (the "Board") of the Northern Inyo Healthcare District (the "District") may invest surplus monies not required for the immediate necessities of the District in accordance with the provisions of California Government Code Section 53600 *et seq*.; and

WHEREAS, the District may also deposit its moneys with an eligible state or national bank, savings association or federal association, and state or federal credit union located in California, as provided in Government Code Section 53630 *et seq*.; and

WHEREAS, the District now wishes to approve the deposit and/or investment of surplus District moneys in eligible certificates of deposit and with the Local Agency Investment Fund ("LAIF"), in accordance with the law and as provided herein.

NOW, THEREFORE, BE IT RESOLVED, DETERMINED, AND ORDERED by the Board of Directors of the Northern Inyo Healthcare District as follows:

1. The above recitals are true and correct, and the Board of the District so finds and determines.

2. All deposits and/or investments of District funds shall be done in compliance with law and the limitations applicable to public agencies, including pursuant to Government Code Sections 53600 *et seq*. and 53630 *et seq*.

3. The Board hereby approves the deposit and investment of moneys not required for the immediate needs of the District in the LAIF, in compliance with the California Government Code Section 16429.1.

4. The Board hereby approves the deposit of moneys not required for the immediate needs of the District in non-negotiable certificates of deposit with eligible financial institutions and securities, for a term not to exceed 5 years in compliance with the California Government Code.

5. The Board hereby delegates the authority to manage and authorize the deposits and investments of funds in eligible certificates of deposit and LAIF to its Chief Financial Officer and Interim Associate Financial Officer. The Chief Financial Officer or Interim Associate Financial Officer shall confirm that any deposit of funds into a certificate of deposit is done with an eligible financial institution that can hold public funds, in compliance with the limitations and requirements of the California Government Code, including with respect to

limitations on securities and required collateral described in California Government Code Section 53652.

BE IT FURTHER RESOLVED BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting; and this Resolution shall take effect immediately after its adoption on the date hereof.

PASSED, APPROVED, AND ADOPTED by the Northern Inyo Healthcare District this 18th day of September 2024, by the following vote:

AYES: _____

NOES: _____

ABSTAIN: _____

ABSENT: _____

By:_____
Chair of the Board
Northern Inyo Healthcare District

ATTEST:_____
Clerk of the Board
Northern Inyo Healthcare District

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

Date: September 18, 2024

Title: BOARD RESOLUTION 24-07

Synopsis: It is recommended that the Board of Directors approve and adopt the Resolution to add Interim Associate Financial Officer, Andrea Mossman, as a Fiduciary of the Northern Inyo County Local Hospital District Retirement Plan(s) and to authorize and act on its behalf.

Prepared by: Stephen DelRossi
CEO/CFO

NORTHERN INYO HEALTHCARE DISTRICT
DISTRICT BOARD RESOLUTION 24-07

WHEREAS, California Health and Safety Code, Division 23, Section 32000 et seq. established Health Care Districts; and

WHEREAS, the Board of Directors of the Northern Inyo Healthcare District sponsors the Northern Inyo County Local Hospital District Retirement Plan(s) (the "Plans") for the benefit of certain employees; and

WHEREAS, Section 9.1 of the Plan(s) allow the Board to designate certain individuals to act as Named Fiduciaries for the Plan(s) to control and manage the operation and administration of the Plan(s); and

WHEREAS, new Named Fiduciaries are required due to the departure of prior Named Fiduciaries.

NOW THEREFORE, BE IT RESOLVED, determined, and ordered by the Board of Directors of the Northern Inyo Healthcare District that the following individuals be named as Fiduciaries of the Northern Inyo County Local Hospital District Retirement Plan(s) and authorized to act on its behalf:

Stephen DelRossi, Chief Executive Officer and Chief Financial Officer

Andrea Mossman, Interim Associate Financial Officer

Allison Partridge, Chief Operations Officer and Chief Nursing Officer

Alison Murray, Chief Human Resources Officer

Adam Hawkins, DO, Chief Medical Officer

At all times, two authorized individuals will be required to initiate transactions.

BE IT FURTHER RESOLVED BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting; and this Resolution shall take effect immediately after its adoption on the date hereof.

PASSED, APPROVED, AND ADOPTED by the Northern Inyo Healthcare District this 18th day of September 2024 by the following vote:

AYES: _____

NOES: _____

ABSTAIN: _____

ABSENT: _____

By: _____
Melissa Best-Baker, Chair of the Board
Northern Inyo Healthcare District

ATTEST: _____

Clerk of the Board
Northern Inyo Healthcare District

Northern Inyo Healthcare District
July 2024 – Financial Summary

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	MOM % Variance
Net Income (Loss)	2,041,456	1,312,840	(820,721)	728,616	2,862,177	-55%
Operating Income (Loss)	1,459,716	826,940	(1,114,573)	632,775	2,574,289	-77%
EBIDA (Loss)	2,482,790	2,199,377	(457,143)	283,412	2,939,932	-13%

Income is favorable to budget due to improved net revenue (higher volume along with lower bad debt and better payor mix) and compared to prior year due to reduced expenses.

IP Gross Revenue	3,914,942	4,249,397	3,580,913	(334,454)	334,029	-8%
OP Gross Revenue	13,644,556	17,607,677	14,496,482	(3,963,122)	(851,926)	-23%
Clinic Gross Revenue	1,578,797	1,869,529	1,428,325	(290,731)	150,472	-16%
Net Patient Revenue	10,473,138	11,067,002	8,959,472	(593,864)	1,513,666	-5%
Cash Net Revenue % of Gross	55%	47%	46%	8%	9%	17%

While gross revenue was slightly lower than prior year and budget, payor mix was better with more mix in blue cross and less in self pay and medicare. Additionally, AR >270 decreased $1.2M reducing our bad debt reserved and increasing net revenue. Last July had over $2M in bad debt right offs due to AR cleanup

Admits (excl. Nursery)	75	64		11		17%
IP Days	268	197		71		36%
IP Days (excl. Nursery)	238	172		66		38%
Average Daily Census	8	6		1.94		34%
ALOS	3.17	2.69		0.49		18%
Deliveries	18	19		(1)		-5%
OP Visits	4,288	3,382		906		27%
RHC Visits	2,626	2,371		255		11%
Rural Health Clinic Visits	1,963	1,808		155		9%
Rural Health Women Visits	472	419		53		13%
Rural Health Behavioral Visits	191	144		47		33%
NIA Clinic Visits	1,626	1,504		122		8%
Bronco Clinic Visits	-	1		(1)		-100%
Internal Medicine Clinic Visits	-	190	Not Available	(190)	Not Available	-100%
Orthopedic Clinic Visits	324	362		(38)		-10%
Pediatric Clinic Visits	565	544		21		4%
Specialty Clinic Visits	533	263		270		103%
Surgery Clinic Visits	147	101		46		46%
Virtual Care Clinic Visits	57	43		14		33%
Surgeries IP	24	12		12		100%
Surgeries OP	153	122		31		25%
Total Surgeries	177	134		43		32%
Cardiology	2	-		2		100%
General	87	56		31		55%
Gynecology & Obstetrics	18	12		6		50%
Ophthalmology	27	33		(6)		-18%
Orthopedic	31	33		(2)		-6%
Pediatric	-	-		-		0%
Plastics	1	-		1		100%
Podiatry	1	-		1		100%
Urology	10	-		10		100%
Diagnostic Imaging	2,274	2,108		166		8%
Emergency Visits	888	898		(10)		-1%
ED Admits	33	33		-		0%
ED Admits % of ED Visits	3.7%	3.7%		0.0%		1%
Rehab	733	661		72		11%
Nursing Visits	919	730		189		26%
Observation Hours	1,223	2,053		(830)		-40%

Volumes were higher in all areas other than deliveries compared to prior year. Surgeries were up 32% due to added general surgeon and urology.

Payor mix

Northern Inyo Healthcare District
July 2024 – Financial Summary

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	MOM % Variance
Blue Cross	30.0%	27.7%		2.3%		8%
Commercial	5.4%	5.5%		0.0%		-1%
Medicaid	19.0%	18.4%		0.5%		3%
Medicare	41.0%	43.2%	N/A	-2.2%	N/A	-5%
Self-pay	2.2%	3.8%		-1.6%		-42%
Workers' Comp	1.1%	1.2%		-0.1%		-4%
Other	1.2%	0.2%		1.0%		569%
DEDUCTIONS						
Contract Adjust	8,798,796	8,525,888	9,243,968	272,908	(445,172)	3%
Bad Debt	(654,669)	3,538,776	732,044	(4,193,445)	(1,386,713)	-118%
Write-off	523,465	596,323	570,235	(72,858)	(46,770)	-12%

Payor mix shifted from Medicare & Self Pay to Blue Cross which reduced our contractual adjustments and increased our net revenue.
Bad debt allowance was reduced by $1.2M due to AR >270 days declining by that amount which also increased net revenue

DENIALS

Denials are down $2.4M from RSM project baseline (December 2022) and $1.4M from 6 month average (Jan to Jun 2024)

CHARITY	164	13,044	-	(12,880)	164	-99%

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

BAD DEBT

Bad debt write offs were $687k which is $2M lower than last July and $405k lower than 3-month average

CASH

Cash for July was favorable by $219k due to receiving higher than standard patient collections along with HQAF IGT.

CENSUS						
Patient Days	238	172		66		38%
Adjusted Days	1,164	960		204		21%
Employed Paid FTE	366.38	365.27		1.11		0%
Contract Paid FTE	29.45	30.38	N/A	(0.93)	N/A	-3%
Total Paid FTE	395.83	395.65		0.18		0%
EPOB (Employee per Occupied Bed)	1.66	2.23		(0.56)		-25%
Adjusted EPOB	8.13	12.13		(4.00)		-33%

SALARIES						
Per Adjust Bed Day	$ 2,886	$ 3,819		$ (933)		-24%
Total Salaries	$ 3,359,076	$ 3,665,256	$ 3,539,022	(306,180)	(179,946)	-8%
Average Hourly Rate	$ 51.76	$ 56.65		$ (4.89)		-9%
Employed Paid FTEs	366.38	365.27		1.11		

Salaries decreased to budget and prior year due to staffing changes made last year

BENEFITS						
Per Adjust Bed Day	$ 1,297	$ 2,364		$ (1,067)		-45%
Total Benefits	$ 1,509,407	$ 2,268,962	$ 2,071,100	$ (759,555)	(561,693)	-33%
Benefits % of Wages	45%	62%	59%	-17%		-27%
Pension Expense	$ 446,946	$ 846,569	$ 498,951	$ (399,623)	(52,005)	-47%
MDV Expense	$ 704,677	$ 1,369,933	$ 748,612	$ (665,256)	(43,935)	-49%
Taxes, PTO accrued, Other	$ 357,784	$ 52,460	$ 823,537	$ 305,324	(465,753)	582%

PTO, Pension, and MDV all lower than prior year and budget. Pension changes didn't occur until August 2023.

Salaries, Wages & Benefits	$ 4,868,483	$ 5,934,218	$ 5,610,122	$ (1,065,735)	(741,639)	-18%

Northern Inyo Healthcare District
July 2024 – Financial Summary

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	MOM % Variance
SWB/APD	$ 4,183	$ 6,183		$ (2,000)		-32%
SWB % of Total Expenses	54.0%	55.8%	55.7%	-1.8%	-2%	

Total SWB for the month is lower than last July or budget due to less benefit expenses

PROFESSIONAL FEES						
Per Adjust Bed Day	$ 2,036	$ 2,629	$ 2,311	$ (593)	(275)	-23%
Total Physician Fee	$ 1,553,004	$ 1,473,263	$ 1,462,222	$ 79,741	90,782	5%
Total Contract Labor	$ 507,387	$ 590,440	$ 349,333	$ (83,053)	158,054	-14%
Total Other Pro-Fees	$ 309,118	$ 459,095	$ 405,978	$ (149,977)	$ (96,860)	-33%
Total Professional Fees	$ 2,369,509	$ 2,522,798	$ 2,217,533	$ (153,289)	151,976	-6%
Contract Paid FTEs	29.45	30.38		(0.93)		-3%
Contract AHR	$ 97.26	$ 109.71		(12.46)		
Physician Fee per Adjust Bed Day	$ 1,334	$ 1,535		$ (201)		

Physician expense increased due to adding a general surgeon and urology. However, this is contributing to higher volumes and revenue and is lower on a per patient basis. Contract labor has been reduced compared to last year due to reduce FTEs and renegotiated rates

PHARMACY						
Per Adjust Bed Day	$ 60	$ 403		$ (343)		-85%
Total Rx Expense	$ 69,925	$ 386,545	$ 461,460	$ (316,620)	(391,535)	-82%

Pharmacy decreased due to over-accruals in prior month

MEDICAL SUPPLIES						
Per Adjust Bed Day	$ 273	$ 46		$ 227		498%
Total Medical Supplies	$ 317,685	$ 43,787	$ 427,568	$ 273,898	(109,883)	626%

Medical expenses lower than budget but higher than prior year due to accounting errors in prior year

EHR SYSTEM						
Per Adjust Bed Day	$ 135	$ 142		$ (8)		-5%
Total EHR Expense	$ 156,658	$ 136,392	$ 135,000	$ 20,266	21,658	15%

Expense is higher than prior year and budget due to additional Cerner contracts/changes made since last year

OTHER EXPENSE						
Per Adjust Bed Day	$ 679	$ 746		$ (68)		-9%
Total Other	$ 789,829	$ 716,330	$ 858,784	$ 73,499	(68,955)	10%

Other expenses are up due to higher utlities, insurance, and sales taxes on supplies which has increased.

DEPRECIATION AND AMORTIZATION						
Per Adjust Bed Day	$ 379	$ 924		$ (544)		-59%
Total Depreciation and Amortization	$ 441,333	$ 886,537	$ 363,578	$ (445,204)	77,755	-50%

Amortization is higher due to a change in lease (GASB 87) and software accounting (GASB 96) requiring assets to be added for contracts and those assets are amortized over the life of the contract.

Total Expenses	$ 9,013,422	$ 10,626,607	$ 10,074,045	$ (1,613,185)	$ (1,060,623)	27%
Per Adjust Bed Day	$ 7,745	$ 11,072		$ (3,327)		
Per Calendar Day	$ 290,756	$ 342,794	$ 324,969	$ (52,038)	(34,214)	-15%

Expenses were lower due to lower benefits and supplies

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2025

	7/31/2024	July Budget	7/31/2023	Budget Variance	PYM Change
Gross Patient Service Revenue					
Inpatient Patient Revenue	3,914,942	3,580,913	4,249,397	334,029	(334,454)
Outpatient Revenue	13,644,556	14,496,482	17,607,677	(851,926)	(3,963,122)
Clinic Revenue	1,578,797	1,428,325	1,869,529	150,472	(290,731)
Gross Patient Service Revenue	19,138,295	19,505,720	23,726,602	(367,425)	(4,588,308)
Deductions from Revenue					
Contractual Adjustments	(8,798,796)	(9,243,968)	(8,525,888)	445,172	(272,908)
Bad Debt	654,669	(732,044)	(3,538,776)	1,386,713	4,193,445
A/R Writeoffs	(370,847)	(570,235)	(596,323)	199,389	225,476
Other Deductions from Revenue	(152,618)	-	-	(152,618)	(152,618)
Deductions from Revenue	(8,667,591)	(10,546,248)	(12,660,987)	1,878,656	3,993,396
Other Patient Revenue					
Incentive Income	-	-	-	-	-
Other Oper Rev - Rehab Thera Serv	2,435	-	1,387	2,435	1,048
Medical Office Net Revenue	-	-	-	-	-
Other Patient Revenue	2,435	-	1,387	2,435	1,048
Net Patient Service Revenue	**10,473,138**	**8,959,472**	**11,067,002**	**1,513,666**	**(593,864)**
CNR%	**55%**	**46%**	**47%**	**9%**	**8%**
Cost of Services - Direct					
Salaries and Wages	2,843,836	2,996,180	3,103,051	(152,345)	(259,216)
Benefits	1,276,362	1,751,750	1,919,121	(475,389)	(642,759)
Professional Fees	1,714,593	1,720,190	1,779,264	(5,597)	(64,672)
Contract Labor	449,823	309,701	523,454	140,122	(73,631)
Pharmacy	69,925	461,460	386,545	(391,535)	(316,620)
Medical Supplies	317,685	427,568	43,787	(109,883)	273,898
EHR System Expense	156,658	135,000	136,392	21,658	20,266
Other Direct Expenses	644,383	700,320	584,136	(55,936)	60,248
Total Cost of Services - Direct	7,473,265	8,502,169	8,475,750	(1,028,904)	(1,002,485)
General and Administrative Overhead					
Salaries and Wages	515,240	542,841	562,204	(27,601)	(46,964)
Benefits	232,685	319,349	349,862	(86,665)	(117,177)
Professional Fees	147,529	148,010	153,093	(482)	(5,565)
Contract Labor	57,563	39,632	66,986	17,931	(9,422)
Depreciation and Amortization	441,333	363,578	886,537	77,755	(445,204)
Other Administative Expenses	145,808	158,465	132,175	(12,657)	13,633
Total General and Administrative Overhead	1,540,158	1,571,876	2,150,857	(31,718)	(610,699)
Total Expenses	**9,013,422**	**10,074,045**	**10,626,607**	**(1,060,623)**	**(1,613,185)**
Financing Expense	194,607	185,154	227,966	9,453	(33,359)
Financing Income	286,867	238,960	509,123	47,906	(222,257)
Investment Income	39,776	46,181	64,726	(6,405)	(24,950)
Miscellaneous Income	449,705	193,865	140,017	255,840	309,688
Net Income (Change in Financial Position)	**2,041,456**	**(820,721)**	**926,295**	**2,862,177**	**1,115,161**
Operating Income	1,459,716	(1,114,573)	440,395	2,574,289	1,019,320
EBIDA	2,482,790	(457,143)	1,812,832	2,939,932	669,957
Net Profit Margin	19.5%	-9.2%	8.4%	28.7%	11.1%
Operating Margin	13.9%	-12.4%	4.0%	26.4%	10.0%
EBIDA Margin	23.7%	-5.1%	16.4%	28.8%	7.3%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2025

	FYE 2024	7/31/2024	7/31/2023	PM Change	PY Year
Assets					
Current Assets					
Cash and Liquid Capital	18,718,424	20,537,240	17,067,550	1,818,817	3,469,690
Short Term Investments	6,418,451	7,565,620	10,513,789	1,147,169	(2,948,169)
PMA Partnership	-	-	-	-	-
Accounts Receivable, Net of Allowance	17,964,704	18,260,024	10,701,794	295,320	7,558,230
Other Receivables	4,753,311	4,292,445	5,538,617	(460,866)	(1,246,172)
Inventory	5,193,281	5,176,986	5,120,179	(16,295)	56,807
Prepaid Expenses	1,119,559	1,463,798	2,054,965	344,240	(591,166)
Total Current Assets	**54,167,729**	**57,296,114**	**50,996,894**	**3,128,384**	**6,299,219**
Assets Limited as to Use					
Internally Designated for Capital Acquisitions	-	-			
Short Term - Restricted	1,467,786	1,467,914	1,466,418	128	1,496
Limited Use Assets				-	-
LAIF - DC Pension Board Restricted	-	-	870,163	-	(870,163)
LAIF - DB Pension Board Restricted	15,684,846	15,684,846	19,296,858	-	(3,612,012)
PEPRA - Deferred Outflows	-	-		-	-
PEPRA Pension	-	-		-	-
Deferred Outflow - Excess Acquisition	573,097	573,097		-	573,097
Total Limited Use Assets	16,257,943	16,257,943	20,167,021	-	(3,909,078)
Revenue Bonds Held by a Trustee	376,411	370,707	1,072,482	(5,704)	(701,774)
Total Assets Limited as to Use	**18,102,140**	**18,096,564**	**22,705,921**	**(5,576)**	**(4,609,357)**
Long Term Assets					
Long Term Investment	1,846,138	751,539	2,776,508	(1,094,598)	(2,024,969)
Fixed Assets, Net of Depreciation	84,273,088	83,991,474	77,115,335	(281,615)	6,876,139
Total Long Term Assets	**86,119,226**	**84,743,013**	**79,891,843**	**(1,376,213)**	**4,851,170**
Total Assets	**158,389,095**	**160,135,691**	**153,594,658**	**1,746,596**	**6,541,033**
Liabilities					
Current Liabilities					
Current Maturities of Long-Term Debt	4,146,183	4,217,792	825,158	71,609	3,392,634
Accounts Payable	5,005,057	4,446,736	7,688,430	(558,321)	(3,241,694)
Accrued Payroll and Related	6,224,657	6,279,496	9,917,379	54,839	(3,637,883)
Accrued Interest and Sales Tax	109,159	192,510	170,685	83,352	21,825
Notes Payable	446,860	446,860	1,633,671	-	(1,186,811)
Unearned Revenue	(4,542)	(4,542)	(4,542)	-	-
Due to 3rd Party Payors	693,247	693,247	693,247	-	-
Due to Specific Purpose Funds	-	-	-	-	-
Other Deferred Credits - Pension & Leases	1,917,457	1,915,387	2,146,080	(2,070)	(230,693)
Total Current Liabilities	**18,538,078**	**18,187,487**	**23,070,109**	**(350,590)**	**(4,882,621)**
Long Term Liabilities					
Long Term Debt	36,301,355	36,202,581	33,455,530	(98,775)	2,747,051
Bond Premium	165,618	162,481	200,126	(3,137)	(37,645)
Accreted Interest	16,991,065	17,084,422	17,218,877	93,358	(134,455)
Other Non-Current Liability - Pension	47,257,663	47,257,663	50,366,473	-	(3,108,810)
Total Long Term Liabilities	**100,715,702**	**100,707,147**	**101,241,006**	**(8,554)**	**(533,859)**
Suspense Liabilities	-	-			
Uncategorized Liabilities (grants)	31,506	94,166	649,721	62,660	(555,555)
Total Liabilities	**119,285,285**	**118,988,800**	**124,960,836**	**(296,485)**	**(5,972,035)**
Fund Balance					
Fund Balance	31,992,031	37,637,520	26,446,580	5,645,489	11,190,940
Temporarily Restricted	1,467,786	1,467,914	2,610,349	128	(1,142,435)
Net Income	5,643,993	2,041,456	(423,106)	(3,602,537)	2,464,563
Total Fund Balance	**39,103,810**	**41,146,890**	**28,633,823**	**2,043,080**	**12,513,068**
Liabilities + Fund Balance	**158,389,095**	**160,135,691**	**153,594,658**	**1,746,596**	**6,541,033**
(Decline)/Gain	-	1,746,596	(1,047,521)	1,746,596	2,794,116
	-	-	-		

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

	HOSPITAL FUND ONLY	
Numerator:		
Excess of revenues over expense	$ 2,041,456	1 month of earnings
+ Depreciation Expense	441,333	
+ Interest Expense	194,607	
Less GO Property Tax revenue	187,516	
Less GO Interest Expense	42,425	
"Income available for debt service" *(definition per 2010 and 2013 and 2021 Indenture)*	**$ 2,447,455**	
Denominator:		
Supplemental Indenture of Trust)		
2021A Revenue Bonds	$ 112,700	
2021B Revenue Bonds	905,057	
2009 GO Bonds (Fully Accreted Value)		
2016 GO Bonds		
Financed purchases and other loans	1,704,252	
Total **Maximum Annual Debt Service**	**$ 2,722,009**	Full year of debt
	226,834	YTD debt
Ratio: (numerator / denominator)	**10.79**	YTD debt service coverage
Required Debt Service Coverage Ratio:	1.10	
In Compliance? (Y/N)	**Yes**	

Unrestricted Funds and Days Cash on Hand

	HOSPITAL FUND ONLY
Cash and Investments-current	$ 28,102,860
Cash and Investments-non current	751,539
Sub-total	28,854,400
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	(370,707)
Building and Nursing Fund	(1,467,914)
Total Unrestricted Funds	**$ 27,015,779**
Total Operating Expenses	$ 9,013,422
Less Depreciation	441,333
Net Expenses	8,572,089
Average Daily Operating Expense	$ 276,519
Days Cash on Hand	**98**

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2025

CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts from and on Behalf of Patients	$	10,778,002
Payments to Suppliers and Contractors		(2,335,988)
Payments to and on Behalf of Employees		(5,375,509)
Other Receipts and Payments, Net		229,381
Net Cash Provided (Used) by Operating Activities		3,295,887
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Noncapital Contributions and Grants		74,517
Property Taxes Received		99,351
Other		-
Net Cash Provided (Used) by Noncapital Financing Activities		173,868
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES		
Principal Payments on Long-Term Debt		-
Interest Paid		(194,607)
Purchase and Construction of Capital Assets		(441,333)
Payments on Lease Liability		(5,245)
Payments on Subscription Liability		(92,094)
Property Taxes Received		187,516
Net Cash Provided (Used) by Capital and Capital Related Financing Activities		(545,763)
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment Income		39,776
Rental Income		2,219
Net Cash Provided (Used) by Investing Activities		41,994
NET CHANGE IN CASH AND CASH EQUIVALENTS		2,965,986
Cash and Cash Equivalents - Beginning of Year		25,136,874
CASH AND CASH EQUIVALENTS - END OF YEAR	$	28,102,860

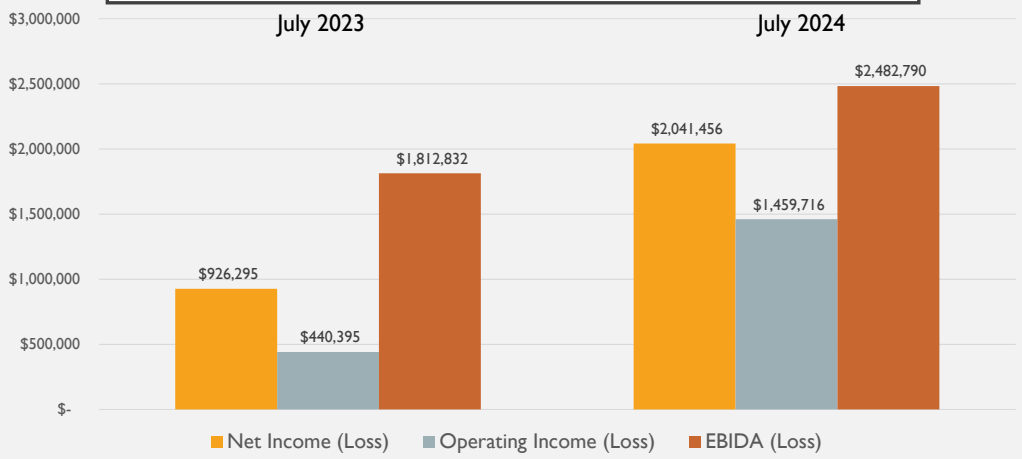
Key Financial Performance Indicators	Industry Benchmark	Jul-22	FYE 2023 Average	Jul-23	Apr-24	May-24	Jun-24	Jul-24	Variance to Prior Month	Variance to FYE 2023 Average	Variance to Prior Year Month	Variance to Benchmark	Reduction Target	Comment
Volume														
Admits	41	77	68	64	63	86	71	75	4	7	11	34		Mammoth monthly average in 2022 per HCAI
Deliveries	n/a	17	17	19	15	22	22	18	(4)	1	(1)	n/a		
Adjusted Patient Days	n/a	915	977	951	1,156	1,321	1,145	1,164	19	187	213	n/a		
Total Surgeries	153	134	120	134	148	140	148	177	29	57	43	24		Mammoth monthly average in 2022 per HCAI
ER Visits	659	890	810	898	856	896	879	888	9	78	(10)	229		Mammoth monthly average in 2022 per HCAI
RHC and Clinic Visits	n/a	3,742	4,353	3,875	4,819	4,999	4,554	4,252	(302)	(101)	377	n/a		
Diagnostic Imaging Services	n/a	1,960	2,020	2,108	2,250	2,293	1,814	2,274	460	254	166	n/a		
Rehab Services	n/a	738	762	661	835	970	670	733	63	(29)	72	n/a		
AR & Income														
Gross AR (Cerner only)	n/a	$ 52,995,998	$ 53,638,580	$ 51,928,721	$ 52,118,365	$ 53,102,112	$ 54,287,686	$ 56,859,164	$ 2,571,477	$ 3,220,584	$ 4,930,442	n/a		
AR > 90 Days	$ 7,688,895.45	$ 22,785,117	$ 23,440,542	$ 23,660,417	$ 21,921,549	$ 22,672,126	$ 22,959,460	$ 24,988,857	$ 2,029,397	$ 1,548,315	$ 1,328,440	$ 17,299,962	(17,299,962)	15% of gross AR is benchmark
AR % > 90 Days	15%	43.0%	45.3%	45.8%	42.8%	43.4%	43.0%	44.5%	1.6%	-0.8%	-1.3%	29.5%		Industry average
AR Days	43.00	92.0	91.35	90.52	83.7	82.1	82.02	89.02	7.00	(2.33)	(1.50)	46.02		California CAH
Net AR	n/a	$ 22,573,731	$ 17,800,084	$ 13,605,084	$ 17,119,074	$ 13,540,975	$ 17,964,704	$ 18,260,024	$ 295,320	$ 459,941	$ 4,654,940	n/a		
Net AR % of Gross	n/a	42.6%	33.1%	26.2%	32.8%	25.5%	33.1%	32.1%	-1.0%	-0.9%	5.9%	n/a		
Gross Patient Revenue/Calendar Day	n/a	$ 534,613	$ 546,652	$ 589,494	$ 687,640	$ 656,765	$ 610,465	$ 617,364	$ 6,900	$ 70,713	$ 27,871	n/a		
Net Patient Revenue/Calendar Day	n/a	$ 280,345	$ 243,317	$ 281,629	$ 331,651	$ 311,352	$ 284,303	$ 337,843	$ 53,540	$ 94,526	$ 56,214	n/a		
Net Patient Revenue/APD	n/a	$ 9,498	$ 7,622	$ 9,180	$ 8,607	$ 7,307	$ 7,449	$ 8,998	$ 1,549	$ 1,376	$ (183)	n/a		
Wages														
Wages	n/a	$ 2,874,071	$ 3,281,173	$ 3,246,211	$ 3,340,105	$ 3,311,797	$ 3,033,481	$ 3,359,076	$ 325,595	$ 77,903	$ 112,865	n/a		
Employed paid FTEs	n/a	386.52	384.63	365.27	367.13	357.91	353.75	366.38	12.63	(18.25)	1.11	n/a	0%	
Employed Average Hourly Rate	$ 38.00	$ 41.98	$ 48.51	$ 50.17	$ 53.07	$ 52.24	$ 50.02	$ 51.76	$ 1.74	$ 3.24	$ 1.59	$ 13.76		According to California Hospital Association data
Benefits	n/a	$ 2,025,555	$ 1,907,194	$ 1,782,070	$ 2,493,560	$ 1,571,990	$ 1,456,281	$ 1,509,407	$ 53,126	$ (397,787)	$ (272,663)	n/a		
Benefits % of Wages	30%	70.5%	58.7%	54.9%	74.7%	47.5%	48.0%	44.9%	-3.1%	-13.7%	-10.0%	14.9%	(269,509)	Industry average
Contract Labor	n/a	$ 685,234	$ 808,284	$ 493,990	$ 320,113	$ 968,946	$ 774,264	$ 507,387	$ (266,877)	$ (300,897)	$ 13,397	n/a		
Contract Labor Paid FTEs	n/a	49.84	40.27	30.74	21.07	29.72	25.95	29.45	3.50	(10.82)	(1.29)	n/a		
Total Paid FTEs	n/a	436.36	424.90	396.01	388.20	387.63	379.71	395.83	16.12	(29.07)	(0.18)	n/a		
Contract Labor Average Hourly Rate	$ 81.04	$ 77.61	$ 112.84	$ 90.72	$ 88.62	$ 184.04	$ 174.03	$ 97.26	$ (76.77)	$ (15.58)	$ 6.54	$ 16.22	$ (66,865)	Per zip recruiter as of August 2023 for California, higher range is benchmark
Total Salaries, Wages, & Benefits	n/a	$ 5,584,859	$ 5,996,651	$ 5,522,271	$ 6,153,778	$ 5,852,733	$ 5,264,026	$ 5,375,870	$ 111,844	$ (620,781)	$ (146,401)	n/a		
SWB% of NR	50%	64.3%	79.8%	63.3%	61.8%	60.6%	61.7%	51.3%	-10.4%	-28.4%	-11.9%	$ 0	$ (591,023)	Per Becker Healthcare, max should be 50%
SWB/APD	2,607	$ 6,104	$ 5,912	$ 5,807	$ 5,323	$ 4,431	$ 4,597	$ 4,618	$ 21	$ (1,294)	$ (1,188)	$ 2,011	$ (11,543)	Industry average
SWB % of total expenses	50%	61.5%	66.0%	58.7%	58.8%	58.5%	64.4%	59.6%	-4.8%	-6.4%	0.9%	10%	$ (1,010,368)	Industry average
Physician Spend														
Physician Expenses	n/a	$ 1,255,502	$ 1,400,634	$ 1,369,822	$ 1,591,311	$ 1,780,354	$ 1,621,499	$ 1,553,004	$ (68,495)	$ 152,370	$ 183,182	n/a		
Physician expenses/APD	n/a	$ 1,372	$ 1,451	$ 1,440	$ 1,377	$ 1,348	$ 1,416	$ 1,334	$ (82)	$ (117)	$ (106)	n/a		
								$ -	$ -	$ -				
Supplies														
Supply Expenses	n/a	$ 527,078	$ 544,557	$ 786,000	$ 1,009,496	$ 746,075	$ (820,071)	$ 387,610	$ 1,207,681	$ (156,947)	$ (398,390)	n/a		
Supply expenses/APD		$ 576	$ 579	$ 826	$ 873	$ 565	$ (716)	$ 333	$ 1,049	$ (246)	$ (494)	n/a		
Other Expenses														
Other Expenses	n/a	$ 1,713,006	$ 1,138,604	$ 1,724,605	$ 1,704,419	$ 1,625,275	$ 2,106,900	$ 1,696,938	$ (409,962)	$ 558,334	$ (27,667)	n/a		
Other Expenses/APD	n/a	$ 1,872	$ 1,178	$ 1,813	$ 1,474	$ 1,230	$ 1,840	$ 1,458	$ (382)	$ 280	$ (356)	n/a		
Margin														
Net Income	n/a	$ 49,888	$ (1,448,727)	$ (341,503)	$ (192,661)	$ (36,142)	$ 785,068	$ 2,041,456	$ 1,256,388	$ 3,490,183	$ 2,382,959	n/a		
Net Profit Margin	n/a	0.6%	-20.8%	-3.9%	-1.9%	-0.4%	9.2%	19.5%	10.3%	40.3%	23.4%	n/a		
Operating Income	n/a	$ (389,742)	$ (2,495,327)	$ (590,588)	$ (509,466)	$ (352,524)	$ 356,735	$ 1,459,716	$ 1,102,981	$ 3,955,043	$ 2,050,304	n/a		
Operating Margin	2.9%	-4.5%	-33.0%	-6.8%	-5.1%	-3.7%	4.2%	13.9%	9.7%	46.9%	20.7%	11.0%		Per Kaufman Hall September Natitonal Hospital Flash
EBITDA	n/a	$ (268,199)	$ (1,789,289)	$ (16,938)	$ 245,536	$ 411,699	$ 1,224,650	$ 2,482,790	$ 1,258,140	$ 4,272,079	$ 2,499,728	n/a		
EBITDA Margin	12.7%	-3.1%	-22.6%	0.2%	2.5%	4.3%	14.4%	23.7%	9.3%	46.3%	23.5%	11.0%		CLA critical access hospitals
Debt Service Coverage Ratio	3.70		(5.8)	0.6	3.8	3.6	3.9	10.8	6.88	16.60	10.19	7.09		Per bond requirement, need to be at 1.1
Cash														
Avg Daily Disbursements (excl. IGT)	n/a	$ 327,914	$ 363,636	$ 296,364	$ 382,730	$ 342,362	$ 332,307	$ 367,107	$ 34,800	$ 3,471	$ 70,743	n/a	$ (40,487)	14%
Average Daily Cash Collections (excl. IGT)	n/a	$ 200,069	$ 340,919	$ 254,229	$ 352,222	$ 294,096	$ 291,820	$ 349,783	$ 57,963	$ 8,864	$ 95,554	n/a	$ 40,487	20%
Average Daily Net Cash		$ (127,846)	$ (22,716)	$ (42,135)	$ (30,508)	$ (48,265)	$ (40,487)	$ (17,324)	$ 23,163	$ 5,393	$ 24,811	n/a	$ 40,487	-366%
Unrestricted Funds	n/a	$ 29,183,993	$ 25,185,410	$ 30,155,529	$ 14,442,406	$ 27,788,508	$ 25,138,815	$ 27,015,779	$ 1,876,964	$ 1,830,369	$ (3,139,750)	n/a		-10%
Change of cash per balance sheet	n/a	$ -	$ 204,360	$ (1,480,790)	$ (4,672,727)	$ 13,346,102	$ (2,649,693)	$ 1,876,964	$ 4,526,656	$ 1,672,603	$ 3,357,754			
Days Cash on Hand (assume no more cash is collected)	196	100	83	102	46	90	84	98	14	15	(4)	n/a		Per bond requirement, we need 75 minimum. Other California CAH average 196
Estimated Days Until Depleted		228	1,109	716	247	482	447	508	60	(601)	(208)	n/a		
Years Until Cash Depletion		0.63	3.04	1.96	0.68	1.32	1.23	1.39	0.17	(1.65)	(0.57)	n/a		

NIHD FINANCIAL UPDATE

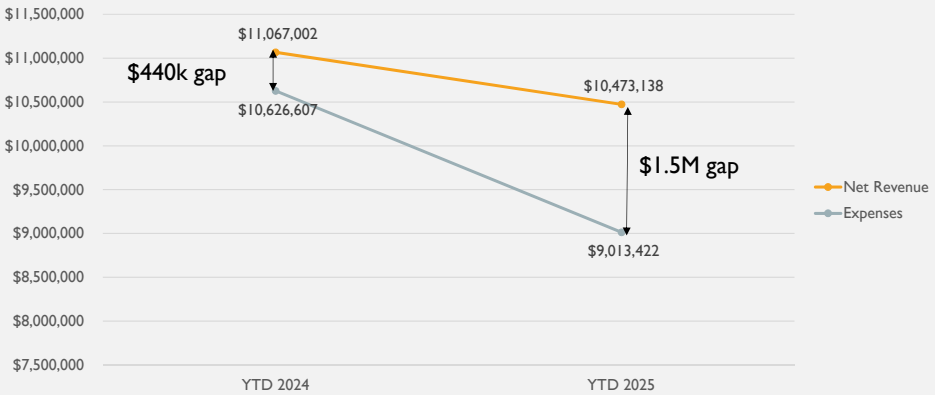
July 2024

INCOME

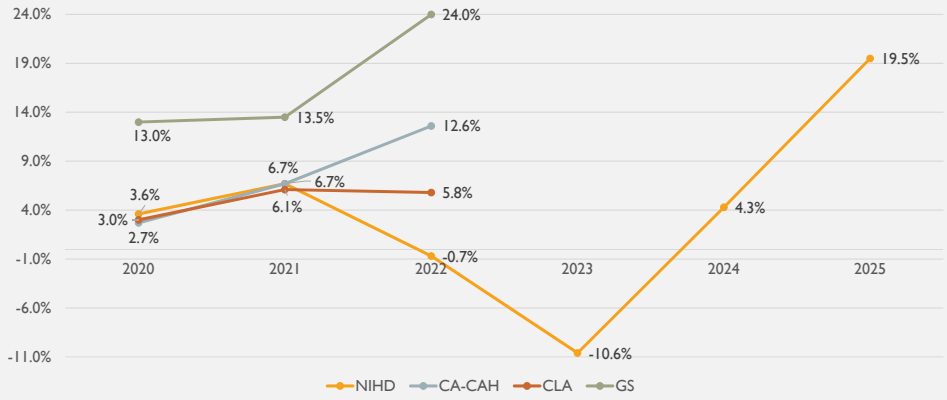
JULY 2024 FINANCIAL PERFORMANCE



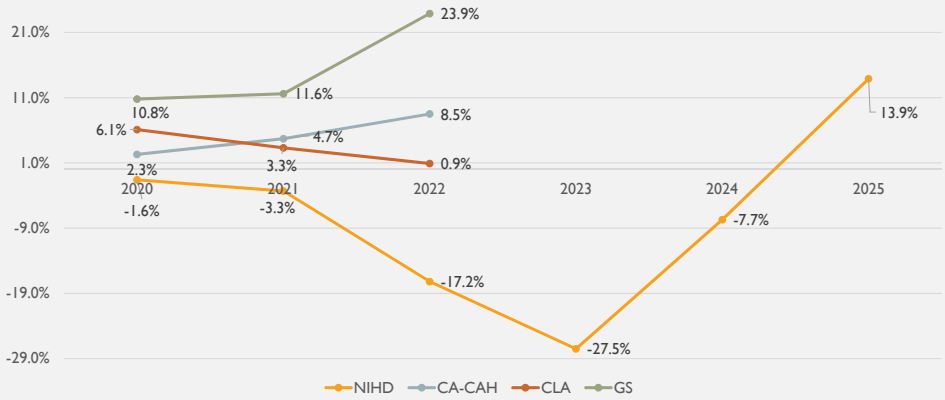
YTD OPERATING INCOME (LOSS) PERFORMANCE



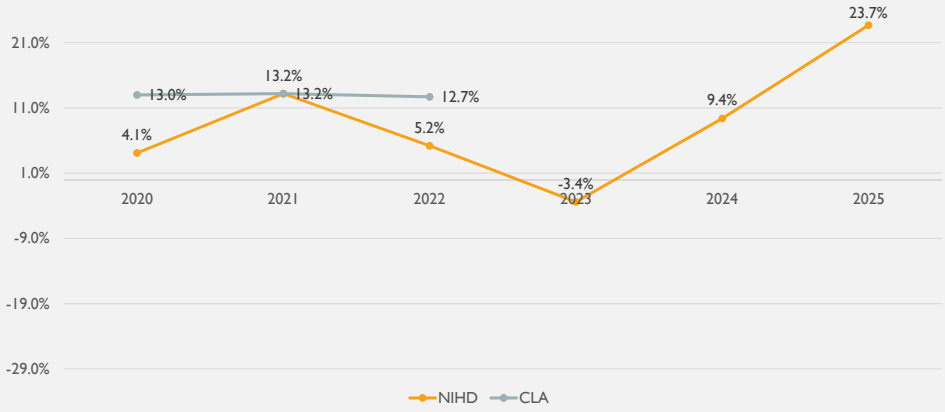
NET PROFIT MARGIN



OPERATING MARGIN

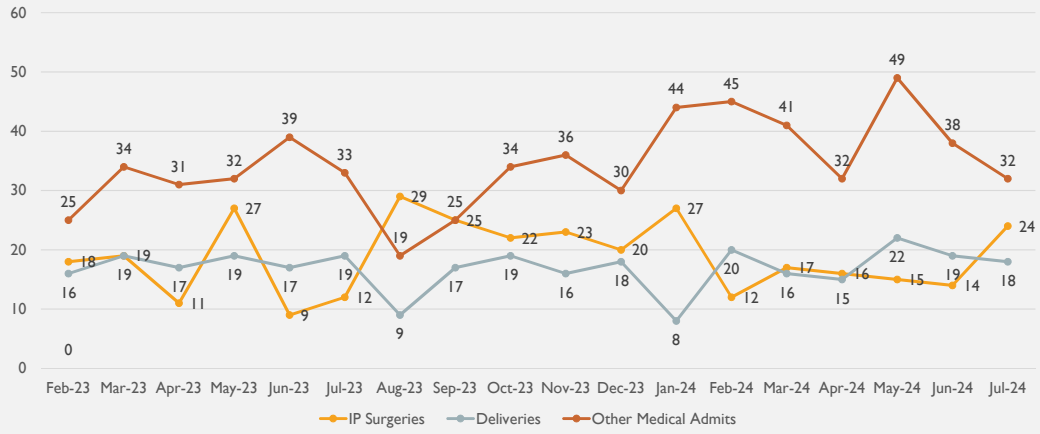


EBIDA MARGIN

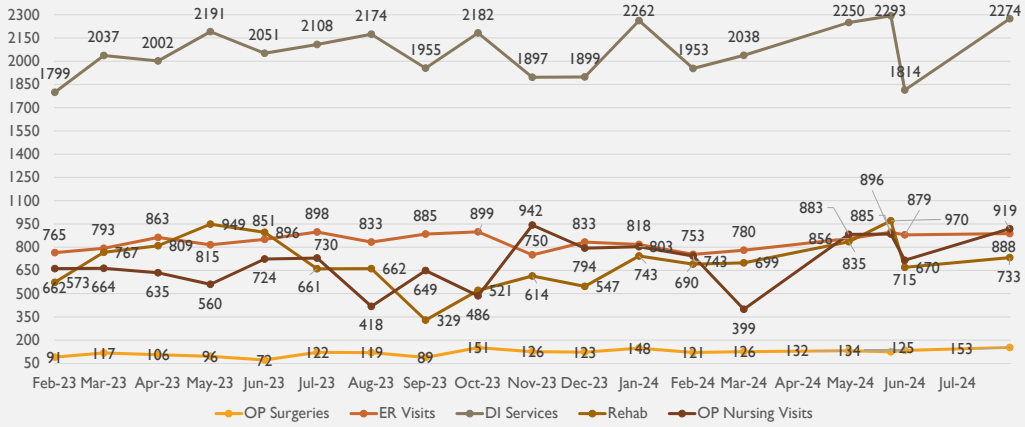


VOLUMES

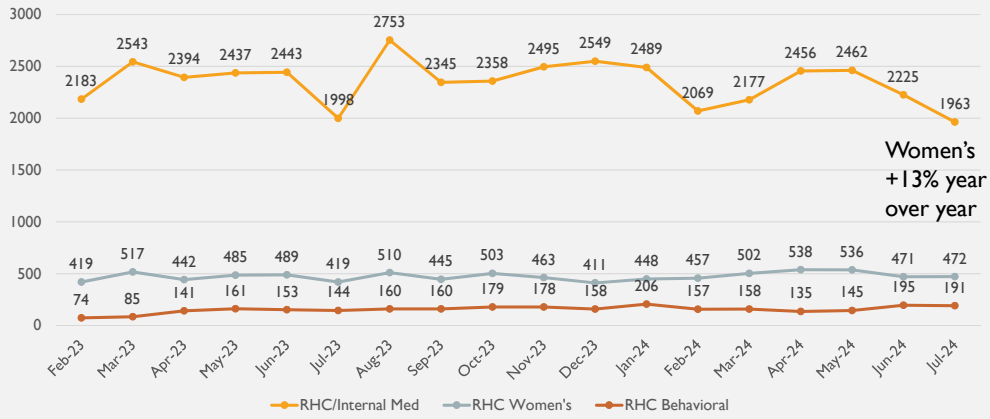
INPATIENT VOLUME PERFORMANCE



OUTPATIENT VOLUME PERFORMANCE

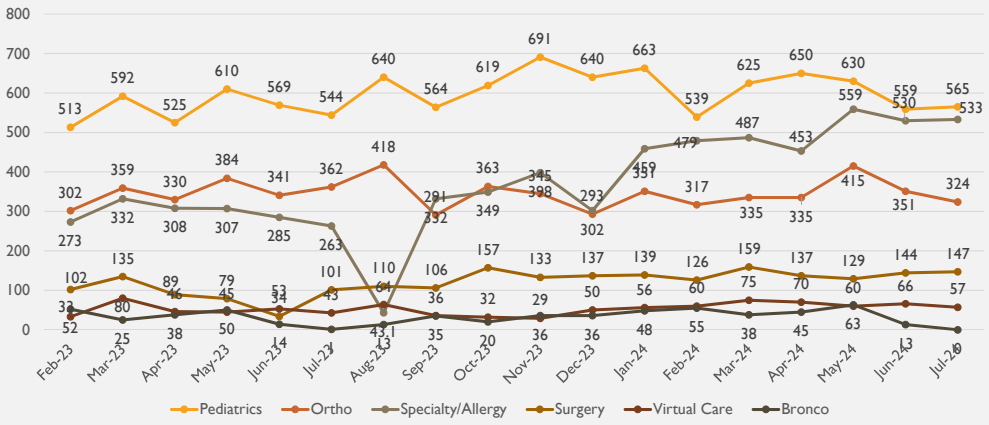


RHC VOLUME PERFORMANCE



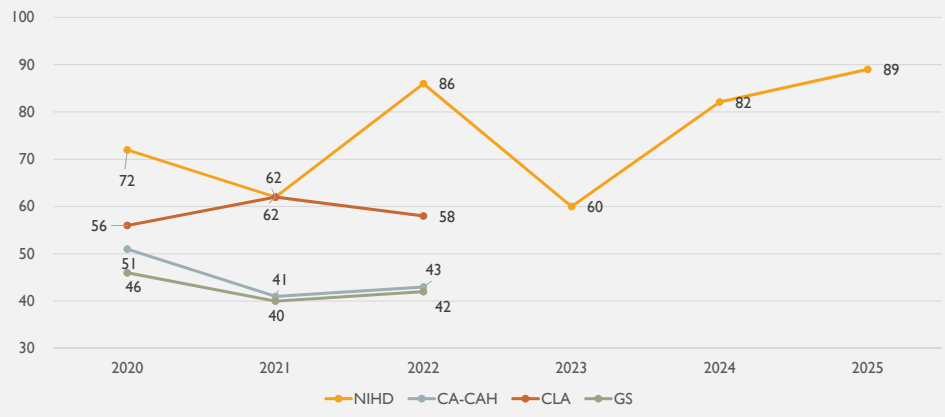
Women's +13% year over year

CLINIC VOLUME PERFORMANCE

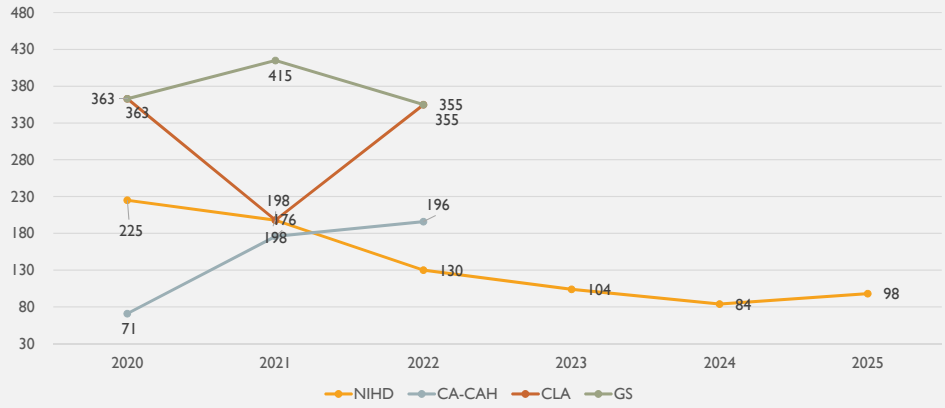


KEY PERFORMANCE INDICATORS

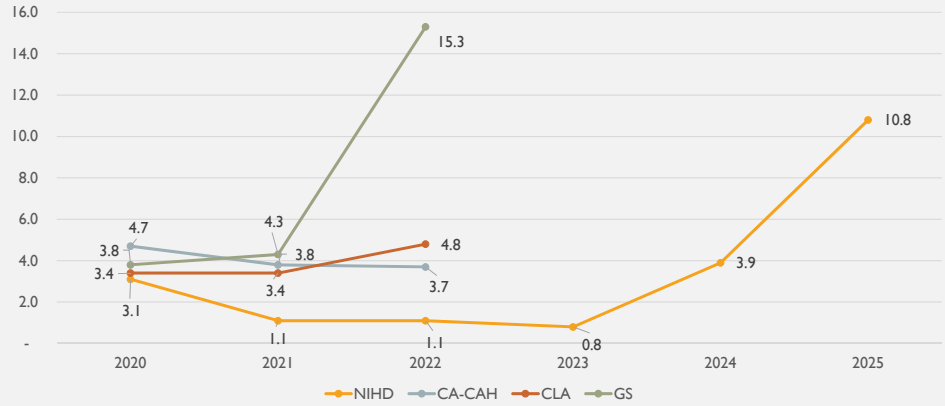
AR DAYS



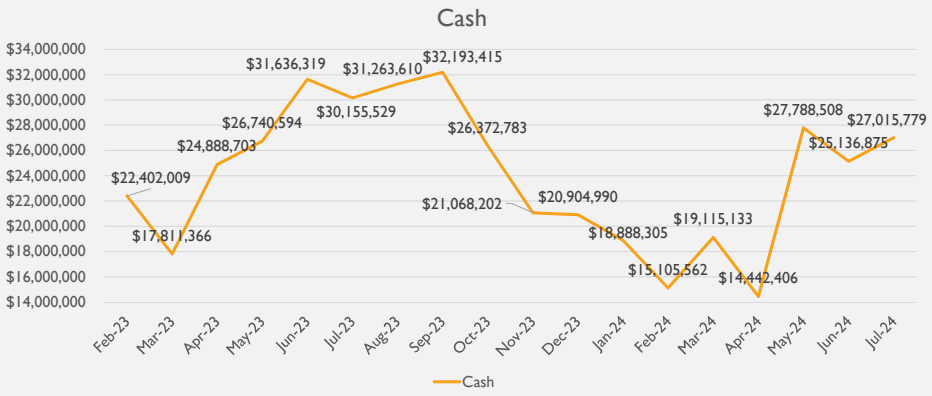
DAYS CASH ON HAND



DEBT SERVICE COVERAGE RATIO



UNRESTRICTED FUNDS



WAGE COSTS

	July 2022	July 2023	July 2024
Total Paid FTEs	436	396	396
Salaries, Wages, Benefits (SWB) Expense	$5,584,859	$5,522,271	$5,375,870
SWB % of total expenses	61.5%	58.7%	59.6%
Employed Average Hourly Rate	$41.98	$50.17	$51.76
Benefits % of Wages	70.5%	54.9%	44.9%

Northern Inyo Healthcare District
www.nih.org

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811

Date: 09/09/2024
To: Board of Directors
From: J. Adam Hawkins, DO Chief Medical Officer
Re: Bi-Monthly CMO report

Medical Staff Department update

Project Updates:

- Expansion of Existing Service Lines:
    - General Surgery:
        - Spyglass Cholangioscopy: Spyglass Cholangioscopy is an endoscopic procedure that allows for direct visualization and evaluation of the biliary and pancreatic ductal system. This is commonly required for treatment of impacted gallstones or to further evaluate for malignancy. Our General Surgeon, Dr. Connor Wiles brought this expertise with him from his residency training down at Cottage Health in Santa Barbara, CA. He successfully performed this procedure on a patient at NIHD in August. This resulted in a successful patient outcome that historically was only possible via transfer to a tertiary care facility.
        - Surgical Hiatal Hernia repair: Dr. Wiles is scheduled to complete the first elective repair of a hiatal hernia in September. This is procedure not previously performed at NIHD. This procedure increases the quality of life of patients who are suffering from acid reflux disease (GERD) as well as preventing more serious complications.
        - AV Fistula Program: We continue to work towards being able to provide our community members and patients with the ability to undergo creation of an AV fistula to aide in the stabilization of dialysis access. This is a nuanced and wide-ranging project that requires meticulous workflow optimization, policy creation, and interdepartmental collaboration. Dr. Wiles and I are working with additional medical staff departments to safely bring access to this procedure to the community in the near future.
- Women's Services:
    - Labor and Delivery Update: As you may recall from my March, 2024 CMO report, I touched on the troubling trend of reduced access to reliable women's healthcare, both regionally and nationally. According to a recent Becker's Healthcare article, between 2011 and 2021, 267 rural hospitals nationwide have dropped obstetrics services, representing nearly a quarter of America's rural obstetric units. Over the past month, two more rural California hospitals have announce that they too will be suspending or shutting down their labor and delivery service lines; Mad River Community Hospital and Hemet Global Medical Center. I want to highlight that this problem is more pronounced

in California compared to other states. To make matters worse, the structural issues forcing these closures are most pronounced in rural communities. The following quote from Mad River Community Hospital's CEO about their Hospital's decision to close their labor and delivery unit should really be eye opening to our community members as we face identical challenges:

- ""This is one of the hardest decisions I have made in my tenure as CEO," said Douglas Shaw. "Mad River has been the premier L&D provider for Humboldt County for many years. However, over the past four years, volumes have declined significantly to the point where we are performing, on average, less than 25 births per month. We used to average 60-plus births per month, which was necessary to fund the service line. At our current volume, the L&D has been sustaining a seven-figure annual loss for the past several years. When the decline in volume is combined with inadequate and stagnated reimbursements rates under Medi-Cal, unfunded mandates for seismic compliance, and other significant challenges for rural healthcare, the continuation of L&D service will jeopardize the hospital's continued viability in the community. We are working with local hospitals and clinic providers to facilitate the absorption of our L&D volume."

- I feel it is my duty as our communities Chief Medical Officer to bring into context the real challenges that we face maintaining a service line that I feel is imperative for the sustainability of the communities of the Eastern Sierra. Medi-Cal, the Medicaid program in California, has reimbursement rates for obstetric care that are fifth-lowest in the nation. Medi-Cal pays for more than 50% of the deliveries in California. These realities are sobering. We are hopeful that legislative help will materialize in the near future to make the situation more sustainable. In the meantime, our leadership teams and providers will do everything we can to maintain our programs viability.

Physician Recruitment Update:

- Physician Departures: It is with sadness for The District and the community of Bishop that I formally announce the pending departure of Dr.'s Kristin and Rich Meredick.
  - Dr. Kristin Meredick will have been a member of the medical staff for seven years. During her time as a Pediatrician she served as the Chief of the Pediatric Department as well as having served as Member at Large on the Medical Executive Committee. She is a strong leader amongst our medical staff. Dr. Meredick personally helped me in many difficult clinical scenarios where I was relieved to have her by my side.
  - Dr. Rich Meredick will have been a member of the medical staff for nearly 11 years. During his time as an Orthopedic Surgeon at NIHD he served as the Chief of the Orthopedic Surgery Department, Vice Chief of Staff, and Chief of Staff. Dr. Meredick always went above and beyond for his patients. His commitment to his craft and to his patients is something I aspire to emulate in my own medical practice. Dr. Meredick has helped establish a new wave of cutting edge technology to treat chronic joint pain at NIHD.
  - Both of these physicians leave behind a legacy of clinical excellence and compassion. I am excited for them and their family as they embark on the next chapter of their lives as a family and as physicians. We will miss them both!
- Recruitment Efforts:
  - **Orthopedic Surgery**: Although Dr. Rich Meredick's departure from the department poses short term challenges, the clinical leadership team at NIHD has taken the opportunity to reimagine the future of this department. We are steadfastly committed

to maintaining the full scope of services that we currently offer within the orthopedic department at NIHD. With that being said, the leadership team at NIHD has been engaged in creative recruiting and program building for the past few months. Although the detailed plans surrounding the future of this department are outside the scope of this report, I am passionately optimistic for the next chapter in this departments legacy.

- **Pediatrics**: It is important to point out the unique and challenging job that our pediatricians are asked to perform while providing inpatient and outpatient coverage for our patients at NIHD. Over the past one to two decades the specialty of pediatrics has seen a shift towards specialization. Pediatricians coming out of residency training generally choose one of three paths for their clinical practice; work exclusively in an outpatient clinic, work exclusively as an inpatient pediatrician but not caring for newborns; or work as an inpatient pediatrician that does care for newborn babies. At NIHD we ask one provider to perform all three of these roles. This dynamic has contributed to NIHD's pediatrician recruiting challenges. With this in mind, we have begun looking at different staffing models for the future of this department. We are still continuing our dedicated recruiting efforts and we will be hosting a booth at the upcoming Annual National American Academy of Pediatrics Conference in Orlando, FL later this month.

Quality Department Update

- The Quality Department has completed all HSAG audit activities for the 2023 QIP program, and all 12 measures submitted have been accepted for full achievement values. This will ensure the full QIP payment of approximately 3.4 million dollars. For 2024 the Quality Department continues to work closely with numerous clinics and hospital departments on QIP performance improvement measures with the intent to once again report the maximum number of measures. They are working to increase outreach to patients due for care, and to improve workflows to capture additional information to improve patient outcomes. Due to a requirement for continuous improvement, and a decrease in assigned Medi-Cal lives due to the Medi-Cal redetermination, full achievement will be more difficult this year. That being said, we have created Quality Performance Leadership Meetings along with QIP Workgroup meetings in order make a strong end of the year push in an attempt to once again achieve all 12 possible metrics.
    - As a result of this work, we were able to offer an additional clinic day that focused exclusively on allowing women in the community to be seen for their well woman exams in hopes of improving our District's chances at achieving the cervical cancer screening QIP metric. I want to recognize Jen Joos, our advanced practice provider lead in the RHC, for being willing to add an additional day in of clinic availability to offer these appointments to our patient's.
    - The leadership team working on QIP is committed to continuing to find creative ways to achieve the QIP metrics that we need to secure the reimbursement associated with this program.

Rehab Department Update

- As I mentioned in my previous report, our entire Rehabilitation Department is undergoing an operational overhaul with the hopes of simultaneously improving therapist satisfaction and the patient experience. With those goals in mind, our Director of Rehabilitation Services, Joanne Henze has been hard at work changing our provider schedule templates to create more consistency for patients and improve therapist availability throughout the day. I am also excited to announce that we just hired a full-time and local Physical Therapist Assistant, Luke Hamilton. Luke comes to us from Bear valley Community Healthcare District in Bear Valley, CA where he

was a PTA in their outpatient rehab clinic. Luke has hit the ground running and his schedule has been filling up since his start date a few weeks ago.

References:

1. https://www.latimes.com/opinion/story/2024-08-30/maternal-mortality-labor-delivery-medi-cal-medicaid
2. https://lostcoastoutpost.com/2024/aug/21/breaking-birth-center-mad-river-community-hospital/

September 2024 Statement

Open Date: 08/07/2024 Closing Date: 09/05/2024

[redacted]

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

[redacted]

New Balance	**$295.55**
Minimum Payment Due	**$10.00**
Payment Due Date	**10/01/2024**

Activity Summary

Previous Balance	+	$2,108.88
Payments	-	$16,040.04CR
Other Credits	-	$82.97CR
Purchases	+	$14,309.68
Balance Transfers		$0.00
Advances		$0.00
Other Debits		$0.00
Fees Charged		$0.00
Interest Charged		$0.00
New Balance	**=**	**$295.55**
Past Due		**$0.00**
Minimum Payment Due		**$10.00**
Credit Line		$37,500.00
Available Credit		$37,204.45
Days in Billing Period		30

[redacted]

Please detach and send coupon with check payable to: U.S. Bank [redacted]

[redacted]

Account Number	[redacted]
Payment Due Date	10/01/2024
New Balance	$295.55
Minimum Payment Due	$10.00

24-Hour Cardmember Service: [redacted]

. to pay by phone
. to change your address

[redacted]

Amount Enclosed $_____

[redacted]

[redacted]

What To Do If You Think You Find A Mistake On Your Statement

If you think there is an error on your statement, please call us at the telephone number on the front of this statement, or write to us at:

In your letter or call, give us the following information:

- *Account information:* Your name and account number.
- *Dollar amount:* The dollar amount of the suspected error.
- *Description of Problem:* If you think there is an error on your bill, describe what you believe is wrong and why you believe it is a mistake.

You must contact us within 60 days after the error appeared on your statement. While we investigate whether or not there has been an error, the following are true:

- We cannot try to collect the amount in question, or report you as delinquent on that amount.
- The charge in question may remain on your statement, and we may continue to charge you interest on that amount. But, if we determine that we made a mistake, you will not have to pay the amount in question or any interest or other fees related to that amount.
- While you do not have to pay the amount in question, you are responsible for the remainder of your balance.
- We can apply any unpaid amount against your credit limit.

Your Rights If You Are Dissatisfied With Your Credit Card Purchases

If you are dissatisfied with the goods or services that you have purchased with your credit card, and you have tried in good faith to correct the problem with the merchant, you may have the right not to pay the remaining amount due on the purchase.

To use this right, all of the following must be true:

1. The purchase must have been made in your home state or within 100 miles of your current mailing address, and the purchase price must have been more than $50. (Note: Neither of these are necessary if your purchase was based on an advertisement we mailed to you, or if we own the company that sold you the goods or services.)
2. You must have used your credit card for the purchase. Purchases made with cash advances from an ATM or with a check that accesses your credit card account do not qualify.
3. You must not yet have fully paid for the purchase.

If all of the criteria above are met and you are still dissatisfied with the purchase, contact us in writing at: Cardmember Service,

While we investigate, the same rules apply to the disputed amount as discussed above. After we finish our investigation, we will tell you our decision. At that point, if we think you owe an amount and you do not pay we may report you as delinquent.

Important Information Regarding Your Account

1. **INTEREST CHARGE:** Method of Computing Balance Subject to Interest Rate: We calculate the periodic rate or interest portion of the **INTEREST CHARGE** by multiplying the applicable Daily Periodic Rate (**"DPR"**) by the Average Daily Balance (**"ADB"**) (including new transactions) of the Purchase, Advance and Balance Transfer categories subject to interest, and then adding together the resulting interest from each category. We determine the **ADB** separately for the Purchases, Advances and Balance Transfer categories. To get the **ADB** in each category, we add together the daily balances in those categories for the billing cycle and divide the result by the number of days in the billing cycle. We determine the daily balances each day by taking the beginning balance of those Account categories (including any billed but unpaid interest, fees, credit insurance and other charges), adding any new interest, fees, and charges, and subtracting any payments or credits applied against your Account balances that day. We add a Purchase, Advance or Balance Transfer to the appropriate balances for those categories on the later of the transaction date or the first day of the statement period. Billed but unpaid interest on Purchases, Advances and Balance Transfers is added to the appropriate balances for those categories each month on the statement date. Billed but unpaid Advance Transaction Fees are added to the Advance balance of your Account on the date they are charged to your Account. Any billed but unpaid fees on Purchases, credit insurance charges, and other charges are added to the Purchase balance of the Account on the date they are charged to the Account. Billed but unpaid fees on Balance Transfers are added to the Balance Transfer balance of the Account on the date they are charged to the Account. In other words, billed and unpaid interest, fees, and charges will be included in the **ADB** of your Account that accrues interest and will reduce the amount of credit available to you.To the extent credit insurance charges, overlimit fees, Annual Fees, and/or Travel Membership Fees may be applied to your Account, such charges and/or fees are not included in the ADB calculation for Purchases until the first day of the billing cycle following the date the credit insurance charges, overlimit fees, Annual Fees and/or Travel Membership Fees (as applicable) are charged to the Account. Prior statement balances subject to an interest-free period that have been paid on or before the payment due date in the current billing cycle are not included in the **ADB** calculation.
2. **Payment Information:** We will accept payment via check, money order, the internet (including mobile and online) or phone or previously established automatic payment transaction. You must pay us in U.S. Dollars. If you make a payment from a foreign financial institution, you will be charged and agree to pay any collection fees added in connection with that transaction. The date you mail a payment is different than the date we receive the payment. The payment date is the day we receive your check or money order at U.S. Bank National Association, 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
HCAI Meeting	08/14	08/12	[redacted]	HOTEL LODG* [redacted] LOD CA MERCHANDISE/SERVICE RETURN	$82.97CR	
HCAI Hotels	08/23	08/23	0000	INTERNET PAYMENT THANK YOU	$2,108.88CR	
AAP Conference	08/23	08/23	0000	INTERNET PAYMENT THANK YOU	$13,931.16CR	
American Academy of Pediatrics Conference				**TOTAL THIS PERIOD**	**$16,123.01CR**	

Purchases and Other Debits

	Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
CMO Conference	08/09	08/08	[redacted]	AMER ASSOC FOR PHYS LE [redacted]	$11,475.00	
HCAI Meeting	08/12	08/10		HOTEL LODG* HILTON [redacted]	$1,059.13	
Marketing	08/15	08/14		FACEBK [redacted]	$400.00	
Board Clerk Conf.	08/19	08/15		CALIFORNIA SPECIAL DIS [redacted]	$1,080.00	
Marketing	09/03	08/31		FACEBK [redacted]	$295.55	
				TOTAL THIS PERIOD	**$14,309.68**	

Fees

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
09/05			ANNUAL MEMBERSHIP FEE	$0.00	
			TOTAL FEES THIS PERIOD	**$0.00**	

2024 Totals Year-to-Date

Total Fees Charged in 2024	$78.00
Total Interest Charged in 2024	$255.74

Company Approval *(This area for use by your company)*

Signature/Approval: _____ Accounting Code: _____

Continued on Next Page

NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

[redacted]

Interest Charge Calculation

Your Annual Percentage Rate (APR) is the annual interest rate on your account.

**APR for current and future transactions.

Balance Type	Balance By Type	Balance Subject to Interest Rate	Variable	Interest Charge	Annual Percentage Rate	Expires with Statement
**BALANCE TRANSFER	$0.00	$0.00	YES	$0.00	24.24%	
**PURCHASES	$295.55	$0.00	YES	$0.00	24.24%	
**ADVANCES	$0.00	$0.00	YES	$0.00	29.99%	

Contact Us

[redacted]

End of Statement

NORTHERN INYO HOSPITA

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

Date: September 18, 2024
To: Board of Directors
From: Stephen DelRossi, CEO
Re: Quarterly CEO Report

CEO Department Leader Updates

ITS – Bryan Harper, Director
The Work Queue Monitoring (WQM) system has been successfully implemented. The issues with Frontier's fax services have been resolved. We are still addressing ongoing challenges with the MyChild system. The installation of the new CCTV camera system is progressing to enhance security. Direct Radiology, our new after-hours reading service, is being integrated to provide efficient off-hours radiological support. Data migration between Athena and Centricity with Hyland continues to advance. We are preparing for the transition of internet services to the primary Frontier connection and upgrading phone SIP trunks with Frontier to newer technology. Security vulnerabilities identified in recent scans have been addressed.
In addition, the biomedical team has completed 769 work orders in the Emaint equipment records tracking system. Incubators for the Pharmacy have been purchased, assembled, and are awaiting final placement. Scott has collaborated with IT and Nursing teams on the MyChild infant security system. Several PACU and ED gurneys have been repaired for brake and lift issues. A sterilizer startup schedule has also been developed and deployed.

Marketing, Communication & Strategy – Barbara Laughon, Manager
NIHD is preparing for two upcoming recruiting events at the end of the month: one in San Francisco focused on Rehabilitation Services, and another in Orlando for Pediatric Physician recruitment. In anticipation of Breast Cancer Awareness Month, we are organizing weekly Moonlight Mammogram nights and a special podcast series featuring Dr. Cheryl Olson, Dietitian Denice Hynd, Lymphedema Therapist Dana Georgeson, and members of the Eastern Sierra Cancer Alliance. We're also partnering with Southern Inyo Healthcare District and Toiyabe Indian Healthcare to offer dedicated mammography days for their patients.

Events – Earlier this month, we unveiled bronze plaques honoring former CEO/CFO John Halfen and former Orthopedic Surgeon and District Trustee Dr. John Ungersma, celebrating their lasting contributions to the District. Additionally, the in-person August Healthy Lifestyle Talk, "Skin Cancer 101," presented by Dr. Stacey Brown, was a great success. Dr. Brown will continue the series with a session on melanoma, scheduled for Thursday, Oct. 3, at 6 p.m.

Foundation – Greg Bissonette, Director
The Foundation is raffling off an original watercolor painting that was recently donated by a local artist. These funds will go towards purchasing an AED for one CARE shuttles that is without it. The need for new plaques in the Healing Garden was also addressed by the Foundation and new ones, made of much more durable material, have been made and are just waiting to be installed.

NORTHERN INYO HEALTHCARE DISTRICT
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Grant Writing
Work is continuing on CalHHS' Data Exchange Framework grant where the District was awarded $100,000 for joining a certified Health Information Exchange and to begin sharing patient data statewide. The District received its first installment of $50,000 for work completed so far. Another grant, through HealthNet, in the amount of $30,000 was also secured and received for this project. The texting communication project, UCC Patient Communications through Cerner, also received funding from HealthNet in the amount of $10,000. Administration and maintenance for all other current grants is ongoing.

Project Management – Lynda Vance, Project Manager
Work continues on several workflow efficiency projects and SmartSheet collaborations. Over the last three years, I have assisted our teams with creating over 100 sheets, dashboards, and reports. I have helped our teams streamline their processes, including the increased innovation of adding QR codes to reduce manual data entry. We are getting closer to the Pharmacy and Outpatient nursing area moves, but no move date has been set. In June, NIHD went live with our first interface connection for the Data Exchange Framework (DxF) project with Manifest. This will allow us to exchange patient data efficiently with other healthcare entities. In July, we completed the vetting process for the outreach through Cerner to connect with Toiyabe and Valley Health for orders and results. The project kick-off for the UCC appointment reminders and enhanced two-way communication for patients was completed. We are targeting a go-live in early October. In Aug, NIHD went live with an updated connection with our third-party collections agency, Hauge. Project Management worked with ITS to enable AI in Zoom to help streamline meeting note-taking at the district. The Move Team completed desk updates in the Specialty Clinic to allow room for two staff to assist with patients. NIHD's third-party reading radiology group is transitioning to a new system to store imaging studies.

Purchasing – Neil Lynch, Director
Over the past 90 days, the Purchasing Department has booked $1,128,098 in goods and services for the Health Care District, reflecting an increase of $91,254 from the previous 90-day period, which totaled $1,036,844. In July, the department procured a Slit Lamp Microscope for the Emergency Department. This significant purchase, funded by the NIH Auxiliary, was received by the Emergency Department at the end of August.

Patient Access – Tanya DeLeo, Director
Patient Access is currently cross-training twenty-three employees who are currently at levels II and III. This will allow staff to work in various areas of patient access, broadening their knowledge base and becoming more valuable team members. In addition to learning various aspects of registration in different Cerner modalities, training includes customer service, with a focus on Acknowledgement, Introduction, Duration, Explanation, and Thank You. Work Queue Management (WQM) was successfully implemented on June 17th. Patient access personnel have completed their training and have seamlessly transitioned to this electronic workflow. This has resulted in improved provider access to patient medical information from external vendors and reduced wait times for examinations and authorizations. This week, we will launch appointment

reminders through UCC Wells, and on October 8th, we will complete our vendor transition from I2I to UCC Wells. This new, robust two-way patient communication system will provide patients with enhanced access to their care team and enable them to receive communication responses in real-time, at their convenience.

Medical Records – Marnie Davis, Manager
Out of office until 9/11/24.

RHC Out-Patient Clinics, Jannalyn Lawrence, Director
Primary Care Clinics – On the primary care side of Outpatient Clinics, we are focusing efforts to improve access to care.

- We just welcomed a new Oncology Navigator to the team- her name is Veronica Hernandez. She is a wonderful addition to our Care Coordination team, and will be a partner to many of our clinicians to support cancer patients in their journey. She is training alongside Rosie Gravies, our past navigator who is now one of our clinic managers, as well as Lynn Kruse, RN in Specialty Clinic who has extensive experience working with breast and prostate cancer patients.
- At the Rural Health Clinic, we have made some changes to standardize and expand provider schedule templates, allowing for increased daily patient volume. This change was effective July 1, and we've seen steady increase in visit numbers over the last two months. Most days we see over 100 patients, with 6-7, sometimes 8 providers per day.
- Women's Clinic continues to see increased patient volume with the closure of Ridgecrest labor and delivery services. Over the last six months, we've added Saturday morning clinic in an effort to expand access. These mornings are consistently full and we hope to eventually extend to full day on Saturdays. Back in mid-June Dr. Arndal started offering a separate clinic for gynecological surgery patients in our Surgery Clinic. We anticipate this change will drive GYN surgery while opening up space within Women's Clinic to see additional prenatal patients.
- Our Pediatric Clinic volume has remained steady and we're gearing up for cold and flu season.

Specialty Care Clinics - On the specialty side of Outpatient Clinics, we're striving to optimize and expand specialty

- We welcomed Dr. Thunder, orthopedic spine surgeon, into our Ortho Clinic in May. We have consistently filled two clinic days per month for Dr. Thunder and he's booking out into Nov/Dec at this point.
- Cardiology growth continues with Dr. Rowan. He has graciously added clinic days over the next couple of months to expand availability for new patients, and allow for additional procedures such as echoes and cardioversion. One Friday earlier this month, he saw 26 patients in clinic, while running a simultaneous pacemaker clinic and completing three procedures in the PACU over lunchtime! Specialty Clinic staff have never been busier, and continue to rise to the occasion every day.

- We're working with Dr. Davis, our urologist, to optimize his existing clinic schedule by ensuring he has enough slots to accommodate in-clinic procedures, surgical follow-ups, and new patient consultations. We recently completed conversion of a manager office into a fourth exam room in Specialty Clinic, which allows us to more efficiently run two specialists at a time. We had a week at the end of August where we had two physicians in clinic every day.
- Dr. Plank, our plastic surgeon, is adding an extra full clinic day every quarter, this started in August. We have implemented telehealth consultations, which allow him to connect to our patients virtually from his location in FL. He is able to see some patients for initial consultation via telehealth, and then can perform in-office or OR procedures when he's on campus; this has greatly improved access to his services, and has been well received by patients.

Revenue Cycle - Gloria Sacco, Consultant
HRS - We are currently preparing the revisions for filing with HRS for the Medicare Cost Reports from 2019 to 2023.

ADHC - We contracted with ADHC to conduct a look back on all accounts underpaid based on our contracts and State Regulation required payments (Workers compensation). We are currently obtaining all 837 claims and 835 remit files from CMP for 2021 to 2024.

Charge Capture Audit – This has been assigned to the CFO for next steps.

Charge Master Pricing Analysis – This has been assigned to CFO for next steps.

Charge Reconciliations by Department - Daily charge reconciliations implemented and performed since January 2024 by each department. This process has identified lost charge issues, incorrect pricing, and incorrect units. An audit is done on a weekly basis to verify all departments are performing this function as required.

Business Office
Novus (Medicaid Billing Company)
- Clean up on 2023 accounts reduced (Dec- 11,498 accts to Aug – 6264 accounts).
- No Increase in AR over 90 days- 56% (Jul) 56% (Aug)
- Novus has hired on additional staff to aid in the cleanup of our accounts.

OS Healthcare (all payers except Medicaid)
- Reduced over 90 days from 22% (Jul) to 21% (Aug). Goal is 15%.
- Increased denial rate from 21% (Jul) to 24% (Aug) goal is 5%
- Transition from EffC to CMP has caused issues, which are being addressed, and caused a delay in reducing over 90 days.

MedPlan
- Self-pay AR has reduced from $9.8 million to $8.9 million.

NORTHERN INYO HEALTHCARE DISTRICT
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- Interphase for MedPlan & Hauge is almost completed.

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Designated Areas for Food and Drink Near Patient Care Areas*		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: District Wide		
Date Last Modified: 09/04/2024	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 2014	

PURPOSE:

To control the spread of infection through the consumption of food and drink in clinical areas and provides guidance on where food and drink may be consumed near a patient care area.

POLICY:

It is the policy of Northern Inyo Healthcare District (NIHD) to maintain a safe and clean environment for patients, physicians, employees, and visitors by limiting the areas where food and drink may be consumed or stored. Food and drink may be contaminated by such processes as the leakage or spillage of specimen containers, or the performance of activities that could generate splashes, sprays, or droplets of blood or other potentially infectious materials.

PROCEDURE:

1. Eating, drinking, applying cosmetics or lip balm, and handling contact lenses is prohibited in areas where there is a reasonable likelihood of occupational exposure. OSHA 1910.1030(d)(2)(ix)
2. Food and drink for employees will not be stored in areas where blood, chemicals, or potentially infectious materials are stored. Food items for employees will be stored in covered containers in offices, lockers, and refrigerators designated for employees.
3. Beverages may be consumed by employees in **covered** containers near patient care areas, as designated in the chart below. Department Leadership are accountable for designating those locations.
4. Food is not permitted in clinical areas (nurse's stations, lab stations, etc.)
5. Food and beverages for employees may be consumed in the cafeteria, staff lounges, and designated areas on patient care units, as specified by the department leader, in collaboration with the Infection Preventionist.
6. Food and beverage containers and utensils used by employees must be discarded in designated waste containers as soon as possible after the food or beverage has been consumed.
7. Food and drink shall not be stored in refrigerators, freezers, shelves, and cabinets or on countertops or bench-tops where chemicals, blood, or other potentially infectious materials are present.
8. Food and drink may not be stored or transported on environmental services carts.

DESIGNATED BEVERAGE AREAS: SEE TABLE BELOW (Hydration Station)

Department	Designated area	Department	Designated area	Department	Designated area
ICU	Nurses Station	**Acute/Sub-acute**	Nurses Station, Report Room, or Employee Break Room	**Emergency Department**	Nurses Front Desk and Lounge, Physician dictation room
Perinatal	Behind Nurses Station by Sink	**PRE- OP PACU:**	Counter behind nurses station	**Outpatient Infusion:**	Break Room
Operating Room:	OR Lounge	**Diagnostic Imaging**	Office Space, Break Room, Non-Clinical Tech work area	**Cardiopulmonary**	RT: Respiratory Office EKG: Break Room PFT: when no patient in room. ECHO: Office
Rehab Services	Staff break rooms, Non-clinical office spaces/at desks.	**Phlebotomy**	Back Room	**Laboratory**	Non-Clinical area, Break Room
RHC	Front Office: Designated countertop Back Office: Designated counter top	**NIA Pediatric**	Break Area	**RHC Women's Clinic**	Front Office: Staff Lounge Back Office: Provider/Nurse Desk
NIA Surgery Clinic	Break Room	**NIA Ortho Clinic**	Break Room	**Specialty Clinic**	Designated counter top
EVS	In the designated food/beverage area for the unit the EVS personnel is assigned to.	**Dietary**	Kitchen/Office Area	**Patient Access**	At Work Station
Pharmacy	Drinks must be covered. No food allowed, except in designated area in new pharmacy.	**Laundry**	Break Area		

REFERENCES:

1. APIC Text of Infection Control and Epidemiology, 3rd Edition, 2009
2. The Joint Commission (2017). Environment of Care Risk Assessment- Staff Food and Drink. Retrieved from https://www.jointcommission.org/standards_information/jcfaqdetails.aspx?StandardsFAQId=1229&StandardsFAQChapterId=64&ProgramId=0&ChapterId=0&IsFeatured=False&IsNew=False&Keyword=&print=y
3. The Joint Commission (2019) Clarifying Food and Drink Safety for Clinicians. Retrieved from https://store-jcrinc.ae-admin.com/assets/1/7/JCP_39_2019_3_fooddrinksafety.pdf
4. Occupational Safety and Health Administration (OSHA) Blood-borne Pathogen Standard: CFR 1910.1030. (Site accessed 7/19/2024). Retrieved from https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=10051&p_table=STANDARDS
5. Occupational Safety and Health Administration. (2006). Requirements for covered beverages at nurses stations: 1910.1030,1910.1030(d)(2)(ix), 1910.141,1910.141(g)(2) (Site accessed 7/19/2024)

RECORD RETENTION AND DESTRUCTION:

NA

CROSS REFERECNES:

1. Bloodborne Pathogen Exposure Control Plan
2. InQuiseek – Building Sanitation and Cleanliness

Supersedes: v.3 Designated Areas for Food and Drink near Patient Care Areas*

Title: Final Payroll Check		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 08/14/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/20/2002	

POLICY:

If you resign, your final check will be available to you from the Human Resources Department on your last day of work if you have given at least 72 hours' notice. If you quit without notice, your check will be available from the Human Resources Department no later than 72 hours after your last day of work. For employees who are terminated, the final paycheck will be available in the Human Resources Department immediately upon termination.

Full and regular part-time employees leaving the District's employment will be paid for any Paid Time Off accrued but not used, and all pay for hours worked to the time of separation. If an employee is enrolled in District provided benefits, any coverage will carry through to the end of the calendar month of separation.

Unused sick leave account benefits are not paid upon separation.

Name badges and other District property must be surrendered (or proof of return of property must be given) to the Human Resources Department at the time the final check is released. Employee uniforms owned by the District may be given to terminating employees at the discretion of the employee's supervisor, department head, or the Administrator if the uniforms cannot be used by another employee.

REFERENCES:

1. State of California – Department of Industrial Relations https://www.dir.ca.gov/dlse/finalpay.pdf

RECORD RETENTION AND DESTRUCTION:

1. Maintain payroll records for non-pension workforce for a minim of 15 years.
2. Employees entitled to pension: life of employee plus 6 years

CROSS REFERENCED POLICIES AND PROCEDURES:

1. InQuiseek – General Employment Policies
2. Payroll Check Advances
3. Payroll Policies and Guidelines

Supersedes: v.2 Final Payroll Check, v.1 Termination Benefits
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Guarantor Verification Procedure - NIHD Admission Services		
Owner: Director of Patient Access	Department: Patient Access	
Scope:		
Date Last Modified: 08/07/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
Guarantor verification ensures the proper direction of the final or self-pay bill and prevents breaches of personal health information (PHI).

PROCEDURE:
Guarantor verification must be done during every registration event.
The person or entity listed as the primary guarantor for a visit is the person or entity financially responsible for either:

- The entire bill (if self-pay) or
- The portion owed after all insurances, Medicare or Medicaid, have paid.

The guarantor must be verified for appropriateness and accuracy for every registration. This includes verifying the accuracy of the address entered for the guarantor to prevent misdirection of the mailed bill.

When verifying or entering the guarantor information in a registration, it is important to note the age of the patient as this helps in determining who is entered as the guarantor.

<u>Adults (18 years of age and older) are their own guarantors unless one of the following is true:</u>

1. The adult patient has a conservator who has charge of the patient's financial affairs. In these cases:
   - The conservatorship paperwork must be on file with the Health Information Management department (HIM) and verifiable in the Electronic Health Record (EHR)
   - The conservator is entered as the primary guarantor
2. Another entity is responsible for the costs of the visit and provides the proper billing instructions. In the following cases the insurance is entered as "self-pay" and the entity described is entered as the guarantor:
   - The employer in the case of any occupational health visit.
   - Another medical institution or government agency for visits such as those related to research grants or transplant/donor cases.
   - A local business that is taking responsibility for a patient's bill due to an accident on their property. In these cases:
     - a written statement of their intent to pay, including billing information must be provided by someone in authority such as the owner or manager of the business
     - This document is scanned into the visit
     - A note regarding their intent must be entered into the visit
   - If a *Medicare* patient is brought to Northern Inyo Healthcare District (NIHD) for services from another healthcare facility and is in "Inpatient Status" at the other healthcare facility (they are billing the

patient's Medicare as primary) that facility becomes the guarantor, with the following exceptions which allow NIHD to bill Medicare as primary:

- The patient becomes an inpatient at NIHD
- Emergency Department visits
- Surgery
- Chemotherapy
- Epoetin injections due to Chemotherapy or Dialysis

Minors (17 years of age and younger)

1. The minor patient's parent or legal guardian (guardianship papers must be on file in HIM and verifiable in the EHR) is usually the guarantor for a minor patient's visit (see exceptions listed in "Minors with Legal Authority to Consent" policy [under Compliance]). The parent/guardian who signs the Conditions of Admission (COA) for the visit is the person entered as the primary guarantor.
   NOTE: If the parent/guardian does not accompany the minor to their visit, one of the following must take place:
   - The parent may give permission in writing for their child to be seen for that visit.
     - The letter giving permission for services to be rendered must be dated and signed
     - The parent who signs becomes the guarantor for that visit
   - When the minor child arrives unaccompanied (without written permission from the parent/guardian), the parent/guardian is to be contacted by phone to obtain verbal permission for the minor to be seen (see attached forms for phone consent). The parent who gives consent over the phone becomes the guarantor for that visit
   - Minor has legal authority to sign COA per "Minors with Legal Authority to Consent" policy (under Compliance).
2. When the minor is in the custody of Child Protective Services the guarantor is entered as "Child Protective Services"

REFERENCES:

CROSS REFERENCE P&P:

1. Minors with Legal Authority to Consent policy (under Compliance)
2. Minor Privacy Procedure – NIH Admission Services

Supersedes: v.1 Guarantor Verification Procedure - NIH Admission Services

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Infection Control Risk Assessments (ICRA) For New Construction or Renovation Projects		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: District Wide		
Date Last Modified: 08/06/2024	Last Review Date: 05/19/2021	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
The purpose of this policy is to establish guidelines and procedures for conducting Infection Control Risk Assessments (ICRA) during construction or renovation projects within healthcare facilities. The intent of the risk assessment is to:

- Identify and control airborne and waterborne biological contaminants in occupied patient care and staff areas during periods of demolition and renovation and new construction projects.
- Identify and evaluate any moisture, temperature or humidity concerns.
- Identify potential noise and vibration associated with construction operations and the potential for impact on the ability to provide patient care or perform normal business functions.
- Identify any potential disruption of utility services and communication systems requirements.
- Ensure the safety of patients, visitors, and healthcare personnel by identifying and mitigating potential sources of infection during construction activities including healthcare-associated infections (HAIs)
- To provide parameters for safe design, construction, maintenance, and sustainability in the healthcare environment.

POLICY:
It is the policy of Northern Inyo Healthcare District (NIHD) to implement rigorous Infection Control Risk Assessments (ICRA) construction and renovation projects within NIHD. These assessments are crucial to maintaining the integrity of infection control measures and safeguarding the health of our patients, staff, and visitors. The following principles guide our ICRA process:

1. **Prevention of Healthcare-Associated Infections (HAIs):** All construction activities must be conducted in a manner that prevents the spread of infectious agents within the healthcare environment. This includes adherence to strict infection control protocols and guidelines established by regulatory bodies such as the:

- American Society for Healthcare Engineering (ASHE)
- Board of Pharmacy
- California Department of Public Health (CDPH)
- Centers for Disease Control and Prevention (CDC)
- Department of Health Care Access and Information (HCAI)
- Facility Guidelines Institute (FGI) when designing and planning for construction activities.
- National Council on Radiation Protection and Measurements (NCRP)
- Occupational Safety and Health Administration (OSHA).
- Other reputable standards and guidelines that provide the equivalent design criteria.

2. **Risk Assessment and Management:** Prior to the commencement of any construction project, a comprehensive ICRA will be conducted to assess potential risks to patient care areas, including but not

limited to infection transmission routes, disruption of HVAC systems, and containment procedures for hazardous materials and dust. When an ICRA is developed a multidisciplinary team that may include qualified infection control professionals in collaboration with maintenance, project management, and department leadership and/or contracted vendor.

3. **Identification of Vulnerable Areas:** Critical patient care areas, immunocompromised patient units, isolation rooms, and other high-risk zones will be identified during the ICRA process. Special precautions and additional infection control measures will be implemented to protect these areas from construction-related contaminants and disturbances.
4. **Communication and Education:** Effective communication between healthcare staff, patients, visitors, and construction personnel is essential. All stakeholders will be informed about the nature of the construction activities, associated risks, and infection control measures in place. Education and training sessions will be conducted to ensure understanding and compliance with ICRA guidelines.
5. **Monitoring and Compliance:** Regular monitoring and inspections will be conducted throughout the construction project to ensure compliance with ICRA protocols and infection control standards. Any deviations or issues will be promptly addressed and corrected to minimize risks to patient safety. The Monitoring Tools if determined during ICRA would be kept on site within the construction activities .

DEFINITIONS:

Design phase - Components include conceptual phase, schematic and structural considerations, programming needs, financial aspects

Infection Control Risk Assessment (ICRA) - tool used to stratify infection control risks associated with construction or renovation

Infection Control Risk Mitigation Recommendation (ICRMR) - Written plans that describe the specific methods by which transmission of air- and waterborne biological contaminants will be avoided during construction as well as during commissioning, when HVAC and plumbing systems and equipment are started/restarted.

Project Manager - assigned person(s) responsible to the project, may be corporate or entity assigned

Project Team - a multidisciplinary planning group that at a minimum should include representation from infection prevention, administration, facility operations, architect, engineer, project manager, and the contractor

PROCEDURE:

Initial Planning Phase:

- Project initiation meeting including infection control personnel, project managers, and construction team.
- Preliminary walkthrough of construction site to identify potential risks and vulnerable areas.
- When planning construction in or around computed tomography (CT), positron emission tomography (PET), or nuclear medicine (NM) services areas, prior to and after installation of new imaging equipment, replacement of existing imaging equipment, or modification to rooms where ionizing radiation will be emitted or radioactive materials will be stored (such as scan rooms or hot labs), a medical physicist or health physicist conducts a structural shielding design* assessment to specify required radiation shielding.

Infection Control Risk Assessment (ICRA):

- Detailed assessment conducted by infection control specialists.
- Identification of infection risks, categorization of patient care areas based on vulnerability, and establishment of risk mitigation strategies.

Development of ICRA Plan:

- Formulation of an ICRA outlines specific infection control measures, containment procedures, and construction protocols which includes four steps:
    1. Identify the type of construction:
        - For the purpose of performing an ICRA, construction activities have been divided into four type: A, B, C, and D.
    2. Identify the patient or staff risk group that will be most affected:
        - Each healthcare facility may have its own unique patient population with different susceptibility to construction related infections. Likewise, each facility may have different department that have strict cleanliness requirements, which can be adversely affected by construction dust. For example, the Sterile Processing Department and Perioperative Department have very strict cleanliness requirement whereas the facility's lobby or waiting areas have less stringent cleaning requirements. The patient and staff risk group is obtained from a table with the different assigned ratings of susceptibility to infections from airborne contamination that may be released during construction/renovation activities.
    3. Determine the level of infection control classification using the ICRA Matrix:
        - Once the type of construction projects and risk group is define, then these two pieces of information are matched in a matrix to determine the infection control classification most appropriate for the project.
    4. Assign appropriate controls that are needed to reduce or eliminate risk to patients, visitors or staff group. Infection control are documented in the ICRA Permit template

Note: All four steps, controls, and examples are listed on the ICRA Permit Template.

Implementation and Execution:

- Communication of ICRA plan to all stakeholders.
- Installation of containment barriers and negative pressure ventilation systems as necessary.
- Documentation of temporary barriers, ventilation requirements, and disposal procedures for construction waste.
- Adherence to strict hygiene practices by construction personnel entering patient care areas.

Monitoring and Evaluation:

- Regular monitoring of construction activities and infection control measures.
- Monitoring will be determined on the ICRA Permit Template.
- Inspection of containment barriers and ventilation systems to ensure effectiveness.
- Continuous assessment of compliance with ICRA guidelines and immediate corrective actions for identified issues.

Completion and Post-Construction Phase:

- Final walkthrough and inspection to verify removal of all construction-related hazards.
- Review of ICRA effectiveness and lessons learned for future projects.
- Documentation and archiving of ICRA reports and related records for regulatory compliance and reference purposes.
- Patient care areas will be cleared by Infection Prevention or designee prior to closing the ICRA

REFERENCES:

1. Association for Professionals in Infection Control and Epidemiology (APIC). (2015). Infection prevention manual for construction and renovation. Washington, DC: APIC
2. Centers for Disease Control and Prevention. (2016). Infection Control Assessment Tool for Acute Care Hospitals. Retrieved from https://www.cdc.gov/hai/pdfs/IC/CDC_IC_Assessment_Tool_Hospital.pdf
3. The Joint Commission. (2024). EC. 02.06.05 The Critical Access Hospital manages its environment during demolition, renovation, or new construction to reduce risk to those in the organization. Retrieved from https://edition.jcrinc.com
4. The Joint Commission. (2024). LS.01.02.01 The Critical Access protects occupants during periods when the Life Safety Code is not met or during periods of construction. Retrieved from https://edition.jcrinc.com/?siteId=8064
5. 29CFR 95.53

RECORD RETENTION:

1. 8 years

CROSS REFERENCE POLICY & PROCEDURE:

1. InQuiseek – Building Sanitation and Cleanliness

Supersedes: v.2 Infection Control Risk Assessments (ICRA) For Demolition, Renovation, Or New Construction Projects, Construction Monitoring EC 02.006.05 EP 3, Preconstruction Risk Assessment PRA EC 02.06.05 EP 2a, New Imaging Construction EC 02.06.05 EP 4 6, Planning Construction Activities EC.02.06.05 EP 1

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: Infection Prevention Plan (IPP)*		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: District Wide		
Date Last Modified: 05/28/2024	Last Review Date: No Review Date 9/21/2023	Version: 10
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/13/1999	

PURPOSE:

1. The purpose of this Infection Prevention Plan (IPP) is to establish and maintain a comprehensive framework for preventing and controlling healthcare-associated infections (HAIs) within Northern Inyo Healthcare District (NIHD). This plan outlines the hospital's commitment to providing a safe environment by implementing evidence-based infection prevention practices.
2. The scope of this comprehensive plan extends coverage to not only the District itself but also the surrounding communities. By adhering to this plan, NIHD aims to minimize the risk of HAIs, protect patient safety, and promote the overall well-being of individuals receiving care within the District, ensuring the well-being and care of all patients, visitors, and employees. The IPP considers the following factors:
    - The facility's geographic location
    - Patient volume
    - Patient population served
    - The Districts clinical focus
    - NIHD workforce
3. The IPP incorporates the following on an ongoing basis:

- Surveillance, prevention and control of infection throughout the organization.
- Develop alternative techniques to address the real and potential infection risks.
- Select and implement evidenced-based practices to minimize adverse outcomes.
- Evaluate and monitor the results and revise strategies as needed.
- Administrative support to ensure adherence to the program standards.

DEFINTIONS:

1. **Hospital- Acquired Infections (HAI's):** Infection people get while they're receiving healthcare for another condition. HAI's can happen in any healthcare facility.
2. **Infection Prevention Program:** A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases
3. **Outbreak-** An increase in the occurrence of cases of infection or disease over what is expected in a defined setting or group in a specified time; synonym of epidemic but used more often when limiting the geographic area.
4. **Risk Assessment:** Is to identify actual or potential infection risks for populations that include patients, employees, and the community and to inform and implement measures that reduce those risks.

POLICY:

1. When problems or opportunities for improvement are identified, actions taken/recommended will be documented. If immediate action is necessary, the Infection Preventionist, Infection Control Committee, or designee has the authority to institute any surveillance, prevention and control measures if there is reason to believe that any patient or personnel is at risk. The actions will be reported to the appropriate committee, and leadership.
2. The Infection Control Committee and the Infection Prevention (IP) team has the responsibility for infection prevention and control activities throughout the organization. The IP committee is presided by a physician having knowledge of infection control and prevention practices and performance improvement methodologies. The physician guides the committee and decisions for improvement of care through the prevention and control if infections.
3. The responsibility and direct accountability for the surveillance, data gathering, aggregation and analysis is assigned to the Infection Prevention team.
4. Hospital personnel and medical staff members share accountability in reporting of isolation cases suspected or confirmed HAI's or other infection control concerns. There is collaboration among departments as well as the Infection Control team to identify any HAI trends or pattern that may occur, or opportunities to improve outcome in the reduction and control of infections.
5. The Infection Prevention team will:
    - Review all positive cultures to determine if HAI's or reportable disease.
    - Review and do an evaluation of confirmed infectious cases to assure correct implementation of PPE as appropriate. Periodic observation of clinical department at assure maintenance or standard precautions on all patients.
    - Complete Infection Prevention and Control inspections.
    - Collaboratively review of hazardous waste management and disposal with the maintenance department.
    - Chair the Sharps Committee.
    - Report to Medical Staff and Cub-Committees on Infection Prevention related concerns and data.
    - Participate in product evaluation.
    - Report to governmental and local agencies.
    - Review Infection Prevention and Control updates and alerts along with information for up-to-date changes for contagious diseases and changes in standards from some of the following agencies resources:
        - Association for Professional in Infection Controls and Epidemiology (APIC)
        - California Department of Public Health (CDPH)
        - California Department of Industrial Relations (Cal/OSHA)
        - Centers for Disease Control and Prevention (CDC)
        - Centers for Medicare and Medicaid Services (CMS)
        - Food and Drug Administration (FDA)
        - Healthcare Infection Control Practices Advisory Committee (HICPAC)
        - Inyo County Public Health
        - International Sharps Injury Prevention Society (ISIPS)
        - National Emerging Special Pathogens Training & Education (NETEC)
        - The Society of Healthcare Epidemiology (SHEA)
        - The Joint Commission (TJC)
        - World Health Organization (WHO)
    - Will complete annual Infection Control Risk Assessments and update as needed
    - Will complete Infection Control Risk Assessment (ICRA) related to construction or renovation.
    - Facilitate and participate with Antibiotic Stewardship Committee and activities.

6. The Infection Prevention team will identify and track key performance measure related to process and outcome in an effort to continuously improve the management of HAI's throughout the organization.
7. Ensures that all team members are effectively trained and educated on infection control issues and procedures through orientation and an ongoing continuing education program.
8. Work collaborative with Executive Team, Department Leadership and Human Resources to provide education related to infection prevention and control practices to ensure a safe environment for patients and healthcare personnel.
9. The Infection Preventionist work closely with the Quality Council to identify potential quality problems throughout the organization.
10. The Infection Prevention team will work closely with Safety Committee to minimize possible infectious issues that are potentially hazardous to patients and staff.
11. Monitor the results of the Infection Prevention Plan (IPP) to determine if the techniques already in effect are working well, or if changed conditions require new or revised techniques. Monitoring is achieved through:
    - Committee interaction
    - Daily job functions of the Infection Prevention team
    - Comparisons of current statistical information and historical data and bench marking
    - Policy and procedure reviews; future surveys and inspections, internal and external.
    - Action plans
12. The following policies govern infection prevention practices within the hospital:
    i. **Hand Hygiene:** All healthcare personnel are required to adhere to proper hand hygiene practices, including handwashing with soap and water or using alcohol-based hand sanitizers before and after patient contact, after touching potentially contaminated surfaces, and before and after performing invasive procedures.
    ii. **Personal Protective Equipment:** Healthcare personnel will utilize appropriate PPE, such as gloves, masks, gowns, and eye protection, based on the anticipated exposure risk to infectious agents during patient care activities.
    iii. **Environmental Cleaning and Disinfection:** Environmental surfaces and patient care equipment will be regularly cleaned and disinfected using hospital-approved disinfectants according to established protocols to reduce the transmission of healthcare-associated pathogens.
    iv. **Isolation Precautions:** Patients with known or suspected infectious diseases will be placed under appropriate isolation precautions, including contact, droplet, or airborne precautions, as indicated, to prevent the spread of pathogens to other patients, visitors, and healthcare personnel.
    v. **Injection Safety:** Safe injection practices will be followed to prevent the transmission of blood borne pathogens, including the use of aseptic techniques, single-use needles and syringes, and proper disposal of sharps and medical waste.
    vi. **Sterilization and High-Level Disinfection**: Medical devices and equipment will be appropriately sterilized or subjected to high-level disinfection processes before use on patients to ensure their safety and prevent healthcare-associated infection
    vii. **Surveillance and Reporting:** Surveillance systems will be implemented to monitor the incidence of healthcare-associated infections, identify trends, and promptly report any clusters or outbreaks to the appropriate authorities for investigation and intervention.
    viii. **Education and Training**: Ongoing education and training programs will be provided to healthcare personnel to ensure awareness of infection prevention guidelines, promote adherence to best practices, and enhance competency in implementing infection control measures.

ix. **Visitor and Patient Education:** Patients and visitors will receive education on infection prevention practices, including hand hygiene, respiratory etiquette, and the importance of adhering to isolation precautions when applicable, to minimize the risk of transmission within the hospital setting

x. **Antimicrobial Stewardship:** Antimicrobial stewardship initiatives will be implemented to promote judicious and appropriate use of antimicrobial agents, prevent the emergence of antimicrobial resistance, and optimize patient outcomes while minimizing adverse effects

xi. **Medical Waste Disposal:** Proper medical waste will be disposed of properly to protect the public and environment from potentially infectious disease and causing agents.

PROCEDURE:

The following procedures outline the specific steps to be followed in implementing the infection prevention policies within NIHD:

1. **Hand Hygiene:**
    - Healthcare personnel will perform hand hygiene according to the World Health Organization's "Five Moments for Hand Hygiene" guidelines.
    - Hand hygiene products will be readily accessible at all patient care areas, including handwashing sinks and alcohol-based hand sanitizer dispensers
    - Refer to Lippincott Procedure Hand Hygiene for more detailed procedures.
2. **Personal Protective Equipment (PPE)**
    - Healthcare personnel will assess the level of PPE required based on the type of patient care activity and anticipated exposure risk.
    - Proper donning and doffing procedures for PPE will be followed to minimize the risk of contamination.
    - Refer to Lippincott Personal Protective Equipment PPE Putting on & Personal Protective Equipment PPE Removal for more detailed procedures.
3. **Environmental Cleaning and Disinfection:**
    - Environmental surfaces will be cleaned and disinfected regularly using hospital-approved disinfectants with demonstrated efficacy against healthcare-associated pathogens.
    - High-touch surfaces and patient care equipment will receive special attention during cleaning and disinfection processes.
    - Patient care equipment will be cleaned and disinfected per manufactures instructions after every patient use.
    - Refer to Lippincott Procedures Disinfection, noncritical patient care equipment ambulatory for more detailed procedures.
4. **Isolation/Transmission-based Precautions:**
    - Patients requiring isolation precautions will be promptly identified and placed in appropriate isolation rooms or designated areas.
    - Signage indicating the type of isolation precautions in place will be displayed outside the patient's room to alert healthcare personnel and visitors.
    - Signage indicating doffing PPE sequence will be placed inside patient’s room for contact and airborne isolation.
    - Infection Prevention and Electronic Lab chart alerts/flag will be placed on patients charts that require transmission- based precautions
    - Refer to the below Lippincott Procedures for more detailed elements
        - Standard Precautions
        - Contact Precautions
        - Airborne Precautions

- Droplet Precautions

5. **Injection Safety Practices:**
   - Healthcare personnel will adhere to aseptic techniques when preparing and administering injections to patients.
   - Single-use needles and syringes will be used for each patient encounter, and sharps will be disposed of in puncture-resistant containers.
   - Refer to Safe Injection Practices Policy and Procedure for more detailed elements.
6. **Sterilization and High-Level Disinfection:**
   - Medical devices and equipment requiring sterilization or high-level disinfection will undergo validated processes according to manufacturer instructions and regulatory requirements.
   - Sterilization logs and documentation will be maintained to ensure traceability and accountability.
   - Refer to the below policies and other policies located in NIHD Policy Manger and Lippincott Procedures for further detailed procedures:
     - Standards of Care- Sterile Processing
     - Basic Principles of Sterilization
     - Biological Monitoring System for Steam Sterilizers
     - Steris Gravity/Pre-vacuum Sterilizer (Autoclave)
     - Cleaning and Care of Surgical Instruments
     - High Level Disinfection of Equipment
     - Immediate Use Sterilization Procedure (IUS)
     - Steris System IE Processor
7. **Surveillance and Reporting:**
   - Surveillance data on healthcare-associated infections will be collected, analyzed, and reported to relevant stakeholders, including hospital administration, infection prevention committees, and regulatory and accrediting agencies.
   - Clusters or outbreaks of community and healthcare-associated infections will trigger prompt investigation and implementation of control measures to prevent further transmission.
   - Surveillance will include HAI's among patient and personnel when possible. Targeted studies will be conducted on infections that are high risk, high volume. In addition, all positive microbiology reports will be monitored and other transmissible diseases lab results.
   - Monitoring and evaluation of key performance aspects of infection control surveillance and management with the following:
     - Device related infections.
     - Multi-Drug Resistant Organisms.
     - TB: Suspected, confirmed, or conversion in patients and staff
     - Occupational Exposure to Blood borne Pathogens
     - Outbreak investigations
     - HAI trends
     - Surgical Site Infections
     - Construction and renovation activities
   - A facility Infection Prevention Risk Assessment will be completed annually and as needed to help identify and review potential infections related to patient care and treatment. Risk factors identified with score >= 9 will be the annual Infection Prevention prioritized goals focusing on action plan and measureable objectives. Some events/conditions with a lower score may be selected because they are an accreditation or regulatory requirement, or can be quickly and easily implemented.

The Risk Assessment identifies, assesses and scores each potential risk factor based on the following:

- **Potential impact** of the event/condition on patients and personnel, determined by evaluating the potential for patient illness, injury, infection, death, need for admission to an inpatient facility; the potential for personnel illness, injury, infection, shortage; potential to impact the organization's ability to function/remain open; and degree of clinical and financial impact.
- **Probability of the event/condition occurring,** determined by evaluating the risk of the potential threat actually occurring. Information regarding historical data, infection surveillance data, the scope of services provided by the facility, the environment of the surrounding area (topography, interstate roads, chemical plants, railroad, ports, etc.), and health department data, are considered when determining this score.
- **Organization's preparedness** to deal with the event/condition, determined by considering policies and procedures already in place, staff experience and response to actual situations, and available services and equipment.

- Refer to Lippincott Reportable Diseases for more detailed procedures.

8. **Staff Education and Training:**
   - Infection prevention education and training sessions will be provided to all healthcare personnel, including new hires, as part of their orientation and ongoing professional development.
   - Training materials and resources will be regularly updated to reflect current evidence-based practices and guidelines.
   - Education upon hire and again annually with particular emphasis on proper use of personal protective equipment (PPE) for healthcare workers at risk of accidental exposure to blood borne pathogens. In addition, emphasis is placed on educating staff regarding transmission based organisms and its mode of transmission.
   - Training can be provided in following ways:
     - Electronic Management Learning System
     - Policy Manager and Lippincott Procedures
     - Hands-on
     - Direct Observation
     - Department and Committee Meetings
     - Just-in-Time
     - Talking Points
     - Department Huddles
   - Infection control team members will have ongoing education and attend training programs to ensure NIHD follows evidenced-based practices and Infection Prevention Strategies to help minimize HAIs and employee and visitor infections.
9. **Visitor and Patient Education:**
   - Patient education materials on infection prevention will be provided to ensure accessibility and understanding.
   - Visitors will receive information on infection prevention practices via signage upon entering the hospital, including the importance of hand hygiene and respiratory etiquette.
   - Refer to Lippincott Respiratory Hygiene and Cough Etiquette, Ambulatory Care for procedures that are more detailed.
10. **Antimicrobial Stewardship:**
    - Antimicrobial stewardship programs will be implemented to promote appropriate antimicrobial use, monitor antimicrobial prescribing practices, and provide feedback to prescribers.

- Guidelines for antimicrobial therapy will be developed based on local epidemiology, antimicrobial resistance patterns, and best practices in antimicrobial stewardship.
- Refer to NIHD Antimicrobial Stewardship Program Plan for further detailed procedures

11. Medical Waste:

- Medical Waste will be handled, stored, treated and disposed of in accordance with regulations as stated in the "Medical Waste Management Act" of the California Health and Safety Code.
- Human body parts and human tissue waste are stored in a multi-freezer Designated Accumulation Area (DAA).
- Other hazardous waste will undergo onsite treatment through the sterilization process.
- Chemo waste and Pharmaceutical waste are picked up Monthly by a medical waste transporter.
- Refer to Medical Waste Management Plan located in Policy Manager for procedures that are more detailed.

OUTBREAK INVESTIGATION METHODOLGY:

1. The Manager of Infection Prevention/Employee Health or designee will conduct outbreak investigations whenever appropriate by following any or all of the below steps if indicated:
    - Verify the diagnosis and confirm possible outbreak
    - Implement immediate control measures if needed
    - Define the outbreak; refine as the outbreak investigation progresses
    - Conduct case findings by making a line listing that may contain:
        i. Name and Medical Record Number
        ii. Age, sex, diagnosis
        iii. Unit or location
        iv. Date of Admission
        v. Date of Symptom Onset
        vi. Procedures
        vii. Symptoms
        viii. Positive Cultures and pertinent labs
    - Form Outbreak Control Team, if preliminary assessment suggests actual outbreak. The team may include all or some of the following:

i. Infection Preventionist
ii. Infection Control Medical Staff Chairperson
iii. Microbiologist
iv. Lab Manager
v. Administrator on call
vi. Inyo County Public Health Officer
vii. Strategic Communications Specialist
viii. Administrative Assistant

- Hospital Incident Command Center will be followed as necessary.
- Evaluate control case (ex: any new cases)
- Communicate findings with leadership.
- Keep record of all data and communication.
- Contact CDC or other agencies for advice or assistance if deemed appropriate or necessary.

SURVEILLANCE METHODOLOGY:

1. Case findings and identification of demographically important HAI's provide surveillance data. Nosocomial infection data, using, as appropriate, rates stratified by infection risk or focused infection studies, are collected on an ongoing basis.

2. In addition to the use of planned surveillance methods, special studies may be conducted that include:
    - The investigation of clusters of infections above expected levels.
    - The investigation of single cases of unusual or epidemiologically significant HAI's
    - A focus on procedures with significant potential for HAI's, particularly when the procedure is new or substantially changed.
    - The comparison of a group of infected patients with an uninfected control group to detect statistically significant risk factors for which control measures can be developed.
3. Interventions to reduce infections risks other than those directly related to prevention of transmission may include the following strategies:
    - The surveillance function itself.
    - Review positive microbiology/Lab results
    - Institution of prevention and control measure as indicated (e.g. isolation, improved hand hygiene, active surveillance of cultures, and environmental cleaning)
    - Perform Surveillance for healthcare –associated infection by:
        i. Follow CDC National Healthcare Safety Network (NHSN) definitions
        ii. Prospective surveillance: Monitor patients during hospitalization and post discharge
        iii. Retrospective surveillance: Identify infections via chart reviews
    - Monitored incidence of healthcare-associated. device-related or procedure-related infections:
        i. Central catheter-associated bloodstream infections
        ii. Ventilator -associated events
        iii. Surgical site infections
        iv. Catheter-associated urinary tract infections
        v. Multi Dug Restraint Organism (MDRO) blood stream infections
    - Conduct Periodic tracer activity
    - Ensure compliance with The Joint Commission Critical Access Hospital requirements and the California Department of Public Health regulations.
4. The assessment of reasons for infection rates not being reduced by surveillance alone and interventions undertaken to address problems in the following areas:
    - Knowledge – innovative educational approaches beyond the routine or standard in services.
    - Behavior – activities by managers to change behavior.
    - Systems – such as staffing, sink number and placement, control of over-crowding, lack of proper equipment and supplies.

POLICIES AND PROCEDURES:

1. Policies and procedures are based on recognized guidelines and applicable law and regulations. Policies and procedures address prevention and control mechanisms used in all patient care and service areas to prevent the transmission of infection among patients, team members, medical staff, contractors, volunteers and visitors; and also, address specific environmental issues.
2. Infection control policies and procedures will be reviewed/revised annually or every three years as needed by the Infection Preventionist Manager with approval of the following committees:
    - Clinical Consistency Oversight Committee (CCOC)
    - Infection Control Committee
    - Medical Staff Committee meeting the policy or procedure affects
    - Medical Executive Committee
    - Board of Directors

LEADERSHIP AND RESPONSIBILITY:

1. **Board of Directors:** has the final authority and oversight of the Infection Control Program. The Board monitors and supports organizational efforts to continuously improve the quality of patient care services and customer satisfaction. The Board ensures the necessary resources and education for the hospital to achieve these goals. The Board delegates the responsibility of maintenance of the Infection Control Program to the Medical Executive Committee and Executive Team.
2. **Medical Executive Committee:** Is responsible for overseeing the Infection Control Program and delegates the development and monitoring of infection surveillance, prevention and control processes to the Infection Control Committee.
    - The Medical Executive Committee receives information related to actions taken to resolve issues of infection control and, if necessary, acts upon any issues related to infection control.
    - The Medical Executive Committee grants the Infection Preventionist Manager authority, under the direction of the Infection Control Committee Chair or his/her designee, to institute surveillance, prevention and control measures of studies, when there is reason to believe that any patient or team member may be in danger. In the absence of the Infection Preventionist Manager, nursing staff trained in Infection Prevention practices assumes the Infection Control responsibilities and are able to take appropriate actions as outlined in Infection Control Policies.
3. **Chief Executive Team:** Serves as liaisons between the Board of Directors and the Medical Executive Committee. They ensures that all hospital departments, programs, and disciplines participate in and provide support for the IPP.
4. **Infection Control Medical Staff Chairperson:** Acts as a resource for the Infection Control Manager. This person will have training and/or experience in infection control as stated in *Senate Bill 158* (Attachment 1) and will review the Infection Control Program, including rates, make recommendations as needed and have input into policies and procedures.
5. **The Manager of Infection Prevention/Employee Health:** Assumes the responsibility of managing and carrying out the infection surveillance, prevention and control functions within NIHD.
    - This person has training in infection surveillance, prevention and control as well as knowledge and job experience in the areas of epidemiological principles and infectious disease, sterilization, sanitation and disinfection practices.
    - This individual also is knowledgeable in adult education principles and patient care practice.
    - This person maintains records and logs of incidents related to infections and communicable disease.
    - The Manager of Infection Prevention/Employee Health and/or designee reviews culture and sensitivity testing, reviews antibiotic usage reports, reports suspected infections, conducts department specific periodic rounding; infection control annual risk assessment and implements isolation procedures in accordance with hospital policy, maintain policies and procedures that are specific to patient care activities and are based on recognized guidelines and applicable laws and regulations.
    - The Manager of Infection Prevention/Employee Health has input into staff education to ensure all team members are competent to participate in infection monitoring, prevention and control activities.
    - The Manager of Infection Prevention/Employee Health may refer cases for physician review and communicates pertinent clinical infection control information to the Infection Control Committee.

6. **NIHD Workforce:** is responsible for being familiar with infection prevention and control policies and procedures.
7. **Quality Council:** Will provide feedback and collaboration related to performance measurements and regulatory guidelines/recommendations.

REPORTING AND COMMUNICATION:

1. Information about infections is reported both internally and to public health agencies, providing clinical practitioners with valid epidemiological measures of the risk of infection in their patients. This will allow them to take action to reduce those risks and decrease infection rates.
2. When the hospital becomes aware that it received a patient from another organization who has an infection requiring action and the infection was not communicated by the referring organization, the Manager of Infection Prevention/Employee Health will inform the referring organization.
3. Upon discharge, the Case Manager, House Supervisor and/or nurse caring for the patient will inform the accepting facility of any infections the patient may have, site treatment and any special precautions. If the patient is transferred to another facility and there are pending laboratory results the transfer form will be completed indicating "Pending Lab Culture and the ordering physician will be notified via telephone and fax with laboratory results. If the ordering physician is no longer caring for the patient, the ordering physician will inform the laboratory technician of the physician or facility caring for the patient.
4. Donor/Tissue postoperative infections/complications identified through surveillance activities that are suspected of being directly related to the use of the tissue will be investigated promptly. Notification of the post-transplant infection or adverse event will be reported to the tissue supplier by the Infection Preventionist Manager as soon as the hospital becomes aware of the event.
5. Infection Control committee meetings will be conducted not less than quarterly and more often as needed. Minutes will be recorded by the Medical Staff Office.
6. Findings, quality assessment activities, performance improvement recommendations, actions and follow-up evaluations will be forwarded to Infection Control Committee members, other medical staff committees as appropriate, Medical Executive Committee and the Board of Directors.
7. Review of infections-and surveillance data within the hospital will be completed quarterly through Infection Prevention Pillars, and annual goals. The data will be presented to the following committees.
    a. Nurse Executive Team (quarterly)
    b. Infection Prevention Committee (quarterly)
    c. Quality Council (at least annually)
    d. Medical Staff (at least annually)
    e. Board of Directors (at least annually)
8. HAI's data will be submitted to National Health and Safety Network (NHSN) as required by CMS and CDPH.

REFERENCES:

1. All Facilities Letter 14-36 California Department of Public Health, 12/19/2014, Regarding SB 1311: Antimicrobial Stewardship Programs.
2. APIC Text of Infection Control and Epidemiology. (April 7, 2020). Outbreak Investigations. Retrieved from https://text.apic.org/toc/epidemiology-surveillance-performance-and-patient-safety-measures/outbreak-investigations?token=2AE989223FAE2142
3. Centers for Disease Control and Prevention. (2021) Infection Control in Health Care Facilities. Retrieved from https://www.cdc.gov/flu/professionals/infectioncontrol/

4. Centers for Disease Control and Prevention. (2021). Outbreak Investigations in Healthcare Settings. Retrieved from https://www.cdc.gov/hai/outbreaks/index.html
5. Centers for Disease Control and Prevention. (2016). Infection Prevention and Control Assessment Tool for Acute Care Hospitals. Retrieved from https://www.cdc.gov/infectioncontrol/pdf/icar/hospital.pdf
6. Centers for Disease Control and Prevention. (2012) (Site accessed April 29, 2021). Principles of Epidemiology in Public Health Practice, Third Editions an Introduction to applied epidemiology and biostatistics Lesson 6: Investigating an outbreak. Retrieved from https://www.cdc.gov/ophss/csels/dsepd/ss1978/lesson6/section2.html
7. Comprehensive Accreditation Manual for Critical Access Hospital (2024) Infection Prevention and Control (IC) Manual. Retrieved from https://edition.jcrinc.com/
8. Association for Professionals in Infection Control and Epidemiology (APIC). (Site accessed 4-29-21) Content of an Infection Prevention and Control Plan. Retrieved from https://apic.org/Resource_/TinyMceFileManager/Education/ASC_Intensive/Resources_Page/Content_of_an_Infection_Prevention_and_Control_Plan.pdf

CROSS-REFERENCE P&P:

1. NIH Medical Staff Bylaws and Rules Amendment, 01/20/2022 Infection Control Committee Section Article XI Section 11.7 pg. 75-76. Retrieved from http://intranet2.root.nih.org/DepartmentDocs/26/NIHD%20Med%20Staff%20Bylaws%20rev01042022.pdf
2. Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program
3. NIHD Antibiotic Stewardship Program Plan
4. Multidrug Resistant Organism (MDRO) Control Plan
5. Emergency Management Plan
6. Scope of Service - Infection Control*
7. Northern Inyo Hospital Surge Plan
8. Lippincott Procedures: Hand Hygiene. https://procedures.lww.com/lnp/search.do?query=hand+hygiene&d=6182
9. Lippincott Procedures Personal Protective Equipment (PPE) Putting on. https://procedures.lww.com/lnp/view.do?pId=3260961&disciplineId=6182
10. Lippincott Procedures Personal Protective Equipment (PPE) Removal. https://procedures.lww.com/lnp/view.do?pId=3260962&disciplineId=6182
11. Lippincott Procedures Disinfection, Noncritical Patient Care Equipment Ambulatory. https://procedures.lww.com/lnp/browse.do?disciplineId=6182
12. Lippincott Procedures
    - Standard Precautions: https://procedures.lww.com/lnp/view.do?pId=3260849&disciplineId=6182
    - Contact Precautions: https://procedures.lww.com/lnp/view.do?pId=3261060&disciplineId=6182
    - Airborne Precautions: https://procedures.lww.com/lnp/view.do?pId=3261141&disciplineId=6182
    - Droplet Precautions: https://procedures.lww.com/lnp/view.do?pId=3261034&disciplineId=6182
13. Safe Injection Practices
14. Cleaning Procedures: Cleaning of Patient Care Areas
15. Cleaning Procedures: Patient Room Discharge
16. Cleaning Procedures: Patient Room Occupied
17. Standards of Care - Sterile Processing
18. Basic Principles of Sterilization
19. Biological Monitoring System for Steam Sterilizers

20. Cleaning and Care of Surgical Instruments
21. High Level Disinfection of Equipment
22. Immediate Use Sterilization Procedure (IUS) Steris System 1E Processor
23. Lippincott Procedures: Reportable Diseases https://procedures.lww.com/lnp/browse.do?disciplineId=6182
24. Lippincott Respiratory Hygiene and Cough Etiquette, Ambulatory Care: https://procedures.lww.com/lnp/view.do?pId=3510743&disciplineId=6182
25. MEDICAL WASTE MANAGEMENT PLAN

Supersedes: v.9 Infection Prevention Plan*

Title: Learning Internships, Clinical or Academic Rotations, and Career Shadowing Opportunities		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 08/28/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

1. To define the requirements for non-employees to explore healthcare careers under the supervision of Northern Inyo Healthcare District (NIHD) staff.
2. To set forth the requirements for participants in the learning internship, clinical or academic rotations, and career shadowing programs and to ensure compliance with relevant laws, regulations, policies and procedures applicable thereto.

POLICY:

Northern Inyo Healthcare District (NIHD) believes its ability to meet the needs of our patients and community is related to its ability to attract and retain adequate numbers of qualified, competent and diverse employees who provide high quality service in a healthcare setting. To accomplish this, NIHD's leadership will foster workforce development programs that include developing a pipeline of talent within the community. It is, therefore, NIHD's policy to establish learning internships, clinical or academic rotations and career shadowing opportunities to attract persons interested in working in the healthcare industry.

DEFINITIONS:

Learning Internship: A learning internship opportunity is for any individual who is looking for an opportunity to explore healthcare careers or healthcare processes. This opportunity is generally for the duration of a semester, or quarter dependent upon school year.

Clinical or Academic Rotation: A clinical or academic rotation opportunity is for any individual or group of individuals under the supervision of an instructor that provides direct application of classroom objectives and is generally focused in patient care areas. An affiliation agreement between the educational institution and NIHD is required prior to the start of any clinical or academic rotation.

Career Shadowing: A career shadowing opportunity is for any individual who requests an observation of a specific position or department for a specific date(s) and times. Career shadowing opportunities may be no longer than fourteen (14) days and a new request must be submitted if the participant wishes to continue past the 14 day period.

PROCEDURE:

1. Opportunities under this policy are coordinated through the Human Resources Department.

    a. Human Resources will refer the request to the Department head(s) where the request is being made.
    b. The Department head will then review and receive approval from their Chief.
    c. If a shadow experience can be accommodated, the Department head:
        1) Notifies HR of approval of request and dates they can accommodate.
        2) Notifies the individual or group to start the pre-requisite requirements.

2. Prior to the commencement of the opportunity, ~~the assigned NIHD supervisor will~~ Human Resources will ensure the individual or group meets all District requirements, including any Employee Health requirements, and completes the pre-screening process ~~completes the required information packet and turns it into Human Resources for approval~~. Upon ~~approval~~clearance, the individual or group will onboard with Human Resources and then be released to the assigned NIHD supervisor to begin the opportunity.

3. The NIHD supervisor will:
    a. Orient the individual or group to their role, the department, and NIHD.
    b. Ensure that all NIHD policies regarding patient confidentiality and privacy are enforced throughout the opportunity.
    c. Ensure that the individual or group meets the objectives of the opportunity.

4. The NIHD supervisor and the individual or group will complete an evaluation form at the end of the program to ensure that the program undergoes continuous improvement.

5. Human Resources will review the program annually and periodically as feedback warrants.

REFERENCES:

The Joint Commission Standards HR.01.02.07, HR.01.03.01, HR.01.04.01, PI.02.01.01, and PI.03.01.01

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCES POLICIES AND PROCEDURES:

1. Employee Health NIHD Workforce Onboarding

Supersedes:
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

NORTHERN INYO HEALTHCARE DISTRICT
EMPLOYEE HANDBOOK

Title: Licensed Employees and Continuing Education		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
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:~~

POLICY:

All Northern Inyo Healthcare District employees who are required by law to be licensed and/or maintain professional certifications in the State of California must have a valid license or certification and are expected to obtain the required renewal. It is the employee's responsibility to pay for all licenses and registration fees, and to notify their department head of renewals and changes.

Additionally, any employee who requires continuing education credits to maintain a professional license or certification required for work at the District is allowed up to sixteen hours of educational pay per calendar year. The sixteen hours of educational pay per calendar year may be rolled over to the next year, and the maximum amount of accumulated educational pay shall be thirty-two hours.

Employees will be responsible for submitting proof of class attendance to their supervisor. Supervisors will be responsible for maintaining records of education days utilized by their staff. Unused educational pay is not paid out upon termination.

REFERENCES: N/A

RECORD RETENTION AND DESTRUCTION:

1. Human Resource records are maintained life of employment plus ten years
2. Payroll records maintained: Employees not entitled to pension: 15 years
3. Employees entitled to pension: life of employment plus six years

CROSS REFERENCE POLICIES AND PROCEDURES: N/A

Supersedes: v.1 Licenses and Registrations, v.2 Education Days for Licensed Employees
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: Musculoskeletal Injury Prevention Plan (MIPP)		
Owner: Employee Health RN Specialist	Department: Employee Health	
Scope: District Wide		
Date Last Modified: 08/28/2024	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE

NIHD is committed to providing its workforce with a safe and healthful workplace that supports and encourages teamwork and collaboration with a goal to be proactive and learn from accidental incidents. The intent of the NIHD Musculoskeletal Injury Prevention Program (MIPP) is to address ergonomic hazards and to provide guidelines that protect patients and prevent and/or minimize the probability of back and musculoskeletal injuries to our workforce.

POLICY

1. NIHD MIPP contains the elements required by Title 8 of the California Code of Regulations, Section 5120 to establish, implement and maintain an effective written Health Care Worker Back and Musculoskeletal Injury Prevention Plan that includes the below:
    - Authority and Responsibility
    - Leadership and Workforce Compliance
    - Communication with Workforce
    - Musculoskeletal Hazards Worksite Evaluation
    - Investigations of Musculoskeletal Injuries to Workforce
    - Hazard Correction
    - Leadership and Workforce Training
    - Record Keeping
2. NIHD MIPP contains the elements of a safe patient handling policy for all departments, both inpatient and outpatient, that provide Direct Patient Care. These departments include all areas of the District where care and treatment of services are rendered directly to the District's patient population and include:
    - All NIHD Clinics
    - Nursing Services
    - Diagnostic Imaging Services
    - Cardiopulmonary Department
    - Rehabilitation Services
    - PACU/Infusion/Wound Care
    - Surgery
    - Acute/Subacute
    - Intensive Care Unit (ICU)
    - Perinatal Unit
    - Emergency Department

3. NIHD workforce has unobstructed access to the MIIP at all times in the Policy Manager including printing at no charge. When the system is down, a hard copy may be obtained from Employee Health, Infection Prevention, or Human Resources. The provision of the plan, in and of itself meets the requirements.
4. The MIIP will be reviewed annually and ad hoc in a multidisciplinary approach, including referencing Log 300, incident reports, employee training, and as needed per regulatory guidelines.
5. Chief Executive Officers support safe patient handling injury prevention financially to help prevent and mitigate patient and employee injuries.

AUTHORITY AND RESPONSIBILITY

1. The multidisciplinary Safety Committee will have oversight and implement the MIIP, with reporting from the Safe Patient Handling Subcommittee and Human Resources injury reporting.
2. Employee Health team will update the MIPP per regulations and recommendations from the Safety Committee.
3. All patient care staff that follow under the scope of the MIPP is responsible for working safety following all safety guidelines and rule for their own protection and that of the patient.
4. NIHD Leadership is responsible for implementing and maintaining the MIPP in their work areas and for answering workforce questions about the program in a language, they understand.

LEADERSHIP AND WORKFORCE COMPLIANCE

1. While this is not a zero lift policy, manual lifting is discouraged. The use of devices and electronic equipment to lift, transfer, repositioning or mobilize a part of or all of a patient's body safely is prioritized as appropriate for the patient.
2. This plan requires hospital leadership to ensure new hire and annual training for designated health care workers in patient care departments on the appropriate use of lifting devices and equipment that they are anticipated to use on a regular basis.
3. Department Leadership:
    a. Remain educated and up-to-date in the use of mechanical lifts and transfer aids. Be aware of their department worker's compensation costs and injury rates and continue to make efforts to reduce the number of incidents in all areas of responsibility.
    b. District Leaders are required to ensure that employees have appropriate assistance in implementing this plan on a task by task basis and have trained their staff members on appropriate safe patient handling matters upon hire and annually.
    c. Department inventory of mechanical lifting devices/aids are available in proper working order, maintained regularly and stored readily accessible in the clinical areas.
    d. Review orientation checklists to make sure that employees complete initial training; ensure employees demonstrate competency; provide re-training when employees are non-compliant with safe patient handling practices; maintain training records for a period of three years.
    e. Recognize workforce who perform safe and preventive work practices such as the Good Catch Safety Award, recognition in department huddles, meetings, Safety Committee and ergo rounding.
    f. Disciplinary action will not occur with respect to a health care worker who refuses to lift, reposition, or transfer a patient due to concerns about patient or worker safety or lack of equipment or trained lift personnel.
    g. Refer all staff reporting patient handling injuries to the House Supervisor and Emergency Department for immediate evaluation and treatment and complete an Unusual Occurrence Report (UOR).

h. Employees who do not utilize proper safe patient handling practices may be subject to corrective action and retraining.

4. RN Coordinator of Care Admitted Patients:
   a. For patients admitted to the hospital, a Registered Nurse will serve as the coordinator of care assessing the patient's mobility needs as afunctional screen in the nursing assessment and identify the level of assistance required, including mechanical device usage, in the Plan of Care. These processes are defined in the Fall Prevention and Management Policy and Fall Risk Prevention-Perinatal.
   b. In departments where Registered Nurses are the coordinators of care, patient lifts and mobilization will be observed and directed by the RN, who will participate as needed.
   c. Information is disseminated in department huddles, during patient care, use of the white boards, and during hand-off.
5. Direct Patient Care Employee Responsibility
   a. Direct patient care employees, are designated to be trained in safe patient handling on department specific equipment and include:
      i. RN: Travelers, House Supervisors, Managers, Assistant Mangers, Directors, Cross Trained
      ii. LVNs
      iii. CNA
      iv. MA
      v. All Cardiopulmonary staff
      vi. All Radiology Techs, CT, Nuclear Med, Mammography
      vii. Scrub Techs
      viii. All Rehab clinical staff
      ix. RN and LVN students
      x. Care Shuttle Drivers
      xi. Note: Floats do not need to train on that department equipment, as there are designated staff available.
   b. Take responsibility for their own health and safety, as well as that of their co-workers and their patients during patient handling activities.
   c. All direct patient care employees are expected to assist each other in the execution of safe patient handling matters.
   d. Complete standard new hire SPH Training and annually per Department Training Plan.
   e. Complete additional training to correct improper use/understanding of safe patient handling and movement.
      i. Notify manager of need for re-training in the use of patient handling equipment and aids.
   f. Assess patient for condition and ability to cooperate with transfer and appropriate level of patient assist.
   g. Identify and avoid hazardous manual patient handling and movement tasks whenever possible.
   h. Use proper techniques, mechanical lifting devices, and other approved equipment and/or aids during performance of high-risk patient handling tasks.
   i. Promptly report to manager or shift supervisor any injury without fear of negative consequence.
   j. Follow procedures for reporting patient handling equipment in need of repair.
   k. If a patient is unable to assist the HCW with repositioning or transfers, then the lifting and moving of the patient will be done with minimum of two-person assist with or without the use of an assistive device.
6. Transferring patients out of any inpatient unit, and/or ED, on a non-propelled gurney or bed, to and from the Imaging Department will be done with a minimum of two-person assistance. One person will act as the lead directing the second person for any assistance needed throughout the transport. One person can

transfer to Imaging Department if using a self-propelled gurney. If a patient is being transferred on a gurney, on a level surface to any inpatient unit or PACU/OR, it is permissible for one person to perform the transport.

7. Biomedical Engineering
   a. Shall maintain safe patient handling mechanical equipment in proper working order
   b. Consult with equipment manufacturers to provide safe equipment installation.
8. Awareness Training is provided once upon hire for non-clinical staff present on patient care units.
9. Lab Techs will contact the House Supervisor in the rare instance that patient mobility issues need to be addressed for specimen collection.
10. Cardiopulmonary and Imaging may prescreen and pre-plan for full assist and bariatric patients when possible, to coordinate with House Supervisor and Acute/Subacute in the use of additional mechanical equipment.

COMMUNICATION WITH WORKFORCE

1. NIHD recognizes that open, two-way communication between management and staff on musculoskeletal safety issues, in a language understood by all parties, is required in order to achieve an injury-free, productive workplace. This includes ensuring patient care workforce feels comfortable notifying their supervisors of hazards they have identified or concerns they have and reporting musculoskeletal injuries or warning signs and symptoms without fear of retaliation.
2. The system of communication is designed to facilitate a continuous flow of safety information between management and staff, in a form that is readily understandable can be found in the NIHD Injury and Illness Prevention Plan (IIPP).
3. Refer to Accident/Exposure Investigation section for workplace injuries reporting.
4. Safe Patient Handling injuries are reviewed in the multidisciplinary SPH Subcommittee and in the multidisciplinary Safety Committee. Safety Committee also reviews other ergonomic related injuries based on the 300 log and Unusual Occurrence Reports (UOR).
5. Each clinical department has an assigned training plan in the learning management system and stored on a Smart Sheet. This plan includes specific designated roles, available assistive devices, and mechanical equipment. In addition, the Clinical Staff Educators (CSE's) and leads are designated trainers and undergo an annual Train the Trainer to ensure standardization.
6. Non-clinical staff present on inpatient care departments receive Awareness Training once upon hire through NIHD Learning Management System to understand how to acquire appropriate assistance when a patient needs helps related to mobility.

MUSCULOSKELETAL HAZARDS WORKSITE EVALUATION

1. Direct patient care staff members in all patient care areas will assess all patient handling tasks in advance to determine the safest way to accomplish the tasks.
2. All staff must follow manufacturer instructions for use, on all Safe Patient Handling Equipment.
3. Staff in outpatient areas such as Rehab, Cardiopulmonary, and Diagnostic Imaging will assess mobility needs prior to procedure, and if possible obtain mobility needs during scheduling of visit. Outpatient areas can collaborate with House Supervisor and other department leaders if powered equipment is needed.
4. Mechanical lift devices or assistive devices, such as gait belts, are to be used on patients requiring assistance. Manual lifting without a mechanical lift device is discouraged. If some degree of lifting is required, caregivers should seek assistance from other staff members and/or employ mechanical aids, and assistive devices whenever possible.

5. Safe Patient Handling equipment selection will be made based on input from all department staff through suggestions to managers, morning department safety huddles, safe patient handling committee, during ergonomic rounding. Staff may also leave suggestions for a department in employee health or infection prevention mailboxes, anonymously.
6. An inventory of mechanical device equipment for each individual patient care areas will be maintained by the department management, or designee, to include Manufacturer, Make, Model, Location of storage and numbers available including. Updates to inventory will be reported to:
    a. Safe patient Handling Subcommittee
    b. Manager of the Learning System
7. Safe Patient Handling Committee will maintain a House Wide list of Safe Patient Handling equipment available by department. Department leaders or designee or individual staff will provide an update in the meeting of
        a. Staff concerns,
        b. How concerns are being addressed,
        c. How the committee can support a change,
        d. New equipment being demonstrated or on order,
        e. Retiring old equipment, or
        f. Training assistance.
8. Rehab will conduct ergonomic rounding in patient care areas and select departments to interact with staff on ergonomic knowledge and acquire feedback on new safety issues in the departments and/or workstations, providing options to remedy perceived unsafe situations. Reports are sent to department leadership and actions to mitigate hazards are reported to the Safety Committee. Documentation is stored in Safety Committee minutes and with Employee Health.

INVESTIGATIONS OF MUSCULOSKELETAL INJURIES TO WORKFORCE

1. Accident investigations will follow the NIHD Injury and Illness Prevention Plan. In addition, a Safe Patient Handling injury will consider:
    - Patient specific risk factor
    - Was the MIPP effectively implemented:
    - availability and correct use of equipment
    - Sufficient staff
    - Were employees involved trained as required by law?
    - Solicit opinions from those involved regarding the cause and prevention measures
2. Any injury resulting from patient lifting or positioning, including strains, sprains, or any other muscular skeletal injury must be handled according to the Health and Safety- Work Related Accidents or Exposures to Blood or Other Potentially Infectious Materials.
3. Identified ergonomic hazards will be promptly addressed through appropriate control measures aimed at eliminating or minimizing the risk of musculoskeletal injuries.
4. Control measures may include engineering controls (e.g., ergonomic equipment, adjustable workstations), administrative controls (e.g., training on safe lifting techniques), and personal protective SPH equipment (e.g., back belts, lifting aids).

HAZARD CORRECTION

1. Safe Patient Handling Equipment may be selected based on UOR's, staff concerns, ergonomic rounding, discussions in Safe Patient Handling Subcommittee or Safety Committee, anonymous recommendations, department huddles, safety huddle, or during an evaluation of an injury or near miss. Equipment selection includes staff feedback and often demonstrations. Equipment is stored in

designated equipment rooms or areas determined with collaboration from leadership and staff. ICU and Acute-Subacute departments share safe patient handling equipment.

2. Designated workers can participate in the view of the effectiveness of the MIPP.
3. In addition to our IIPP procedures for correcting occupational hazards in a timely manner, NIHD will correct musculoskeletal hazards identified during ergonomic evaluations or during the injury investigations by developing procedures to determine if identified corrective measures are implemented appropriately by:
    a. Involving the worker in identifying and evaluating possible corrective measures.
    b. Identifying, assessing, and implementing appropriate equipment or other corrective measures, and then re-evaluating after they have been implemented in the workplace.
    c. Procuring, inspecting, maintaining, repairing, and replacing assistive devices and mechanical equipment.
4. Employees who are determined to be non-compliant must be re-trained and demonstrate competency in equipment use before returning to work. Continued failure to use proper patient handling practices may result in corrective action up to and including termination.

LEADERSHIP AND WORKFORCE TRAINING

1. Each Department has a specific SPH Training Plan for designated staff on equipment they are anticipated to use on a regular basis. This plan was coordinated with department Leadership, CSE's, department Leads, Employee Health, and Human Resources. The plan is maintained as a standing agenda item in Safe Patient Handling Committee to discuss new or retired equipment and adjust the plan as appropriate.
    a. Standard Safe Patient Handling Training occurs during the first week of Orientation. The focus is on applying correct ergonomics with the use of the most common equipment used throughout NIHD.
    b. In addition to new hire Standard SPH Training, additional department specific equipment that staff are anticipated to use on a regular basis, occurs during department orientation.
    c. Staff are trained to apply the following the elements of the NIHD Skills Checklist for Ergonomic SPH procedures, which may include, but not limited to:
        - Five areas of body exposure
        - Neutral spine
        - Risk factors
        - Physical dependence of the patient
        - Patient communication and direction
        - Manual handling
        - Right to refuse for safety
2. Clinical Staff Educators (CSE) and Department Leads, are required to attend an annual Safe Patient Handling Train the Trainer, developed and conducted by Rehab, Human Resources, and Employee Health to standardize training, answer questions, apply ergonomics, and ensure Cal OSHA regulations for safety the of patient and staff are understood. Instruction is provided to staff and patients in a language easily understood. NIHD recognizes CSE's to be the experts on SPH equipment usage, whereas Rehab staff are the ergonomic experts. Training of CSE's and Leads also assist with ongoing training for department staff members and with the introduction of any new equipment.
3. Awareness Training is provided once upon hire for non-clinical staff present on patient care units, through the learning management system and reinforced by Leadership.

RECORD KEEPING

1. Records of hazard assessment inspections, including the person(s) or persons conducting the inspection, the unsafe conditions and work practices that have been identified and the action taken to correct the identified unsafe conditions and work practices, are recorded on a hazard assessment and correction form.
2. Documentation of Ergonomic and Safe Patient Handling training including the worker's name or other identifier, department, training dates, type(s) of training, and training providers is recorded on a worker training and instruction form. Each direct patient care department has an assigned new hire and annual Safe Patient Handling training plan.
3. Inspection records and training documentation will be maintained for one year, except for training records of employees who have worked for less than one year that are provided to the worker upon termination of employment.

DEFINITIONS

1. **Designated health care worker** means an employee responsible for performing or assisting in patient handling activities who is specifically trained to handle patient lifts, repositioning, and transfers using patient transfer, repositioning, and lifting devices as appropriate for the specific patient.
2. **Designated registered nurse** means a registered nurse who has responsibilities under the Plan required by subsection (c), including, but not limited to, the responsibilities of a designated health care worker, preparation of a safe patient handling instruction, the observation and direction of patient lifts or mobilizations, or the communication of patient handling information to patients or their authorized representatives.
3. **Emergency** means unanticipated circumstances that can be life-threatening or pose a risk of significant injuries to the patient, staff or public, requiring immediate action.
4. **General acute care hospital (GACH)** means a hospital, licensed by the California Department of Public Health as such in accordance with Title 22, California Code of Regulations.
5. **Lifting** means the vertical movement of a patient or the support of part or all of a patient's body.
6. **Manual patient handling** means the lifting, transferring, repositioning, or mobilizing of part or all of a patient's body done without the assistance of equipment.
7. **Mobilizing** means the putting into movement, or assisting in the putting into movement, of part or all of a patient's body.
8. **Musculoskeletal injury** means acute injury or cumulative trauma of the muscles, tendons, ligaments, bursa, peripheral nerves, joints, bone or blood vessels.
9. **Patient** means a person who is receiving diagnostic, therapeutic or preventive health services or who is under observation or treatment for illness or injury or for care during and after pregnancy.
10. **Patient care unit** means a unit or department that is included within a general acute care hospital's license that provides direct patient care including but not limited to nursing units, diagnostic imaging, emergency department, or rehabilitation.
11. **Patient handling** means lifting, transferring, repositioning or mobilizing of part or all of a patient's body.
12. **Repositioning** means changing a patient's position on a bed, gurney, chair or other support surface.
13. **Safe Patient Handling Equipment** means a powered or non-powered device that effectively reduces the forces exerted by or on employees while they perform patient handling activities, including all accessories necessary for the operation of the device. Devices and accessories include replaceable and disposable items.
14. **Safe patient handling policy** means a policy that requires replacement of manual lifting and transferring of patients with powered patient transfer devices and lifting devices, as appropriate for the specific patient and consistent with the employer's safety policies and the professional judgment and clinical assessment of the registered nurse.

15. **Transferring** means moving a patient from one surface to another (for example from a bed to a gurney).

REFERENCES:

1. Association of Occupational Health Professionals in Healthcare (AOHP). Safe Patient Handling Position Statement. https://aohp.org/aohp/Portals/0/Documents/ToolsForYourWork/SafePatientHandling.pdf
2. California Hospital Association. The Cal/OSHA Safe Patient Handling Regulation. Health Care Worker Back and Musculoskeletal Injury Prevention Law. August 2014 1st Edition https://calhospital.org/wp-content/uploads/2019/11/safepatienthandling_epubapp.pdf
3. Cal/OSHA Safe Patient Handling in California Fact Sheet 2016 https://www.dir.ca.gov/dosh/dosh_publications/Safe-Patient-Handling-for-Web-fs.pdf
4. Cal/OSHA – Title 8 Regulations. Department of Industrial Relations (2014). *5120. Health Care Worker Back and Musculoskeletal Injury Prevention*. Chapter 4, Subchapter 7, Group 15, Article 106 Ergonomics. https://www.dir.ca.gov/title8/5120.html
5. Cal/OSHA – Title 8 Regulations. Department of Industrial Relations (2014). *5110. Repetitive Motion Injuries.* Chapter 4, Subchapter 7, Group 15, Article 106 Ergonomics https://www.dir.ca.gov/title8/5110.html
6. The National Institute for Occupational Safety and Health (NIOSH) (2023). Safe Patient Handling and Movement (SPHM) https://www.cdc.gov/niosh/topics/safepatient/default.html

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Health and Safety - Work Related Accidents or Exposures to Blood or Other Potentially Infectious Materials (17-01)
2. Injury and Illness Prevention Program
3. Fall Prevention and Management*
4. Gait Belt Policy
5. Safe Patient Handling Subcommittee Charter

RECORD RETENTION AND DESTRUCTION:

Training records will be maintained for a minimum of 1 year per Cal/OSHA requirement (2014 regulation).

Supersedes: Safe Patient Handling – Minimal Lift Policy Sonography Ergonomics Policy

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: NIHD Recruitment and Selection		
Owner: Human Resources Manager	Department: Human Resources	
Scope:		
Date Last Modified: 08/26/2024	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

The purpose of this policy is to provide guidance and outline the definitions, procedures, and responsibilities within the process of recruitment and selection at Northern Inyo Healthcare District. This policy covers all recruitments managed by the department of Human Resources.

DEFINITIONS:

Recruitment – the act of searching for or finding candidates to fill a vacant position.

Job Description – a written document that outlines essential requirements and responsibilities of a position. All positions in the District must have an accompanying job description.

Screening – reviewing a candidate's application, resume, and any additional provided information to ensure a candidate meets the minimum requirements for a vacancy.

Application Rating Tool – a tool utilized in application screening. The screener will assign a point value to the minimum and preferred qualifications of a position based on the job description and evaluate an applicant's education, experience and certifications against said qualifications to obtain a score for passage or failure of the application on to interviews.

Internal Competency Interview – a first round interview conducted by a manager to determine whether an internal candidate meets the competencies, and has the skills and abilities needed for a position. These interviews are only to be utilized for candidates internal to the District at the time of application submission.

Pre-screening Phone Interview – a first round interview conducted by a manager with an external candidate to verify skills, knowledge, and competency, and gather any general information on a candidate to determine if they will be offered a second interview. If an internal competency interview has been conducted and there was no selection or acceptance, the pre-screen phone interview questions should match, or mirror, those of the internal competency interview.

Behavioral Interview – a second round interview conducted by a panel with an external candidate to determine whether a candidate will be the best selection for a vacancy. Behavioral interviews utilize questions that measure a candidate's competence, knowledge, problem solving, and abilities through prior experience.

Intra-departmental Posting – Type of vacancy posting where only employees in a specific department may apply for a vacancy.

Internal Posting – Type of vacancy posting where only employees of the District may apply for a vacancy

External Posting – Type of vacancy posting where any interested party may apply for a vacancy, regardless of if they are already employed by the District.

POLICY:

Northern Inyo Healthcare District is committed to ensuring all recruitments are conducted in a fair and appropriate manner, consistent with all Federal and State regulations the District is required to follow. The Human Resources Department is responsible for overseeing the recruitment and selection process at Northern Inyo Healthcare District. These procedures and processes will be reviewed regularly, and may be amended due to changes in regulations, recommendation of legal counsel, or under other circumstances, as needed.

PROCEDURE:

1. Managers must submit a complete Staffing Request Form to Exec Team for approval
2. Once approved, Managers must submit the completed and signed staffing request form to HR with the following attached:
    a. Up to date job description
    b. All interview questions, including competency/screening and final/behavioral
3. Position will be posted in one of three ways, dependent upon historic recruitments, represented status, and whether the position is considered entry level, hard to fill, or any other special status or conditions:
    a. Intra-departmental
    b. Internal
    c. External
4. Prior to posting, HR will create an application rating tool based on most up to date Job Description and use it to screen applicants to ensure they meet the minimum qualifications, and will conduct any necessary seniority review for internal candidates in represented positions.
5. Managers will receive candidates as they have passed through initial qualification screening to conduct competency interviews for internal candidates, or pre-screen phone interviews for external candidates per the NIHD Candidate Interviews policy. Managers will not have access to the recruitment system at any time during the recruitment and selection process.
6. After conducting any first round interviews, if there are no qualified internal candidates, managers must complete behavioral interviews for their selected finalists.
7. Once the interview process is complete and managers are ready to make a selection, mangers will email the HR Recruiter their selection and submit all interview paperwork, completed, scored, and signed.
8. The HR recruiter will review all documentation for completion, then send out the official offer to the selected candidate.
9. Candidates will go through the onboarding process, and once complete, be oriented and begin working for the District-.

REFERENCES:

RECORD RETENTION AND DESTRUCTION:

All Human Resources records, including those related to hiring, will be retained for the length of employment, plus 10 years

CROSS REFERENCE POLICIES AND PROCEDURES:

NIHD Candidate Interviews
Hiring – Background Screening
Employee Health NIHD Workforce Onboarding

Supersedes: Not Set

Title: Northern Inyo Healthcare District Dress Code		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
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:

As a District employee you will find both the patients and the general community expect a greater degree of cleanliness, neatness and professionalism than might be found in most other industries. Therefore, please be careful to dress discreetly, limit your use of scents and jewelry and always present the clean, neat and professional image our public expects.

POLICY:

The appearance of an employee should not cause concern or irritation to the patient or public.
Due to varying amounts of contact with the public and work tasks, departments may have different dress requirements. What might be appropriate for one department, might not be for another. Some departments may provide the required clothing to their employees, and will have additional requirements regarding these uniforms.
Each department head has the responsibility for clarifying the dress code for their specific areas and for ensuring that it is consistently and fairly enforced. There are general standards that all employees, regardless of position and department, are expected to follow.
General Standards:

- Clothing must be in good condition, free of visible holes and staining;
- Clothing should not be revealing or make others feel uncomfortable under reasonable circumstances:
- Clothing should not have obvious or intentionally offensive words or images;
- Shoes should be in acceptable condition and appropriate for the work environment;
- Employees must wear their badges at all times while working per the Identification Badges policy;
- Employees should maintain good hygiene and grooming practices;

Please report any unsanitary conditions in your department or the District to your supervisor. Failure to comply with this policy, or a department's specific dress code, may result in disciplinary action.

REFERENCES: N/A

RECORD RETENTION AND DESTRUCTION:

1. Human Resources records will be kept for the life of employment, plus ten (10) years

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Identification Badges
2. District Furnished Uniforms
3. Environmental Service: Dress Code Policy
4. Operating Room Attire
5. Fiscal Services Department Dress Code

Supersedes: v.1 Cleanliness and Neatness
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Provider-Performed Microscopy Competency		
Owner: POCT LEAD	Department: Laboratory	
Scope:		
Date Last Modified: 07/26/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date:	

I. PURPOSE

Centers for Medicare and Medicaid Services (CMS), and the State of California laboratory regulations require that all laboratories have on-going mechanisms to monitor accurate patient test management. Federal CLIA ’88 regulations classify all provider-performed microscopy (PPM) as “moderately complex” testing. Therefore all individuals performing PPM, or overseeing PPM procedures (PPMP) performed by trainees, are required to successfully complete a periodic assessment and be credentialed and privileged by Northern Inyo Healthcare District (NIHD). This is to ensure that all providers are proficient in PPMP and reporting test results.

II. PROCEDURE

All testing providers are evaluated for competency on PPM including pre-analysis, analysis and post-analysis components by a colleague. The Point of care (POC) coordinator and department supervisor(s) will develop a program for competency assessment and acceptability standards based on The Joint Commission (TJC) requirements, procedure manuals, and departmental policies. Supervisors and managers will evaluate common group deficiencies, review current policies and procedures and take corrective action to improve performance.

A. Test Menu

Provider-performed microscopy includes the following 4 tests at NIHD:

1. Fern Test
2. KOH (potassium hydroxide) Preparation
3. Direct Wet Mount
4. Urine Sediment

B. Competency

For practitioners new to NIHD or newly requesting PPM privileges, successful initial competency testing must be followed by a 6 month and 12 month evaluation. After the first year, all practitioners will be evaluated annually or as needed.

1. Competency for PPM is assessed using all of the following six methods as required by CMS and TJC:
    a. Direct observation of routine patient test performance, including patient preparation, specimen handling, processing and testing
    b. Monitoring recording and reporting of test results
    c. Review of worksheets, QC records and preventative maintenance records
    d. Direct observation of performance of microscope maintenance and function checks

e. Assessment of test performance through testing external PT samples or testing previously analyzed specimens (blind testing)
f. Assessment of problem solving skills

2. NIHD's POC department utilizes an online competency challenge program hosted by the University of Washington to assess problem solving skills. A link to this program along with additional instructions on how to log into the program is sent via email by the POC team. There are approximately five questions and 80% of the questions must be answered correctly to pass
3. Independent performance with no to little additional support is considered successful
4. Competency is assessed by a qualified colleague
5. Personnel qualified to observe and assess competency are providers fully credentialed and current on PPM competency assessment
6. Observed competency is documented on a competency checklist and filed in the POC department and kept for a minimum of 3 years; a copy of the document(s) is placed in employee personnel file

C. Proficiency testing

The POC department contracts with the Wisconsin State Laboratory of Hygiene (WSLH), a CMS approved proficiency testing program that meets regulatory requirements for variety and frequency of testing. Proficiency testing will be conducted bi-annually and consists of two images (paper and online version).

1. Proficiency samples are rotated among providers who perform patient testing
2. Testing personnel tests the proficiency samples the same way that patient samples are tested
3. The practitioners who perform the proficiency testing and the medical director of the laboratory sign attestations documenting that proficiency samples were tested in the same manner as patient specimens
4. Testing personnel reports proficiency sample results the same way that patient samples are reported
5. Proficiency records are kept for 3 years; proficiency performance evaluations are kept for 5 years
6. A failure is unsuccessful performance in an event and warrants an investigation using the "Proficiency Testing Checklist for Corrective Action"; the investigation is documented and records are kept for 5 years

III. CORRECTIVE ACTION

Reassessment of provider competency must occur when problems are identified with provider performance

A. Criteria for Remediation

Remedial actions are necessary for the following reasons:

1. When testing personnel fails an assigned proficiency test(s)
2. When deficiencies are being observed during competency assessment; this will be at the discretion of the observer
3. When deficiencies are being observed during routine patient testing; this will be at the discretion of the supervisor
4. When an individual fails to comply repeatedly with testing requirements
5. When testing staff is non-compliant with regulatory requirements after reasonable attempts of contact have been made by the supervisor and/or POC department

B. Failure of online competency assessment modules

1. One time failure: Practitioners are allowed to retake the module after one failure. The POC department will sent a notification via email allowing the practitioner to retake the exam.
2. Repeat failure: On repeat failure, the practitioner must be mentored prior to being allowed to retake the examination a second time.

C. Mentoring

After determination that remediation is required, the following process will be initiated:

1. Department supervisor will be notified that individual will require mentoring and that he/she is prohibited to perform PPM without supervision until remediation is complete
2. Department supervisor will assist to identify mentors who have passed the competency assessment and have current privileges in the area(s) of PPM for which the practitioner failed competency
3. Practitioner must correctly interpret ten patient samples with a mentor in each of the examination types that the practitioner failed
4. The Mentor will complete an attestation that the practitioner has successfully completed the ten sample review
5. Attestation will be filed in the POC department and kept for a minimum of 3 years; a copy of the document(s) is placed in employee personnel file

D. Non-compliance

When it has been determined that a provider is non-compliant with following the remediation procedure the following steps will be taken:

1. Notification of department supervisor and/or compliance officer that the individual may not perform PPM testing effective immediately
2. Privileges to perform PPM testing will be revoked until provider has complied with mentoring requirements

IV. REFERENCES

1. 2017 Comprehensive Accreditation Manual of Laboratory and Point-of-Care Testing, The Joint Commission, HR.01.04.01 & HR.01.06.01
2. U.S. Department of Health and Human Services, CLIA ’88 Final Rules, Federal Register, Subpart M, §493.1355 - §493.1365, U.S. Government Printing Office, Wash. DC, www.eCFR.org, March 6, 2017
3. CADPH-Laboratory Field Services. Laws and Regulations Relating to Clinical Laboratories, Excerpts from the California Business and Professional Code and Regulations, Berkeley, CA, January 1, 1991

Supersedes: v.2 Provider-Performed Microscopy Competency*

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Temporary Telecommuting Assignment Policy		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 08/14/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/15/2020	

POLICY:

Northern Inyo Healthcare District (NIHD) recognizes that our employees are by definition, Healthcare Workers, and the first priority of government is continuity of service in the event of a wide spread emergency or disaster (GC §§3100-3109). In the event of such emergency or disaster, it is important that NIHD not only respond to the emergency by stabilizing the emergency, saving lives, and protecting property but also maintain continuity of government. As such, NIHD is implementing this temporary telecommuting assignment policy to ensure the highest level possible of continuity of operations ~~in light of the current COVID-19 (coronavirus) outbreak~~ while addressing health and safety concerns for employees.

This policy will allow Department Heads full discretion to determine if an employee is eligible to be placed in a temporary telecommuting assignment and to determine the length of the telecommuting assignment. Department Heads will be guided in their decision-making by their assessment of job duties that may be conducive to working remotely, and operational needs assessments.

Because NIHD provides essential services to members of the community, there are positions at NIHD that require the employee to be physically present in the workplace. These employees are expected to report to work as scheduled unless otherwise notified by their direct supervisor.

All employees will benefit from the impacts of this policy by way of the increased opportunities to achieve social distancing parameters recommended as a precaution against the spread of the coronavirus.

The temporary telecommuting assignments implemented by this policy are expected to be short-term. NIHD will ~~continue to~~ monitor guidance from emergency and public health officials and may make alterations to or terminate this policy at any time at the direction of the Chief Executive Officer.

Employees should not assume eligibility for a telecommuting assignment. Nor should they assume any specified period of time for telecommuting if so assigned. Employees assigned to a temporary telecommuting assignment will receive specific written instructions and are expected to abide by the following guidelines.

PROCEDURE:

Job Responsibilities & Regular Communication

While telecommuting, to the extent possible, employees should be performing the full range of their normal job duties. Employees and supervisor should maintain communication throughout the workday, through email, by phone, video chat, or other means. Managers and supervisors will be expected to establish and communicate work expectations of employees working remotely, including setting work priorities, deadlines, and reviewing work assignments. Employees are required to log work activity in 30 minute increments in his/her Outlook calendar; daily logs are to be submitted to the supervisor at the end of the work day.

Work Schedules and Time Worked

Telecommuting employees should coordinate with their supervisor the set hours that will be devoted to performing their work. Start and end times for telecommuting employees should be communicated in advance and should be consistent from day-to-day, as much as possible. As approved by the employee's supervisor, an employee's start time and end time may be permitted to be different from the employee's normal hours when working on-site.

Employees who are not exempt from overtime requirements under the Fair Labor Standards Act (FLSA) will be required to accurately record all hours worked. Employees should coordinate with their supervisor for any periods of time during the workday when they will not be working. Employee activity may be subject to audit by NIHD. Any overtime must be authorized in advance by the employee's supervisor. Under this policy, employees are not eligible for shift differential.

While it is anticipated the majority of work performed by the employee will be remotely (not on-site), there may circumstances in which the employee is needed to return to their normal work site. In the event such on-site attendance is required, supervisors will notify the employee, in advance, when on-site attendance is necessary.

Equipment and Tech Support

Electronic equipment needed for employees to telecommute will be supplied by NIHD to the extent resources are available. In certain circumstances and/or if sufficient resources are not available, employees may be required to use their personal phones, computers, or other equipment. Equipment supplied by the employee, if deemed appropriate by the organization, will be maintained by the employee. NIHD accepts no responsibility for damage or repairs to employee-owned equipment and reserves the right to make determinations as to appropriate equipment, subject to change at any time. Equipment supplied by NIHD is to be used for business purposes only. The employee must sign inventory Telecommuting Agreement (Attachment A) with an inventory of NIHD property authorized for telecommuting use and thereby agree to take appropriate action to protect the items from damage or theft. All NIHD-owned equipment issued to an employee must be returned immediately at the conclusion of the temporary telecommuting arrangement. Employees who had been provided with an NIHD computer prior to this temporary policy will not need to return their NIHD issued equipment.

NIHD will provide employees with appropriate office supplies (pens, paper, etc.) as deemed necessary and may reimburse the employee for pre-approved business-related expenses that are necessary and reasonably incurred to carry out the employee's job.

Telecommuting employees will establish an appropriate work environment within his or her home for work purposes and provide the necessary workspace, such as desk, tabletop, or other location that provides optimal work productivity. Given the temporary nature of this program, employees are not expected to purchase furniture or equipment to arrange a home workspace.

Employees should seek advice from a tax advisor if they have questions concerning tax implications of working from home. NIHD is not responsible for substantiating any employee's claim of tax deductions for operation of a home office used to perform work.

Security

Consistent with NIHD's expectations of information security for employees working at the office, telecommuting employees are expected to ensure the protection of NIHD information accessible from their home office. Necessary security steps include appropriate network security measures, regular password maintenance, and any other measures appropriate for the job and the environment.

Safety

Employees are expected to maintain their home workspace in a safe manner, free from safety hazards. Injuries sustained by the employee in a home office location and in conjunction with his or her regular work duties may be covered by Workers' Compensation. Telecommuting employees are responsible for notifying their

supervisor of such injuries as soon as practicable. NIHD assumes no liability for injuries that occur outside the performance of the employee's duties and/or outside the employee's scheduled telecommuting hours.
Employees are prohibited from having face-to-face meetings regarding NIHD business in their homes. Rather, employees shall opt to use video or phone conferencing to maintain social distancing guidelines and personal protection. NIHD will not be liable for any injuries sustained by visitors to an employee's home worksite.

NIHD Policies and Employee Conduct
Working from home inherently changes the workplace dynamic for employees. However, employees are expected to continue to adhere to all NIHD Personnel Rules and Regulations department policies, and relevant Memoranda of Understanding. Employees with questions about the application of a policy or procedure should contact their supervisor for additional information.

REFERENCES:

1. U. S. Office of Personnel Management Questions and Answers on Human Resources Flexibilities and Authorities for Coronavirus Disease 2019 (COVID-19)
   chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/viewer.html?pdfurl=https%3A%2F%2Fwww.opm.gov%2Fpolicy-data-oversight%2Fcovid-19%2Fquestions-and-answers-on-human-resources-flexibilities-and-authorities-for-coronavirus-disease-2019-covid-19.pdf&clen=222418

RECORD RETENTION AND DESTRUCTION:

1. This policy/procedure must be maintained for the life of the document, plus 6 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Standards of Conduct
2. Safety
3. Security Management Plan
4. Temporary Telecommuting Assignment Policy

Supersedes: v.2 Temporary Telecommuting Assignment Policy

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Waste Anesthetic Gases-Trace Gas Testing		
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: The purpose of this policy is to establish a procedure for evaluating and mitigating occupational exposure to waste anesthetic gas (WAG) at Northern Inyo Healthcare District (NIHD).

POLICY :

1. NIHD will perform occupational exposure testing for WAG.
2. NIHD will use Certified Medical Testing company to perform the occupational exposure testing.
3. Testing procedures utilized will conform with and be capable of determining functional results that meet the minimum requirement set forth in NIOSH and / or OSHA standards in effect currently.
4. The testing standard used will be a maximum exposure of 25 ppm-during administration/ACGIH TLV – 50 ppm 8 hr TWA.

    - Leak detection procedures will be performed on high pressure side of each nitrous oxide hose drop and anesthesia machine prior to the commencement of the subsequently measured procedure.
    - An absorbent type nitrous oxide monitor will be placed in the referenced area for a duration of 0.25 hours after which it will be secured in a protective atmosphere and forwarded to a testing laboratory for analysis.
    - The Method of analysis will be NIOSH # 6600, OSHA # 166

REFERENCE:

1. National Institute for Occupational Safety and Health (NIOSH). Method #6600
   Occupational Safety and Health Administration (OSHA) Metho # 166

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCE POLICIES AND PROCEDURES: N/A

Supersedes: v.1 Waste Anesthetic Gases-Trace Gas Testing

Title: Wages - Pay Scale and Pay Adjustments		
Owner: Human Resources Manager	Department: Human Resources	
Scope: District Wide		
Date Last Modified: 08/14/2024	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date:	

POLICY:

Each position in the District is assigned to a pay scale. This pay scale is based upon the degree of responsibility, the technical skills, and the professional capacity that the job requires. ~~Full-time and regular part-time~~All personnel ~~are normally hired at the minimum of the pay scale for their position. Per diem personnel may be hired above the minimum of the pay scale, since per diem employees do not receive benefits~~will be reviewed upon selection and placed at a level commensurate with the employee's applicable experience, education, certification, or other requirements. Per Diem employees will receive an additional percentage added to their pay, as they do not receive benefits. Your position anniversary date ~~and performance~~ is used in determining ~~eligibility or standing for~~ the date of your annual pay increases. Personnel will not be advanced beyond the maximum of the pay scale for their position.

Positions are reviewed regarding their relationship to comparable positions in the District and in the healthcare industry. The review of positions and any wage or benefit surveys are conducted by Human Resources on a regular basis, upon the development of a new position, or upon the request of the ~~Senior Management~~Executive Team. Other District personnel are not authorized to conduct wage or benefit surveys during working hours or at hospital expense. If you have any questions regarding your wage or your potential for advancement, please feel free to talk with your manager or with the Human Resources Manager.

Your pay may be adjusted by either an incremental increase, ~~or~~ a salary adjustment, or a Board of Directors approved cost of living increase. The basis for an incremental increase is ~~your performance as evaluated on~~ your position anniversary date. ~~If you have performed satisfactorily, y~~You ~~may~~ will be eligible for an incremental increase at the beginning of the pay period following each position anniversary date until you have reached the ~~top~~ max of your position pay scale.

If your position is affected by a salary adjustment, this adjustment will not affect your eligibility for incremental increases. When you have reached the ~~top~~ max of your position pay scale, you may still receive any salary adjustments that affect your position.

The District has a long-standing practice of conducting regular audits of employee pay. These audits consist of reviewing employee salaries against the most current official pay scales, as maintained by Human Resources. In cases where an audit finds an employee has been paid a rate over the max of their scale, Human Resources will correct the mistake prospectively, with proper notice to the employee.

REFERENCES: N/A

RECORD RETENTION AND DESTRUCTION:

1. Maintain payroll records for non-pension workforce for a minim of 15 years.
2. Employees entitled to pension: life of employee plus 6 years

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Performance Evaluations
2. Hiring – Anniversary Date

Supersedes: v.3 Wages - Pay Scale and Pay Adjustments (05-03; 07-03)
Legal Review: Atkinson, Andelson, Loya, Ruud & Romo 10/30/2020