April 15 2020 Regular Meeting

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AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
April 15, 2020 at 5:30 p.m.
2957 Birch Street, Bishop, CA

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

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: At this time, persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers are limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the agenda.
3. New Business:
   A. Financial impact of Covid 19 on NIHD *(information, possible direction to staff)*
   B. Pioneer Home Health 5 Year Action Plan (*information item*)
   C. Emergency Mutual Aid Memorandum of Understanding, Northern Inyo Healthcare District; Southern Mono Healthcare District; Southern Inyo Healthcare District; Toiyabe Indian Health Project (*action item*)
   D. Appointment of Interim Chief Medical Officer (*information item*)
   E. Approval *of Identity Theft Red Flags Rule* Policy and Procedure (*action item*)
   F. *Temporary Floating Staff* Policy (*action item*)
   G. *Temporary Telecommuting Assignment* Policy (*action item*)
   H. *Safety in the Operating Room* Policy and Procedure (*action item*)

I. *Asset Control* Policy and Procedure approval (*action item*)

J. *Asset Management Policy and Procedure* approval (*action item*)

K. *Capitalization of Assets* Policy and Procedure approval (*action item*)

L. *Fixed Assets and Depreciation* Policy and Procedure approval (*action item*)

4. Old Business:
   A. Building separation construction project update (*information item*)
5. Reports (*information items*):
   A. RHC Building update
6. Chief of Staff report, Stacey Brown, MD
   A. Medical Staff Bylaws Amendment for Disaster Privileging (*action item*)
   B. Policy and Procedure approvals (*action items*):
      1. *Credentialing Healthcare Practitioners in the Event of a Disaster*
      2. *Biological Monitoring System for Steam Sterilizers*
      3. *High-Level Disinfection of Equipment*
      4. *Steris System 1 E Processor*
      5. *Manual Jet Ventilator*
      6. *Clinic Patient No-Show, Missed Appointment, and Late Cancellation Policy*
      7. *OP Hospital No-Show, Missed Appointment, and Late Cancellation Policy*
      8. *New Line of Service Implementation Policy and Procedure*
   C. Physician recruitment update (*information item*)

   The following items were submitted for approval and tabled at the March 18 2020 District Board meeting:

   D. Annual Approvals (*action items*)
      1. Critical Indicators
         i. *ICU*
         ii. *Medical Services*
         iii. *Perinatal*
      2. Policies and Procedures
         i. *Plan to Eliminate or Substantially Reduce Medication-Related Errors*
         ii. *Standardized Procedure – Emergency Care Policy for the Nurse Practitioner or Certified Nurse Midwife*
         iii. *Standardized Protocol – Emergency Care Policy for the Physician Assistant*

iv. *Standardized Procedure – Medical Screening Examination for Obstetrical Patient*

v. *Standardized Procedures for Medical Functions by RN in the Emergency Department*

3. Radiation Safety Policies

i. *ALARA Program*

ii. *DI – Area Monitoring and Controls*

iii. *DI – Radiation Protection for the Patient*

iv. *DI – Reportable/Recordable Events in CT, Fluoroscopy and Nuclear Medicine*

v. *DI CT Radiation Safety Policy*

vi. *DI – Lead Apron/Protective Equipment Policy*

vii. *Diagnostic Imaging – C-Arm (Fluoroscope) Radiation Safety*

viii. *Diagnostic Imaging – Disposal of Radioactive Sharps*

ix. *Diagnostic Imaging – Handling of Radioactive Packages, Non-nuclear medicine personnel*

x. *Diagnostic Imaging – Nuclear Medicine New Employee/Annual Orientation*

xi. *Diagnostic Imaging – Ordering Radioactive Materials*

xii. *Diagnostic Imaging – Radioactive Material Hot Lab Security*

xiii. *Diagnostic Imaging – Radioactive Material Spills Procedure*

xiv. *Diagnostic Imaging – Radioactive Materials Delivery After-hours Policy/Procedure*

xv. *Diagnostic Imaging – Radioactive Waste Storage and Disposal*

xvi. *Dosimetry Program – Occupational Radiation Exposure Monitoring Program*

xvii. *Radiation Policy for Management of Patients with Excessive Exposure*

xviii. *Radiation Safety Committee*

xix. *Radiology Services Pregnant Personnel*

xx. *Responsibilities and Duties f Radiation Safety Committee (RSC)*

Consent Agenda (action items)

7. Approval of minutes of the March 18 2020 regular meeting
8. Financial and statistical reports as of February 2020
9. Policy and Procedure annual approvals

10. Reports from Board members (*information items*).
11. Adjournment to Closed Session to/for:
    A. Confer with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d)(2)*).
    B. Conference with Legal Counsel regarding existing litigation, Inyo County Local Agency Formation Commission and Northern Inyo Healthcare District v. Southern Mono Healthcare District (*pursuant to Government Code Section 54956.9*).
    C. Public Employee Performance Evaluation (*Government Code Section 54957(b*)) title: Chief Executive Officer.
    D. Public Employee Performance Evaluation (*Government Code Section 54957(b*)) title: Chief Financial Officer.
12. Reports from Board members (*information items*).
13. Adjournment.

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

Northern Inyo Healthcare District Impact of COVID-19 & Governor Newsom's Order

As of April 8, 2020

Timeline of Situation

- March 12, NIHD Activates Incident Command
- Patient cancellations start occurring, No Shows increase
- March 16 NIHD on budget for March revenues, patients and providers begin to agree to delay services like surgery
- March 19, 2020 – Governor Newsom Issues stay at home order, closes many businesses, work from home policy starts
- March 20 NIHD reduces to essential services – RHC drive-up screening and ER Big Room in full operation
- March 24th; CMS says they don't have authority to expand telemedicine to RHCs or hospital outpatient services (rehab, respiratory, dietician)
- March 27th, Cures Act Signed; volumes drop by 70% for most services, only inpatient and infusion are normal
- March 31st; Revenues for month are ($3.0 million) less than budget, COVID-19 response in full at NIHD; New Operational Paradigm in place
- April 6th; NIHD begins discussions on expansion of services beyond essential and planning for appropriate precautions for surgeries and other services above "essential"

COVID-19 Operational Paradigm

- NIHD Offering Essential Services Only
  - No departments totally closed
  - Patients are acute or telemedicine
    - RHC offering telemedicine on fee for service basis
    - NIA offering telemedicine through existing program
- Patients avoiding health care
  - Daily acute census for March 5.95 per day
  - Emergency room services drop to 12 per day
  - Revenues for Week ended April 7th. $1,308,302 versus budget of $3,182,895; 41% of budget
- Operational Expenses
  - Small reductions in supplies expense at end of March
  - Payroll ended 3/30/2019 was $1,259,760 plus $92,511 in taxes

Cures Act & Other Federal Help

- General Acute Care Hospitals assistance - $100 Billion; 60% in the form of a payment of $25,000 per bed; $625,000
- Delay of Sequestration Cuts - $80,000 in 2020 and another $210,000 in 2021 (estimated)
- HRSA $100 million grants; $90,000 to NIHD
- Paycheck Protection Program; NIHD ineligible
  - Cromer-Tyler Group to apply for perhaps $1 million
  - Sierra Emergency Group reviewing for eligibility
  - Discussions with Radiology Group to occur on same
  - Preparing application with Pioneer Homecare & Hospice
- FEMA Grants and Other Support
  - NIHD recording direct cost and staff assigned hours, approximately $250,000 each two weeks
  - Private Foundation support being applied for
- Medicare Cash Advance of $15.1 million application in process

Financial Situation

- February 29, 2020:
  - Year to Date Net Income $478,424
- March 31, 2020:
  - Census and outpatient revenues falls from budget to ($3.0 million) less than budget.
  - Expenses same level and salaries slightly higher than February
  - Expected Net Loss ($1,500,000) turning year negative ($1 million)
- April 30, 2020:
  - Revenues now trending down to $5,670,000 after 8 days for month
  - Expenses dropping 5% based on 3/30/20 payroll average
  - Expected loss based on $7.9 in total expenses of ($4.1 million)
  - Year to Date loss to be ($5.1 million)
- Cash trending $1.5 million of weekly receipts due to continued collections on Athena AR. Expect downturn end of April

Pioneer Home Health Care, Inc.
Five Year Action Plan
for
Responsible Growth and Financial Stability

I. Background

Pioneer Home Health Care, Inc. (PHHC) was originally created to address an unmet health care need within the communities of Inyo and Mono Counties. It is a State Licensed and Medicare Certified home health agency. This program was created in late 1990 and was licensed to begin care in early 1991. With over 85% of the patients being Medicare beneficiaries and reimbursement being paid based on costs, the agency was able to both provide a new health care service and was financially solvent as the agency grew.

In 1998, Medicare's payment methodology for home health changed radically, causing a severe challenge especially to small, rural providers, as reimbursement became based on a standardized patient episode, with very little consideration to the higher costs in the vast rural area. This program could no longer cover its own costs.

However, at the same time, as Pioneer was known to be a trustworthy home care provider, the community asked us to begin a second program – hourly attendant care in the home. With our new program's employees being paid just above minimum wage, and reimbursement coming directly from our private clients, this new Personal Care Program was able to make enough of a profit to cover the home health care losses.

Our next program, hospice care, was again created at the request of the community. This program opened its doors to patients in mid-2016. We began with donated start-up funds, however, in the four years it took before being able to begin licensed care, we required additional financial resources. Based on all national and state data, this program should be providing care to at least 12 – 15 patients at any given time, yet we have not reached this census goal. In seeking to provide this needed service to our community, we are working to educate our local physicians for earlier referrals to the program.

Year after year, there have been significant cuts to Medicare's home health reimbursement. As a result, we were no longer able to provide salaries and benefits competitive with other local health care providers and it became impossible to recruit new employees. Our ability to accept orthopedic and rehab referrals was hampered due to insufficient therapy staff. We became financially challenged, unable to grow, and unable to meet the combined home care needs of our community. A partnership was necessary. We needed an opportunity to parallel our salaries and benefits with the rest of the health care district in order to recruit, hire, and retain staff, to receive more patient referrals, and to grow all of our programs in order to better meet the total home care needs of our community. Our goal has always been financial stability while meeting these needs.

Thus began our partnering relationship with the Northern Inyo Healthcare District (NIHD). The District Board and Administration acknowledged the value of our programs, the benefit of supporting their ongoing existence, and the desire to see them grow to benefit many more members of our community. This required NIHD financial support. With that

initial support, we have been able to parallel our salaries and hire needed staff – registered nurses, physical therapist, social worker, and home care aides. We were also given the opportunity to parallel our benefits, especially our health insurance and our 401k employer match. In addition, we received the needed financial and IT support to initiate a new, seriously needed, electronic medical records system (NDoc).

All this has come at considerable financial support of the District. It is now our responsibility, with the District's continued support, to utilize all our new resources to the fullest, grow all of our programs, perhaps even add other grant-supported programs, and find a way for our community programs to financially support themselves. To this end, we have put together a 5-year financial action plan which ties into our strategic plan of 2019.

II. Goal / Plan

This plan has been created to set in writing our goal to provide all of Pioneer's programs to our community with little or no financial support from our NIHD partner within the next 5 years. While we have attempted to include the daily encounters that could stall our plan from happening sooner, it does not take into account any major disasters.

Our Action Plan is supported by our Strategic Plan which was created by our staff and approved by our corporate board in November 2019. The two main precepts of our strategic plan are to transition our administrative leadership successfully and grow our quality programs responsibly for the betterment of our community. We will list here all portions of our strategic plan that will have an impact toward our financial sustainability.

A. Embrace and support the transition of Pioneer Administrators
   1. Provide hands-on training of new administrator, and send off-site to all important workshops and conferences.
   2. Past administrator to provide ongoing advisory support to new administrator as needed/requested.

   In summary, in the initial year of 2020, there will be a salary and benefit savings of over $40,000. In 2021, that savings could be close to $50,000. However, at the some point, most likely when the home health average daily census reaches 45 and hospice average daily census reaches 8, it will be necessary to recruit and hire a licensed clinician to take on the responsibilities of Clinical Supervisor and Quality Assurance Coordinator, as the one Administrator will not be able to continue to manage all these responsibilities alone. There will be no additional costs for recruitment, as we presently have a credit with a recruitment company.

B. Grow our 3 services to meet the projected needs of our community (projections based on national average in rural areas) while demonstrating responsible fiscal management with the goal to increase referrals (see attached Projected PHHC Revenue sheet).
   1. Actively engage in daily NIHD discharge planning meetings, continuing to educate all present in the meeting regarding the services we provide for a safe transition home.
   2. Actively engage with healthcare providers of NIHD Rural Health Clinic and other local health care providers.

3. Proactively work with referral sources in Mammoth and Lone Pine; meet and educate.
4. Proactively meet and educate orthopedic office and therapy clinics locally, in Southern Inyo and in Mammoth.
5. Actively engage with out-of-area referral sources, making sure they are aware of all our programs.
6. Initiate use of Facebook/social media to engage the community and educate regarding our services.
7. Request that NIHD stop referring attendant care hours to unlicensed, "under the table" entities, which takes revenue away from PHHC while creating risk management issues for the District.
8. Train additional Certified Home Health Aides (CHHAs) through state approved 40-hour certification program update for Certified Nurse Assistants (CNAs).

C. Preserving the Medicare Rural Add-on Revenue
We do not want to completely lose the additional Medicare Rural Add-on revenue, which is presently decreasing annually by 1%, from 5% to 0% (we are currently only receiving 3% in 2020). We must enlist the full force of our providers and boards in a crusade to make sure federal legislation is passed to secure us the 5% add-on permanently.

D. Continue to expand hospice fundraisers with the help of NIHD in order to enhance publicity and support
1. Annual Spring Breakfast Buffet and Silent Auction
In 2019, this function brought in $4,586.01
2. Annual Light-Up-A-Life (LUAL) is both a fundraiser and a memorial service
In 2019, this function brought in $3,350.25
3. Annual Holiday Tree Raffle
In 2019, this function brought in $4,601.00
4. Various yard sales, raffles, etc. held through the year
5. Serious consideration is given to creating a Hospice Thrift Store. We are already looking into foundation grant sources for start-up funding. Time line to begin this plan is scheduled for 2023. Much research would be needed to consider present competition, cost of operation, amount of volunteerism available, and anticipated revenue.

E. Meet the home care needs of the patients in our community by creating and implementing a Disease Management Program to support our rural, elderly population having multiple chronic comorbidities and repeat hospitalizations.
1. Specifically define the project based on needs
   a. Use of home telehealth program/equipment for monitoring and educating our chronically ill patients
      i. Be able to keep unstable home health patients on service for at least 60 days, while minimizing clinical travel visits/costs.
      ii. Be able to increase a percentage of our current 30-day patient admission periods into 60 day admission periods. This can potentially create an

additional 40% in Medicare reimbursement. (Presently only 50% of our patients are on service for home health more than 30 days)

b. Be able to closely monitor medication regimens for patients unable to manage without support.

c. Offer home "Tuck-in" services by our Personal Care Program
   i. Meet vulnerable patients "at the door" after hospital discharge.
   ii. Make sure patients have filled their prescriptions, take their new medications as ordered, have food in the refrigerator and a good meal in front of them, making sure they will be safe until the home health nurse arrives the next day.

2. Find foundations willing to fund our project over a five-year initial period, and complete the appropriate grant writing, training and implementation.

In summary, the goal will include increasing our traditional home health admissions by 5% each year over the next five years initial grant funded program. Each new home health admission specifically for disease management through telehealth or medication management will generate additional revenue of $3,600 - $4,000 if kept on service for 60 days. We would need the addition of a part-time LVN to work under one of our RN's in order to run this program.

The "Tuck-in" program will require 1-2 additional employees on an hourly as-needed basis. Keeping high risk patients from early readmissions will show the benefit of the "Tuck-in" program. In the future, it may find further grant funding, or consider charging a fee for this service, or work with NIHD to incorporate this program into the hospital discharge plan, in addition to taking them home in the care shuttle. Collectively all these programs aid NIH in providing safe discharges home. In addition, we would be able to keep and continue to utilize all the telehealth and medication management for continued use at no added equipment cost.

III. Final Summary

This Action Plan shows a reasonable growth projection within our rural population base. Any larger numbers than these would not be reality based. It also shows the plan for increasing services and revenue. There will, obviously, be step increases in costs. While much of the overhead costs will remain relatively consistent, additional staffing needs will occur as we grow. This will likely include an additional registered nurse and physical therapist, as well as hours from a licensed vocational nurse and home care aides. At some point, additional billing help may also be needed.

We are extremely grateful to the NIHD Board and to Dr. Flanigan for acknowledging the value of our multiple home care programs and stepping in to partner with us as we grow to our full potential. We in the home care arena firmly understand our collaborative importance in the large picture of this unique community's health care needs. It is our firm collective intent to meet the home care needs of our community while practicing sincere fiscal responsibility.

Projected PHHC Revenue

Home Health Care - paid by Medicare in 30-day episodes, and assuming at least 75% will be 60-day episodes.

In 2017, our average dialy census was 12-14

In 2019, our average daily census increased to 35

	Daily Census =	Admissions =	Revenue	
2020	40	248	$ 843,200.00	(at $3,400 per episode per Home Health Gold)
2021	45	278	$ 973,000.00	(at $3,500 per)
2022	50	308	$ 1,108,800.00	(at $3,600 per)
2023	55	338	$ 1,250,600.00	(at $3,700 per)
2024	60	368	$ 1,398,400.00	(at $3,800 per)

Hospice Care - paid by all payor sources on a "per-diem" rate

In 2019, our average daily census was 3

	Daily Census	Admissions X	Length of Stay =	# of Days X	Approximate Expected Daily Rate =	Revenue
2020	5	30	30	900	$200.00	$ 180,000.00
2021	8	33	33	1089	$210.00	$ 228,690.00
2022	11	36	36	1296	$215.00	$ 278,640.00
2023	14	40	39	1560	$218.00	$ 340,080.00
2024	18	45	40	1800	$220.00	$ 396,000.00

Personal Care Program - privately paid at $25 per hour

In 2019, our average hours of care per week was 380

	Hours per Week	Revenue
2020	400	$ 10,000.00
2021	450	$ 11,250.00
2022	500	$ 12,500.00
2023	550	$ 13,750.00
2024	600	$ 15,000.00

Total PHHC Revenue Projection

2020	$ 1,033,200.00
2021	$ 1,212,940.00
2022	$ 1,399,940.00
2023	$ 1,604,430.00
2024	$ 1,809,400.00

GOALS & ACTION PLANS

2 main issues
- Transition Leadership Successfully
- Grow Responsibly

Overall Progress: 4%

1. PATIENTS

GOALS/ACTION PLANS/TASKS	OWNER	RESOURCES	DUE DATE	UPDATES	PROGRESS
1.1 Create and implement a disease management program	Select Owner	3/20/20 Foundation Grant Search now in progress Nicki/PAT Marianne	Select Date	Update	0%
1.1.1 Specifically define our project	Select Owner		Select Date	Update	0%
1.1.2 Find Foundations that will fund our project	Select Owner		Select Date	Update	0%
1.1.3 Write grants	Select Owner		Select Date	Update	0%
1.1.4 Implement programs	Select Owner		Select Date	Update	0%
1.2 Create an integrated Patient/Client approach to ensure all needs are met	Select Owner		Select Date	Update	0%
1.2.1 Create Care Coordination Plan between clinical programs and PCP for interagency referrals	Tracy Watkins Ruby Allen	Completed Communication has improved.	01/31/2020	Update	0%
1.2.2 Identify all community resources available to help our patient/client needs	Select Owner	Patric	11/30/2019	Update	0%

2. EMPLOYEES

GOALS/ACTION PLANS/TASKS	OWNER	RESOURCES	DUE DATE	UPDATES	PROGRESS
2.1 Train all staff on optimal job performance	Select	In progress on going	Select	Update	0%

	Owner		Date		
2.1.1 Keep current on Annual Competencies	Ruby Allen	completed completed	08/31/2020	Update	0%
2.1.2 Prepare for PDGM 2020 New Medicare Reimbursement System	Ruby Allen	Pat	01/31/2020	Update	0%
2.1.3 Identify and provide ongoing training needs	Ruby Allen	Blair Caraway	11/08/2019 On Going	Update	0%
2.1.4 provide an adequate orientation process for all new staff	Select Owner		11/08/2019 On Going	Update	0%
2.1.5 Continue to train on the best use of NDOC	Select Owner	Selah	11/08/2019 On Going	Update	0%
2.2 Recruit/hire qualified staff/volunteers to meet the demands of our growing organization	Select Owner		Select Date	Update	0%
2.2.1 Work with a recruiter to find RN case manager	Pat West	Hired additional RN	01/31/2020	Update	0%
2.2.2 Continue local recruitment for PCP employees • Job Fairs • CNA Students	Select Owner		11/08/2019 On Going	Update	0%
2.3 Embrace and support the transition of role and responsibilities from Pat to Ruby	Select Owner	Completed Pat Retired 2/28/20	Select Date	Update	0%
2.3.1 Establish a list of all issues to be addressed/transitioned	Pat West		Select Date	Update	0%
2.3.2 Carve out routine training time	Ruby Allen	Pat	Select Date	Update	0%
2.4 Promote a positive work environment	Select Owner		Select Date	Update	0%
2.4.1 Create monthly PCP staff gatherings (food optional) for collaboration and training	Select Owner	Have gone to a twice a mo newsletter	Select Date	Update	0%
2.4.2 Explore options R/T improved mileage reimbursement	Ruby		Select	Update	0%