August 21 2019 Regular Meeting

August 21 2019 Regular Meeting - August 21 2019 Regular M

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

August 21, 2019 at 5:30 p.m.

2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 pm).
2. 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. Speakers are limited to a maximum of three minutes each).*
3. Strategic Plan update, Workforce Experience Committee report (*information item*).
4. New Business:
   A. Cardiac Care interventions, David Young (*information item*).
   B. Northern Inyo Health Articles of Incorporation (*action item*).
   C. Northern Inyo Health Bylaws (*action item*).
   D. District Board Resolution 19-06, 2013 CDPH survey monitoring cessation (*action item*).
   E. Policy and Procedure approval, *Group Intervention* (*action item*).
   F. Determination of date for Town Hall meeting/Community Information Night (*action item*).
5. Chief of Staff Report, William Timbers, MD:
   A. Policy and Procedure approvals (*action items*):
      1. *Accepting Orders from Non-Privileged Practitioners*
      2. *Administration of Drugs – Patient's Own Medications*
      3. *Color-Coded Wristband Use*
      4. *Drugs of Abuse Test McKesson 12-Drug Panel with Adulterants*
      5. *IV Service When NIHD IV Room is Closed*
      6. *Medication Dosing in Renal Failure*
      7. *Pharmacy Confidentiality: Storage and Destruction of PHI-Containing Documents*
      8. *Point of Care QuickVue Dipstick Strep A Test*
      9. *Unusable Drugs*
   B. Emergency Medicine Core Privilege form update (*action item*).
   C. 2019 Critical Indicator updates (*action items*):
      1. *Emergency Department*

2. Rural Health Clinic

D. Physician recruitment update (*information item*).

6. Community Health Needs Assessment and Inyo County Strategic Roadmap (*information item*).

Consent Agenda (action items)

7. Approval of minutes of the July 13 2019 special meeting
8. Approval of minutes of the July 17 2019 regular meeting
9. Approval of minutes of the August 3 2019 special meeting
10. Financial and statistical reports as of April 30, 2019
11. Medical Staff Services Quarterly and Annual reports
12. Policy and Procedure Annual Approvals

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13. Reports from Board members (*information items*).
14. Adjournment to closed session to/for:
    A. Discuss trade secrets, new programs and services (estimated public session date for discussion yet to be determined) (*Health and Safety Code Section 32106*).
    B. Conference with Labor Negotiators; Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
    C. Confer with Legal Counsel regarding threatened litigation, 1 matter pending (*pursuant to Government Code Section 54956.9(d)(2)*).
    D. Conduct Public employee performance evaluation, Chief Executive Officer (*pursuant to Government Code Section 54957*).
15. Return to open session and report of any action taken in closed session.
16. 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.

BYLAWS

OF

NORTHERN INYO HEALTH,

a California nonprofit public benefit corporation

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OF

NORTHERN INYO HEALTH,
a California nonprofit public benefit corporation

ARTICLE I
NAME AND PRINCIPAL OFFICE

1.1 Name. The name of the corporation shall be as listed in the Articles of Incorporation, namely, Northern Inyo Health (the "Corporation"), a nonprofit public benefit corporation organized under the laws of the State of California.

1.2 Principal Office and Place of Business. This Corporation shall have and continuously maintain a registered office in Inyo County, California and may have other offices within the State of California, as the Board may from time to time determine.

ARTICLE II
PURPOSES

The primary purpose of this Corporation is to own a supplier of durable medical equipment, and the provision of other healthcare services benefitting the healthcare needs of the healthcare district residents or supporting the healthcare activities of the North Inyo Hospital in furtherance of this Corporation's charitable purposes.

In addition, this Corporation is formed for the purposes of performing all things incidental to, or appropriate in, the achievement of the foregoing primary purposes. The Corporation shall not, except to an insubstantial degree, engage in any activities or exercise any powers that are not in furtherance of its primary charitable purposes.

This Corporation shall hold and may exercise all such powers as may be conferred upon a nonprofit corporation by the laws of the State of California and as may be necessary or expedient for the administration of the affairs and attainment of the purposes of the Corporation.

ARTICLE III
MEMBERSHIP

3.1 General Member. There shall be one member of this Corporation who shall be the Northern Inyo Healthcare District, a political subdivision of the State of California (the "General Member"). The General Member, and only the General Member, shall be entitled to exercise fully all rights and privileges of members of nonprofit corporations under the California Nonprofit Public Benefit Corporation Law, and all other applicable laws. The General Member may not be expelled or suspended as the General Member without its consent. Any reference in these Bylaws to the

"member," "Member," "general member," "General Member," "corporate member," or "Corporate Member" of this Corporation, or any similar such reference, shall mean the Northern Inyo Healthcare District, a political subdivision of the State of California. By reason of the rights or status of the General Member herein, there has been no express or implied delegation of any public agency authority from the General Member to this Corporation.

3.2 General Member Approvals. The following actions or items will require the approval of the General Member prior to implementation or becoming effective:

(a) An amendment or restatement of the Articles of Incorporation of the Corporation;

(b) An amendment or restatement of the Bylaws of the Corporation;

(c) A merger, consolidation, reorganization or dissolution of the Corporation;

(d) Any material transfer by sale, lease, debt or encumbrance, or other disposition, of any of the assets of the Corporation, real or personal, outside the ordinary course of Corporation's business;

(e) Any transaction that causes or is anticipated to cause a downgrade in bond rating by a standard rating agency of the General Member regardless of size of the transaction;

(f) Contracting with an unrelated third party for all, or substantially all (fifty percent (50%) or greater), of the management of the assets or operations of this Corporation or any subsidiary or affiliate entity;

(g) Approval of long-term or material agreements involving more than fifty thousand dollars ($50,000), including borrowings, equity financings, capitalized leases or installment contracts, and agreements involving the purchase, sale, disposition, lease, gift, exchange, pledge or encumbrance of any asset which involve the receipt or payment of more than fifty thousand dollars ($50,000);

(h) Approval of the Corporation's strategic plan and business plan;

(i) Approval of the Corporation's operating and capital budgets;

(j) Appointment of an independent auditor and the hiring of independent corporate counsel except where a legal conflict of interest exists as determined by the General Member's corporate counsel;

(k) Approval of transactions of this Corporation in which a Director or officer of this Corporation has a material financial interest;

(l) Any changes to the corporate dissolution rights (initiation of dissolution and disposition of assets) of the General Member; and

(g) Approval of individuals for Board membership.

In addition, the General Member shall have the authority to require the prior review and approval of those activities of the Corporation which the General Member determines to be major activities.

"Major Activities" shall be those which the General Member has declared major, by written notice to this Corporation, delivered personally or deposited by registered or certified mail, return receipt requested. Such notice shall specifically identify the matter or matters requiring approval of the General Member and shall refer to this Bylaw provision granting such approval rights to the General Member. Notices received pursuant to this Section shall be recorded in the minutes of this Corporation. The General Member's approval or disapproval of such matter or matters shall be recorded in the minutes of this Corporation, and written approvals or disapprovals of the General Member shall be filed with the minutes of this Corporation.

3.3 Exercise of Membership Rights. The General Member shall exercise its membership rights through its own Board of Directors. Subject to the provisions of the General Member's own bylaws, and except as otherwise provided in these Bylaws, the Board of Directors of the General Member may, by resolution, authorize a person or committee of persons to exercise its vote on any matter to come before the membership of this Corporation. In addition, the General Member may exercise its membership rights at any regular or special meeting of the Board of Directors of the General Member. The functions required by law or by these Bylaws to be performed at the annual membership meeting or any regular or special meeting of the members of this Corporation may be performed at any regular or special meeting of the General Member's own Board of Directors.

3.4 Liabilities and Assessments. The General Member shall not be liable for the debts of this Corporation. The Board of this Corporation shall have no power to levy and collect assessments on the General Member. The provisions of this paragraph cannot be amended in any manner.

ARTICLE IV
BOARD OF DIRECTORS

4.1 Responsibility. Except as otherwise provided by the Articles of Incorporation or by these Bylaws, the management of the affairs of this Corporation shall be vested in a Board of Directors (the "Board"). Specifically, the Board of Directors shall be empowered as follows:

(a) To control and be responsible for the overall governance of the Corporation, including the provision of management and planning.

(b) To make and enforce all rules and regulations necessary for the administration, governance, protection and maintenance of the Corporation and other facilities under its jurisdiction and to ensure compliance with all applicable laws.

(c) To review and approve annual operating and capital budgets as may be further specified herein and within financial policies adopted by the Board.

(d) To do any and all other act and things necessary to carry out the provisions of these Bylaws or of the provisions of the California Nonprofit Public Benefit Corporation Law.

4.2 Number. The Corporation shall have not less than three (3) nor more than five (5) Directors, with the exact number to be fixed within these limits by approval of the Board or the General Member, if any, in the manner provided in these Bylaws. The number may be changed by amendment of this Bylaw, or by repeal of this Bylaw and adoption of a new Bylaw, as provided by these Bylaws.

4.3 Composition of the Board. Anything to the contrary herein notwithstanding, (i) the Board of Directors shall nominate the Directors to the Board of Directors, who shall become Directors upon final approval of the General Member and (ii) in the event the Board of Directors' nominees are rejected by the General Member, the Board of Directors may nominate additional nominees until the requisite number of nominees are approved by the General Member.

4.4 Vacancies. Subject to the provisions of section 5226 of the California Corporations Code, any Director may resign effective upon giving written notice to the Chief Executive Officer, the Secretary or the Chairperson or Treasurer, unless the notice specifies a later time for the effectiveness of such resignation.

A vacancy or vacancies in the Board of Directors shall be deemed to exist in case of the death, resignation or removal of any Director, or if the authorized number of Directors is increased.

Vacancies in the Board of Directors shall be filled pursuant to Section 4.3 of these Bylaws.

Directors may be removed without cause by the General Member.

A person elected to fill a vacancy as provided by this Section shall hold office until the next meeting for nomination of Directors by the Board of Directors or until his or her earlier death, resignation or removal from office.

4.5 Voting Rights. Each voting Director shall be entitled to one (1) vote on all matters before the Board. There shall be no voting by proxy.

4.6 Organizational Meeting. As soon as reasonably possible after the formation of this Corporation, the Board of Directors shall meet for the purposes of organizing the Board, the election of officers, and the transaction of such other business as may come before the meeting.

4.7 Regular Meetings. The Board shall hold an annual meeting, and may hold additional meetings as determined by the Board, at such time and place as the Board shall from time to time determine.

4.8 Special Meetings. Special meetings of the Board for any purpose or purposes shall be called by the Secretary upon the request of the Chair, the Chief Executive Officer or any two (2) Directors.

4.9 Notice of Meetings. Notice of the time and place of any meeting shall be delivered personally, communicated by telephone or electronic mail, or sent to each Director by first-class mail, charges prepaid, addressed to the Director either at his or her address as it is shown on the records or if it is not so shown or is not readily ascertainable, to the place where the principal office of the Corporation is located. If sent by mail, such notice shall be mailed at least four (4) days prior to the meeting.

4.10 Quorum. A majority of the voting members of the Board then serving shall constitute a quorum at any meeting of the Board. The act of the majority of the voting power present at any meeting at which a quorum is present shall be considered the act of the Board.

4.11 Place. The Board shall hold its meetings at the principal office of the Corporation, or the principal office of the General Member, or such other place as the Chair or the Directors requesting the meeting may designate.

4.12 Validation of Transactions. The transactions of the Board of Directors at any meeting, however called or noticed, or wherever held, shall be as valid as though had at a meeting duly held after regular call and notice, if a quorum be present and if, either before or after the meeting, each Director entitled to vote at the meeting for that purpose not present signs a written waiver of notice, a consent to the holding of such meeting, or an approval of the minutes thereof. All such waivers, consents or approvals shall be filed with the corporate records and made a part of the minutes of the meeting.

4.13 Action Without Meeting. Any action required or permitted to be taken by the Board under the provisions of the California Corporations Code, the Articles of Incorporation, or these Bylaws may be taken without a meeting, if all members of the Board shall individually or collectively consent in writing to such action. Such action by written consent shall be filed with the minutes of the proceedings of the Board. Such action by written consent shall have the same force and effect as a unanimous vote of such Directors. Any certificate or other document filed on behalf of the Corporation relating to an action taken by the Board without a meeting shall state that the action was taken by a unanimous written consent of the Board without a meeting, and that the Bylaws of this Corporation authorize its Directors to so act.

4.14 Quorum Initially Present. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of Directors if any action is approved by at least a majority of the required quorum for such meeting, or such greater number as is required by the California Corporations Code, the Articles of Incorporation or these Bylaws.

4.15 Telephonic Meetings. Members of the Board may participate in a meeting through use of a conference telephone or similar communications equipment, so long as each Director participating in such meeting can simultaneously hear all other Directors so participating. Participation in a meeting pursuant to this Section constitutes presence in person at such meeting.

4.16 Conflict of Interest Policy. The Board shall adopt and adhere to the then current conflicts of interest policy adopted by the General Member (the "Conflicts Policy").

4.17 Self-Dealing. Prior to conducting a business session at a meeting of the Board, Board members shall disclose and discuss their individual conflicts or potential conflicts and that of other members of the Board. Actual conflicts shall be subject to resolution pursuant to the Conflicts Policy and applicable federal and state non-profit corporation laws. In the exercise of voting rights by members of the Board, no individual shall vote on any issue, motion, or resolution which directly or indirectly inures to his or her benefit financially or with respect to which he or she has any other conflict of interest, except that such individual may be counted in order to qualify a quorum and, except as the Board may otherwise direct, may participate in the discussion of such an issue, motion, or resolution if he or she first discloses the nature of his or her interest. Board members shall adhere to the Conflict of Interest Policy enacted pursuant to Section 4.16 of these Bylaws, and the Fiduciary Policy developed and implemented by the Board.

4.18 Access to Board Records and Reports. Upon request, officers of the General Member shall have access to the Corporation's documents for review (but not possession) that have been reviewed by the Board of Directors. Such review shall be subject to the officer executing an agreement to maintain the confidentiality (no disclosure beyond officers of the General Member) of information reviewed. Documents that are protected by legal privileges and confidentiality (e.g., personnel, peer review, legal, vendor contractual confidentiality), those containing pending competitive business transaction information shall not be subject to review. Subject to the execution of an agreement to maintain confidentiality, Board member and Board selected candidate conflict disclosure filings shall be available for review at the Corporation's offices only to the chief executive or designated legal counsel of the General Member upon request.

4.19 Bylaw Review. Consistent with regulatory and industry standards, the Board shall periodically conduct a review of these Bylaws in order to update and improve them. At least every two (2) years, the Board shall seek the input of the General Member in connection with such a review.

ARTICLE V
OFFICERS

5.1 Officers of this Corporation. The officers of the Corporation shall be a Chair of the Board, a Vice Chair of the Board, a Chief Executive Officer, a Secretary, and a Treasurer. The Corporation may also have, at the discretion of the Board of Directors, one or more assistant secretaries, one or more assistant treasurers, and such other officers as may be appointed by the

Board of Directors. Any number of offices may be held by the same person except that neither the Secretary, Treasurer, nor Chief Financial Officer may serve as the Chief Executive Officer or Chair of the Board.

5.2 Officers Elected by the Board. The Chair of the Board, Vice Chair of the Board, Treasurer, and the Secretary shall be elected annually by the Board. Nominations shall be submitted in advance of the selection by the Board of Directors or a nominating committee formed by the Board of Directors for that purpose. Each officer elected by the Board shall hold office at the pleasure of the Board and until his or her successor shall be elected and qualified to serve. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the Board for the unexpired term at any meeting of the Board.

5.3 Resignation or Removal. Any officer of the Board may resign at any time or be removed as follows: (a) any officer elected pursuant to Section 5.2 may be removed by the vote of the Board; and (b) any officer appointed by the Chief Executive Officer may be removed by the Chief Executive Officer.

5.4 Vacancies in Office. A vacancy in any office because of death, resignation, removal, or any other cause shall be filled in the manner prescribed in these Bylaws for regular appointments.

5.5 Chair. The Chair of the Board shall preside at all meetings of the Board. Unless the signature of the Chief Executive Officer is required by law, the Chair of the Board shall possess the same power as the Chief Executive Officer to sign all certificates, contracts, or other instruments of this Corporation when he is so authorized by the Board. The Chair of the Board shall exercise and perform such other powers and duties as may be prescribed by the Board from time to time. The Chair of the Board shall serve as the Board's liaison to the Chief Executive Officer.

5.6 Vice Chair. In the absence of the Chair of the Board or in the event of the Chair's disability, inability, or refusal to act, the Vice Chair of the Board shall perform all of the duties of the Chair and in so acting shall have all of the powers of the Chair. The Vice Chair shall have such other powers and perform such other duties as may be prescribed from time to time by the Board or by the Chair.

5.7 Chief Executive Officer.

(a) Appointment and Removal. The Chief Executive Officer of this Corporation shall be engaged by the Board and shall serve at the pleasure of the Board, which may terminate the services of the Chief Executive Officer of this Corporation subject to any employment agreement.

(b) Responsibilities and Authority. The Chief Executive Officer shall be the general manager, administrator and Chief Executive Officer of this Corporation. The Chief Executive Officer shall be given the necessary authority and responsibility to operate this Corporation in all of its activities. The Chief Executive Officer shall be subject to such policies as may be adopted and such orders as may be issued by the Board of this Corporation or by any of its

committees to which the Board has delegated the power for such action; with respect to program execution and overall management performance, the Chief Executive Officer shall be subject to the authority of and shall report to the Board. The Chief Executive Officer shall act as the duly authorized representative of the Board of this Corporation in all matters in which the Board has not formally designated some other person to so act.

5.9 Treasurer. The Treasurer of this Corporation shall keep and maintain or cause to be kept and maintained adequate and correct account of the properties and business transactions of the Corporation, including accounts of its assets, liabilities, receipts, disbursements, gains and losses. The books of account shall at all times be open to inspection by any Board member. The Treasurer shall be charged with safeguarding the assets of the Corporation and he or she shall sign financial documents on behalf of the Corporation in accordance with the established policies of the Corporation. He or she shall have such other powers and perform such other duties as may be prescribed by the Board from time-to-time. The Treasurer may fulfill these responsibilities and perform his or her duties through appropriate delegation, with Board oversight, to individuals or firms charged with the financial management of the Corporation.

5.9 Secretary. The Secretary shall keep or cause to be kept a book of minutes at the principal office or at such other place as the Board may order of all meetings of the Board with the time and place of holding, whether regular or special, and if special how authorized, the notice thereof given, the names of those present at the Board meetings, and the proceedings thereof. The Secretary shall give or cause to be given notice of all the meetings of the Board required by these Bylaws or by law to be given, and the Secretary shall keep the seal of this Corporation in safe custody and shall have such other powers and perform such other duties as may be prescribed by the Board from time to time.

ARTICLE VI
COMMITTEES

6.1 Establishment of Committees. Subject to the duty of the Board to exercise ultimate direction over the activities and affairs of the Corporation, the Board may authorize any special committee to carry out certain specified functions or responsibilities, or to provide such advice and recommendation as the Board shall require, but no such committee shall have the authority to determine Corporation policy or otherwise exercise any powers of the Board with respect to the business and affairs of the Corporation.

6.2 Vacancies. Vacancies in any committee shall be filled for the unexpired portion of the term in the same manner as provided in the case of original appointment.

6.3 Expenditures. Except as expressly delegated, any expenditure of corporate funds by a committee or any commitment by a committee to expend corporate funds shall require prior approval of the Board.

ARTICLE VII
GENERAL PROVISIONS

8.1 Compensation of Board Members. The members of the Board shall receive no compensation as such, except that they may be reimbursed from time to time for all expenses incurred on behalf of this Corporation.

8.2 Indemnification. To the fullest extent permitted by law, this Corporation shall indemnify its "agents", as described in Section 5238(a) of the Law, including its directors, officers, employees, and volunteers, and including persons formerly occupying any such position, and their heirs, executors, and administrators, against all expenses, judgments, fines, settlements, and other amounts actually and reasonably incurred by them in connection with any "proceeding," as that term is used in said Section 5238(a), and including an action by or in the right of the Corporation, by reason of the fact that the person is or was a person described in that Section. "Expenses" shall have the same meaning as in said Section. Such right of indemnification shall not be deemed exclusive of any other rights to which such persons may be entitled apart from this Article 8, Section 9. To the fullest extent permitted by law and except as otherwise determined by the Board in a specific instance, expenses incurred by a person seeking indemnification in defending any "proceeding" shall be advanced by the Corporation before final disposition of the proceeding upon receipt by the Corporation of an undertaking by or on behalf of that person to repay such amount unless it is ultimately determined that the person is entitled to be indemnified by the Corporation for those expenses.

The Corporation shall have power to purchase and maintain insurance to the fullest extent permitted by law on behalf of any agent of the Corporation, against any liability asserted against or incurred by the agent in such capacity or arising out of the agent's status as such, or to give other indemnification to the extent permitted by law.

8.3 Fiscal Year. The fiscal year of this Corporation shall end on December 31 of each year.

8.4 Construction and Definitions. Unless the context requires otherwise, the general provisions, rules of construction, and definitions in the California Nonprofit Corporation Law shall govern the construction of these Bylaws. Without limiting the generality of the preceding sentence, the masculine gender includes the feminine and neuter, the singular number includes the plural, the plural number includes the singular and the term “person” includes both a legal entity and a natural person.

8.5. Bylaws and Articles of Incorporation Amendment. Amendment of the Articles of Incorporation and these Bylaws may only be adopted by the approval of the Board of Directors and by the approval of the General Member of this Corporation.

SECRETARY'S CERTIFICATE

I certify that I am the Secretary of Northern Inyo Health, a California nonprofit public benefit corporation (the "Corporation"), and that the attached Bylaws of the Corporation are the current bylaws of the Corporation as adopted by the Board of Directors of the Corporation on _____, 2019, and by the General Member, the Northern Inyo Healthcare District, on _____, 2019, respectively.

Dated: _____, 2019

_____

_____, Secretary

ARTICLES OF INCORPORATION
OF
NORTHERN INYO HEALTH

I

The name of this corporation is Northern Inyo Health.

II

A. This corporation is a nonprofit public benefit corporation and is not organized for the private gain of any person. It is organized under the California Nonprofit Public Benefit Corporation Law for charitable purposes.

B. The primary purposes of this corporation is to own a supplier of durable medical equipment the provision of other healthcare services benefitting the healthcare needs of the healthcare district residents or supporting the healthcare activities of the North Inyo Hospital in furtherance of this corporation's charitable purposes.

C. The general purpose of this corporation is to have and exercise all rights and powers conferred on nonprofit public benefit corporations under the laws of the State of California.

III

A. This corporation is organized and operated exclusively for charitable purposes within the meaning of section 501(c)(3) of the Internal Revenue Code of 1986, as amended, and successor provisions thereto (the "Code").

B. No substantial part of the activities of this corporation shall consist of carrying on propaganda, or otherwise attempting to influence legislation, and the corporation shall not participate or intervene in any political campaign (including the publishing or distribution of statements) on behalf of any candidate for public office.

IV

Northern Inyo Healthcare District, a political subdivision of the State of California, is the sole member of this corporation. The corporation may also from time to time use the term "members" to refer to persons associated within, but such persons shall not be members within the meaning of Section 5056 of the California Corporations Code.

V

The property of this corporation is irrevocably dedicated to charitable purposes and no part of the net income or assets of this corporation shall ever inure to the benefit of any director, officer or member thereof or to the benefit of any private person. Upon the dissolution or winding up of the corporation, its assets remaining after payment or provision for payment of all

debts and liabilities of this corporation shall be transferred exclusively to and shall become the property of the Northern Inyo Healthcare District, a political subdivision of the State of California. If the Northern Inyo Healthcare District no longer: (a) exists; or (b) is organized and operated exclusively as a healthcare district under California law, then the assets of this corporation shall be transferred to and shall become the property of such nonprofit funds, foundations or corporations as are designated by the Board of Directors of this corporation and which: (1) have established their tax-exempt status under section 501(c)(3) of the Code; and (2) are organized and operated exclusively for religious, charitable, hospital, scientific purposes, or charitable *and* educational purposes meeting the requirements for exemption provided by Section 214 of the Revenue and Taxation Code.

VI

The name of the corporation's initial agent for service of process is:

Cathy Deubel Salenko, Esq.
Best Best & Krieger LLP
500 Capitol Mall, Suite 1700
Sacramento, California 95814

VII

The initial street and mailing address for the principle office of the corporation shall be: Northern Inyo Healthcare District, 150 Pioneer Lane, Bishop, California 93514

DATED: August __, 2019.

_____
Cathy Deubel Salenko, Esq., Incorporator

NORTHERN INYO HEALTHCARE DISTRICT BOARD RESOLUTION 19-06

Whereas Northern Inyo Healthcare District (District) had a Center for Medicare and Medicaid Services (CMS) site survey in March of 2013; and

Whereas that CMS site survey resulted in the identification of deficiencies*;* and

Whereas several of those deficiencies had a corrective action plan that required monthly reporting to the District Board of Directors; and

Whereas those reports have been consistently delivered to the Board of Directors from 2013 to 2018; and

Whereas corrective actions taken immediately after the 2013 survey have resulted in improvements as evidenced by the monitoring reports; and

Whereas other corrective actions taken since the original plan have only resulted in minimal changes in the results reported; and

Whereas the District has had surveys by The Joint Commission in 2016 and 2019; and

Whereas the 2016 and 2019 surveys by The Joint Commission have not found any deficiencies in the areas identified by CMS during the 2013 survey; and

Whereas the District has 'deemed' status;

NOW THEREFORE, BE IT RESOLVED that the Board of Directors of Northern Inyo Healthcare District hereby determines:

1. that the intent of the 2013 corrective action plan and monthly reports to the Board of Directors has achieved its goal of improvement in the areas of deficiency
2. that the District leadership shall no longer generate or report to the Board of Directors the results of the monitoring program developed as a result of the 2013 CMS site survey
3. that future corrective action plans shall have clear delineation of when a corrective action plan has been achieved and no further reporting to the Board of Directors shall be necessary

Approved: August 21, 2019

_____

Mary Mae Kilpatrick
Northern Inyo Healthcare District Board President

Title: Group Intervention	
Scope: District Wide	Manual: RHC
Source: Care Coordination Manager	Effective Date:

PURPOSE: To identify the policy and procedure for providing a Medication Assisted Treatment (MAT) Stabilization Group intervention for patients who are engaged in the MAT Program.

POLICY: Northern Inyo Health Care District (NIHD) providers recognize that Medication Assisted Treatment (MAT), in combination with counseling and/or behavioral therapies, is a holistic and evidence based best practice used to treat opioid use disorders for long-term recovery. NIHD collaborates with patients to develop individualized treatment plans. The model used for the MAT Stabilization Group is strength-based and emphasizes self-sufficiency, in an effort to empower patients to make lifestyle changes that will support long-term recovery. The group facilitator will coordinate care between primary care provider, psychiatrist/NP, and individual psychotherapy provider as needed.

PROCEDURE: When a patient is enrolled in the MAT Program they agree to participate in a Stabilization Group. The flexible curriculum used in the Stabilization Group allows patients to join at any time. The Stabilization Group is divided into three phases: Phase One meets weekly, Phase Two meets every two weeks, and Phase Three meets once a month. Patients progress through the different phases based on the clinical judgement of the behavioral health staff and the commitment level of the patient. Patients are required to repeat previous phases at any time if their need for additional support increases. During Group sessions, patients are provided psychoeducation to facilitate their physical, emotional, and mental health stabilization to support long-term recovery. Patients will both give and receive peer support throughout their stabilization process. Motivational interviewing techniques will be utilized throughout treatment. The Stabilization Group(s) will be led by a member of the behavioral health staff. The group facilitator will be responsible for providing information about addiction and recovery; responding to patient questions, helping patients relate personally to concepts discussed, facilitate group interaction, validate issues or struggles, model healthy behaviors, challenge counterproductive activities and behaviors that interfere with groups ability to achieve goals, encourage attendance in self-help groups, and motivate patients to talk directly to each other when sharing. The group facilitator is less of an "expert" and more of a skilled implementer of discussions related to recovery concerns, problems, and issues. The group facilitator will demonstrate an attitude of understanding and acceptance, utilize active and reflective listening skills to help patients explore and resolve ambivalence, and support the patient's transformation through the stages of change.

<u>Group Structure:</u>

1. Groups are divided into three phases (weekly, every two weeks, once a month)
2. Groups are 30-45 minutes in length
3. Groups will have 4 basic elements:
    a. Introductions, overview of group purpose, high/low check-in

Title: Group Intervention	
Scope: District Wide	Manual: RHC
Source: Care Coordination Manager	Effective Date:

b. Educational/experiential presentation
c. Discussion
d. Wrap-Up; patient commitment to goals for coming week

Introduction/Orientation:

Purpose of group, content, process, and working conditions will be articulated. All new members will receive an introduction from facilitator. The facilitator may elect to have new patient(s) come 5 minutes early to group to acclimate them. The purpose of MAT Stabilization Group is to allow the patient to become more aware of their own problems and issues and how they relate to opiate addiction and recovery. Patients are able to give and receive support through providing feedback and sharing problems, successes, hopes, and strength. Through the group experience, group members learn the importance of mutual support, confronting negative attitudes, and managing unhealthy behaviors. Patients will also learn recovery coping skills to reduce the chances of relapse and improve functioning. The content of the group is a flexible curriculum. Topics are recovery-oriented and can be altered to address more urgent concerns of group members at any time. The group facilitator will explain the general weekly process of the group so patients are aware what is expected of them and what the program will provide. Patients will be asked to share their expectations for the group so the leader can adjust curriculum or refer patient to another resource to meet their needs. All new members will be required to sign a Group Rules Agreement acknowledging their understanding of and agreement with the rules related to participation in group therapy. Introduction is a time to introduce members and have each member say something about themselves or provide a high and low moment for the prior week. Goals of introductions are to set a positive tone, create a safe and cohesive environment for patients to learn, give and receive supportive feedback, and ask questions.

Group Expectations: Groups work best if there are certain behavioral expectations that are agreed upon. To participate in this group, members are expected to follow the behavioral guidelines below:

1. You are not allowed to come to group sessions intoxicated or high. Any member who comes to a group session intoxicated will be asked to leave and to meet with a member of the MAT Team to discuss the circumstances surrounding his/her drug use.
2. You are expected to make a commitment to attend group sessions as often as indicated in your individual treatment plan. Your consistent attendance and participation supports the strength and unity of the group, which in turn helps to support you in your recovery. If you will be late or absent, contact the group facilitator directly prior to a group session to explain why.
3. Any disruptive behavior or conduct that is disrespectful in nature, threatening, or violent will result in removal from the group and may lead to discharge from the MAT program.
4. Issues that are discussed in group sessions must stay within the group to ensure confidentiality and respect.

Title: Group Intervention	
Scope: District Wide	Manual: RHC
Source: Care Coordination Manager	Effective Date:

Groups Rules: During Group Sessions, each member agrees to the following rules:

- We arrive on time for group
- We are respectful to ourselves and others
- We turn off our cell phones
- We listen
- We avoid "cross talk"
- We use respectful language at all times (no swearing or insults)
- We do not discuss our buprenorphine dose, our cravings, or any episodes of substance use during group time
- We respect the privacy of all group members: "Who we see and what we hear stays here."

----- **(Group Rules may be adjusted to meet the needs of the group as it evolves over time.)** -----

Psychoeducation Curriculum: The curriculum for the MAT Stabilization Group is designed on a flexible scaffold to address the needs of the current group members. Below is a sample outline of the topics discussed in group. The variety, organization, focus, and delivery of recovery topics can be altered at any time to accommodate the specific needs of the group members.

INTRODUCTION: Building Blocks for Developing a Recovery Program

Week 1: Setting the Foundation – Understanding the connection between Events, Thoughts, and Behavior/Emotions

Week 2: Symptoms of Opiate Addiction - Understanding the chronic, relapsing nature of addiction

Week 3: Stages of Change & Denial (pre-contemplation, contemplation, preparation, action, maintenance), evaluating the effects of your addiction, understanding denial

Week 4: Relapse Prevention - learn to cope with situations that precipitate drug use behavior, construct relapse preventive thinking and actions

Week 5: Managing Triggers & Cravings: People, Places, and Things; recognize and anticipate triggers

Week 6: Relationships in Recovery – impacts of addiction on relationships

Title: Group Intervention	
Scope: District Wide	Manual: RHC
Source: Care Coordination Manager	Effective Date:

Week 7: Establishing a Support System – my social support system

Week 8: Managing Feelings in Recovery – a multi-step approach for managing feelings in recovery

Week 9: Coping with Guilt and Shame – strategies for coping with guilt and shame

Week 10: Warning Signs of Relapse – understanding relapse process, high-risk situations, and develop strategies for coping

Week 11: Coping with High-Risk Situations – dealing with the most common relapse dangers

Week 12: Maintaining Recovery – recovery tool checklist and coping with stressful situations

Due to this being an open group, at any point in treatment patients may be ready to progress to Phase 2 or 3 of the group. The group facilitator will honor the journey the patient has made at the current group level, allow time for peers to adjust to the change in membership, offer feedback, and provide encouragement for patient. The facilitator will remind patient and group that anyone is welcome back at any time if they feel their recovery is at risk, need refresher education, or more support. This allows for putting closure on the group experience for the patient and the group. It is also a time to reflect on the impact of the group on each person and to acknowledge any feelings triggered by departure of a group member. Completing the group successfully can be an important event for group members when they see the conclusion of a difficult but successful endeavor.

REFERENCES: Curriculum was developed from various resources including Hazelden, SAMHSA, NIDA, SMART Recovery Program, Group Drug Counseling Participant Recovery Workbook, Group Treatment for Substance Abuse (second edition), Engage the Group Engage the Brain, and The Rewired Workbook.

Title: Group Intervention	
Scope: District Wide	Manual: RHC
Source: Care Coordination Manager	Effective Date:

CROSS REFERENCE P&P: N/A

Approval	**Date**
CCOC	7/29/19
Board of Directors	
Last Board of Directors Review	

Developed:

Reviewed:

Revised:

Supersedes:

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

Medical Staff Office
(760) 873-2136 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: William Timbers, MD, Chief of Medical Staff
DATE: August 6, 2019
RE: Medical Executive Committee Report

The Medical Executive Committee met on this date. Following careful review and consideration, the Committee agreed to recommend the following to the NIHD Board of Directors:

A. Policies and Procedures (*action item*)
    1. *Accepting Orders from Non-Privileged Practitioners*
    2. *Administration of Drugs – Patient's Own Medications*
    3. *Color-Coded Wristband Use*
    4. *Drugs of Abuse Test McKesson 12-Drug Panel with Adulterants*
    5. *IV Service When NIHD IV Room is Closed*
    6. *Medication Dosing in Renal Failure*
    7. *Pharmacy Confidentiality: Storage and Destruction of PHI-Containing Documents*
    8. *Point of Care QuickVue Dipstick Strep A Test*
    9. *Unusable Drugs*

B. Emergency Medicine Core Privilege form update (*action item*)

C. 2019 Critical Indicator updates (*action items*)
    1. Emergency Department
    2. Rural Health Clinic

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Accepting Orders for Outpatient Infusion Services from Non-Privileged Practitioners	
Scope: Referring Practitioners	Manual: Medical Staff, Infusion Center
Source: Medical Staff Support Manager	Effective Date: 07/18/18

PURPOSE:
To establish a process for non-privileged practitioners to order outpatient infusion services at Northern Inyo Healthcare District (NIHD) that is in compliance with federal and state regulations.

POLICY:

A. Non-privileged referring practitioners (i.e., a practitioner who has not been credentialed or privileged by NIHD), may order outpatient infusion services at NIHD if:

1. The practitioner is licensed, in good standing, in California;
2. The practitioner is acting within his or her scope of practice;
3. The practitioner is responsible for the care of the patient;
4. The practitioner is not currently excluded from participation in Medicare, Medicaid or other state or federal health care programs.

B. Ordering practitioners will be required to remain responsible for the care of referred patients and must agree to provide necessary consultation as first call.

C. Ordering practitioners will be required to submit a signed attestation indicating their agreement to comply with this policy.

~~D.~~ If questions or concerns regarding the order cannot be addressed with the ordering practitioner (should the practitioner be unreachable), ~~the patient's case will be reviewed by the Medical Director of the Outpatient Infusion Center. If a change in management is deemed appropriate, orders will be changed and the ordering practitioner will be notified.~~

~~E.~~D. ~~If the Medical Director of the Outpatient Infusion Center cannot be reached,~~ the Outpatient Infusion staff may initiate the following escalating contact protocol:

1. Primary care provider, or;
2. Hospitalist on-call, or lastly;
3. Emergency room physician.

~~F.~~E. Outpatient infusion therapy services will be provided in accordance with policies and protocols approved by the Medical Executive Committee and Board of Directors.

~~G.~~F. Quality evaluation and reviews of the Outpatient Infusion Center will be provided by a physician member of the Medicine and Intensive Care service.

PROCEDURE:

A. At the receipt of an outpatient infusion order from a non-privileged practitioner who is not currently on the approved referring practitioner roster, the Outpatient Infusion staff will send the attached attestation to the ordering practitioner for completion.

B. If the patient's primary care provider is an NIHD privileged practitioner, an effort should be made to send a copy of the order to the primary care provider (with patient consent).
C. Once the attestation has been returned, the outpatient infusion staff is responsible for ensuring the practitioner's information is verified as outlined below:

1. *The practitioner is licensed in California* – online verification of California licensure (including active/inactive status and disciplinary action) can be found on the public Medical Board of California website, or by going to: www.mbc.ca.gov/Breeze/License_Verification.aspx

2. *The practitioner is not currently excluded from participation in Medicare, Medicaid or other state or federal health care programs* – the Office of the Inspector General (OIG) maintains a list of excluded entities and individuals, which can be found online by visiting the OIG website and querying the exclusion database, or by following this link: https://exclusions.oig.hhs.gov/. Medi-Cal maintains a suspended and ineligible provider list in a downloadable format on this website: https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp

D. During normal business hours, the Outpatient Infusion Center staff may coordinate with Medical Staff Office staff to complete the verification of ordering practitioners. A copy of the signed attestation will be sent to the Medical Staff Office.

E. A list of currently verified non-privileged practitioners will be maintained by the Medical Staff Office and will be available to the Outpatient Infusion Center staff. Verifications should be repeated every two years at minimum.

REFERENCES:

1. Centers for Medicare and Medicaid Services Conditions of Participation §482.54
2. Matzka, Kathy. (2006). *The Compliance Guide to the JCAHO Medical Staff Standards.* HCPro, Inc.; 5th edition. Print.
3. Providence Sacred Heart Medical Center and Children's Hospital. (2016). "Non-Staff Practitioners Ordering Outpatient Tests and Treatments." Retrieved from: http://washington.providence.org/~/media/files/providence/hospitals/wa/phc/policies/orderingoutpatienttests_nonstaffpractitioners.pdf/

Approval	**Date**
Medical Executive Committee	7/15/19
Board of Directors	9/19/18
Last Board of Directors Review	1/16/19

Developed: 06/2018 dp
Reviewed:
Revised: 07/2018 nh, 08/2018 dp, 06/2019 dp
Supersedes: N/A
Index Listings: referring practitioner orders, non-staff orders

Outpatient Nursing
Fax: (760) 873-2151
Phone: (760) 873-2845 or (760) 873-2837

Northern Inyo Healthcare District (NIHD) Outpatient Infusion Center Therapy Referral Agreement for Non-Staff Ordering Practitioners

This referral agreement must be completed by Ordering Practitioners who are not members of the NIHD Medical Staff or Allied Health Professional Staff in accordance with the *Outpatient Infusion Ordering by Non-Staff Referring Practitioners* policy.

By signing this order form, the Ordering Practitioner enters into a documented arrangement with NIHD and attests that he/she:

1. Holds a current, unrestricted California license;
2. Is acting within the scope of his/her license;
3. In conjunction with NIHD, is responsible for the care of the patients referred to the Outpatient Infusion center; will be reachable through the phone number identified below; and will provide consultation and documentation as requested by the NIHD Infusion Center;
4. Agrees that failure to provide information or care as requested by Infusion Center staff will terminate this order and disqualify Practitioner from submitting further orders;
5. Will provide any documentation requested by the Infusion Center (e.g., history and physical, authorization for treatment ordered);
6. Has not been excluded from participation in Medicare, Medi-Cal or any other Federal or State health care program.

Failure to comply with the requirements listed may result in the Ordering Practitioner's inability to continue referrals to the NIHD Infusion Center.

_____ _____ _____
CA License Number Primary Phone Secondary Phone

_____
Practice Name and Address

_____
Name of Ordering Practitioner Signature Date

NIHD Office Use Only:

Verification of Agreement Completed By: _____ Date: _____

Please send a copy of this form to the Medical Staff Office

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Administration of Drugs: Patient's Own Medications	
Scope: District Wide	Manual: CPM - Medication (MED), Pharmacy
Source: Director of Pharmacy	Effective Date: 4/15/17

PURPOSE:
To insure the quality and integrity of medications brought to the hospital by patients and administered by NIH personnel. To comply with Title 22 CCR 70263

POLICY:

1. ADMINISTRATION OF PATIENT'S OWN MEDICATIONS

   a. A patient's personal medications will be administered when specifically ordered by the prescribing practitioner responsible for the patient. Patients may self-administer medications only in accordance with the "**Administration of Drugs: Self-Administration"** policy and procedure.

   b. There must be a complete written order, name of the medication, strength, dose, route and frequency, by the prescriber for the nurse to administer the patient's own medications. All medications for patient administration must be positively identified by a pharmacist **(A nurse cannot do this).**

   c. Medications identified for administration in accordance with this policy shall be sent to the pharmacy for confirmation, repackaging and dispensing.

   d. Emergency ~~Room~~ Department patients will not take their own medications unless the medication is not stocked within the hospital and a physician writes an order for "patient's to take their own medication including the order requirements in part b. The pharmacist and/or physician will need to identify/verify the medication prior to administration. If an emergency patient brings in his/her own medications, physician will review and have the ED nurse enter the home medications into the ~~Athena~~ EHR system.

2. IDENTIFICATION OF PATIENT'S OWN MEDICATIONS

   a. Medications brought into the facility by patients will not be administered unless the medication containers are clearly and properly labeled, the drugs have been positively identified, their quality and integrity is not questionable, and documentation of such identification is made on the Medication Administration Record.

   b. All medications (brought from home) potentially for use by the admitted patient must be furnished to the pharmacist for examination and positively identified. Prior to administration. The pharmacist should initial and add + symbol as evidence of confirmation.

   c. Patient's own drugs shall be entered on the MAR as "patient's own med" along with the name, strength, route, and dosage. Nurses will document

administration of patient's own medications per general administration policies.

3. STORAGE OF PATIENT'S OWN MEDS

a. Patient's own medications brought in to the hospital that are not to be administered to the patient in accordance with this policy will be sent home with the patient's family or representative. Nursing staff will initially fill out the home medication list before sending the medications home with the family or patient's agent.

b. In the event the patient's medications cannot returned home, they may be stored in the locked med cabinet.

i. Patient's home medications will be packaged in a sealable "Patient's Medicine Inventory" security bag and stored in a locked cabinet. The nurse will write the patient's name and ID on the face of the security bag. The nurse will, in the presence of the patient or patient's representative, count the number of bottles and list the bottle with the name of the medication as stated on the prescription label. The nurse will not open or inventory the prescription bottles but only note the number of bottles and the label on each.
ii. The nurse will seal the bag in the presence of the patient or patient's representative. The nurse will sign the bag and give the tear off receipt to the patient or patient's representative.
iii. Nursing staff will call pharmacy to inform them that home medications are in the locked cabinet.
iv. Upon discharge, the patient will receive his/her sealed medication bag back. Unclaimed patient meds will be destroyed after 30 days per section 5 below.
.

4. <u>USE OF PATIENT'S OWN MEDS—CONTROLLED SUBSTANCES</u>

Controlled substances brought from home may not be used in the Inpatient or Outpatient setting at NIHD. However, we will review any request for an exception on a case by case basis due to one of the following if in it in the patient's best interest.

a. Pain Pump internal reservoirs
b. Pre-existing placed Fentanyl patches that will be replaced with a district provided new patch at the conclusion of 72-hour wear.
c. Exotic, compounded or unobtainable or non-bioequivalent substitutable medication.

Title: Administration of Drugs: Patient's Own Medications	
Scope: District Wide	Manual: CPM - Medication (MED), Pharmacy
Source: Director of Pharmacy	Effective Date: 4/15/17

5. DESTRUCTION OF UNRETURNED DRUGS

   a. Personal drugs from expired patients and personal drugs on hand more than thirty (30) days after discharge shall be destroyed in accordance with applicable law.

   b. If in the unlikely event that drugs listed in Schedules II, III or IV of the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, as amended, need to be destroyed it will be sequestered for reverse distribution agency return or if not possible recorded and destroyed by two licensed pharmacists of NIHD one being the Director of Pharmacy and the other a FTE of NIHD.

   c. The name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the witnesses required above shall be recorded in a separate log. Such log shall be retained for at least three years.

REFERENCES:

1. The Compliance Guide to the JACHO's Medication Management Standards, Second Edition

CROSS REFERENCES:

1. Administration of Drugs and Biological
2. Controlled Substance Policy, Hospital Wide

Approval	**Date**
Clinical Consistency Oversight Committee	7/9/19
Pharmacy and Therapeutics Committee	6/20/19
Medical Executive Committee	8/6/19
Board of Directors	
Last Board of Directors review	

Initiated: 7/05
Revised: 9/12, 6/15, 01/17, 7/19fl
Reviewed: 10/06, 10/07, 9/08, 9/09, 9/10, 9/11,6/15,1/17/18

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Color-Coded Wristband Use**	
Scope: Nursing Services	Manual: **CPM - Admission, Discharge, Transfer Documentation (ADT)**
Source: Chief Nursing Officer	Effective Date: 12/2008

1. Purpose

To have a standardized process that identifies and communicates patient-specific risk factors or special needs by using color-coded wristbands based upon the assessment of the patient, the patient's wishes and medical status.

2. Objectives

A. To reduce confusion associated with the use of color-coded wristbands by using colors standardized throughout California.
B. To communicate patient-safety risks to all health care providers.
C. To include the patient, family members and significant others in the communication process and promote safe care.
D. To adopt the following risk-reduction strategies:
    1. A preprinted written descriptive text is used on the bands, clarifying the intent (e.g., "Allergy," "Fall Risk" or "DNR").
    2. No handwriting is used on the wristbands.
    3. Color-coded wristbands may only be applied or removed by a nurse conducting an assessment.
    4. If labels, stickers or other visual cues are used in the medical record to communicate risk factors or wristband application, those cues should use the same corresponding color and text as the color-coded band.
    5. Social (community) cause (social cause wristbands include, for example, "LIVESTRONG") wristbands should not be worn by patients in the hospital. Staff should have family members take the social cause wristbands home, or remove them from the patient and store them with their other personal items. This is to avoid confusion with the color-coded wristbands and to enhance patient-safety practices.
    6. When a color-coded wristband is applied, the patient and family are educated regarding the wristband message.

3. General Policies

Colors used for wristbands. The following represents the only color-coded wristbands used:

A. Clear wristbands shall be used for patient identification. The patient identification and admission identification bands may be applied by non-clinical staff in accordance with hospital policy.
B. Purple wristbands shall be used to identify patients with a "Do Not Resuscitate" order written in the medical record in accordance with hospital policy. The letters "DNR" shall be embossed/printed on the wristbands.
C. Red wristbands shall be used to identify patients with allergies. The list of allergies should be written in the medical record in accordance with hospital policy. Allergies should include allergies to medication(s), food, environmental allergens

or other substances that may cause an allergic reaction in the patient. The letters "ALLERGY" shall be embossed/printed on the wristband.

D. Yellow wristbands shall be used to identify patients with a risk of falling. Persons with a risk of previous falls, dizziness or balance problems, fatigability or confusion about their current surroundings should be assessed for potential fall risk. The letters "FALL RISK" shall be embossed/printed on the wristband.
E. Green wristbands shall be used to identify patients with sepsis. This shall be applied when the patient meets the SOFA criteria. The letters "SEPSIS" shall be embossed/printed on the wristband.
F. Pink wristbands shall be used to identify patients with a restricted extremity. A pink band will be placed on the affected extremity alerting staff to avoid using the limb for blood draws, IV insertions, and other medical procedures. The restricted extremity should be limited to only having one pink band loosely placed on it. All other bands should be placed on the side that is not restricted.

Application of color-coded wristbands. During the initial and reassessment procedures, allergies, DNR status and risk factors associated with falls may be identified. Assessment of potential risk is an interdisciplinary process

A. The nurse performing the assessment is authorized to determine fall risk and patient allergies as determined by the assessment, and place the appropriate color–coded wristband on the patient. Only the nurse performing the patient assessment is designated to apply or remove color-coded wristbands. Color-coded wristbands should be used for all patients with these conditions, including all inpatient and emergency department patients
B. The determination of a "Do Not Resuscitate" order must be consistent with hospital policy and must be documented in the patient's medical record prior to the nurse placing the DNR wristband on the patient.
C. Handwriting is not permitted on color-coded wristbands.
D. It should be documented in the patient's medical record that a color–coded wristband was applied, for specific reasons (i.e. Risk Fall, DNR and/or Allergy. **[DO NOT DOCUMENT WRISTBAND COLOR.]**
E. All color-coded wristbands shall be placed on the same wrist as the patient identification wristband EXCEPT for pink wristbands, as noted above.
F. Upon application of the color-coded wristband, the nurse shall instruct the patient and family member(s), if present, that the wristband is not to be removed.
G. In the event that any color-coded wristband(s) must be removed for a treatment or procedure, a nurse will remove the wristband(s). Upon completion of the treatment or procedure, risks shall be reconfirmed and new wristband(s) immediately applied by the nurse.

4. "Social (Community) Cause" Wristbands
   The nurse shall examine the patient for "social (community) cause" wristbands, during the initial assessment. If "social cause" wristbands are present, the nurse will explain the risks associated with the wristbands and ask the patient to remove them. If the patient agrees, the band(s) will be removed and given to a family member to take home, or stored with the patient's personal belongings. If the patient refuses to remove the "social cause" wristband, the nurse will request that the patient sign a refusal form acknowledging the risks associated with the "social cause" wristbands (see attached document).

5. Patient/Family Involvement and Education
   Staff should assist and encourage the patient and family member(s) to be active partners in the care provided and safety measures being used. The nurse should teach all patients and family members to notify the nurse whenever a wristband has been removed and is not reapplied, or when a new band is applied and they have not been given an explanation as to the reason.

   When applying a color-coded wristband(s) to a patient, the nurse shall educate the patient and family member(s) about the meaning of the wristband(s) applied, risks associated with wearing social cause wristbands in the hospital, and their role in color-coded wristbands. During assessment of the patient, the nurse shall educate and re-educate the patient and family members about the meanings of the color-coded wristband(s) applied, the risks associated with wearing social cause wristbands and why they are asked to remove them, and to notify the nurse if color-coded wristband condition(s) have changed.

6. Hand–Off in Care
   The nurse shall reconfirm that the color-coded wristbands are consistent with the documentation in the medical record before invasive procedures, at transfer and during changes in level of care. The nurse shall also confirm this information is consistent with the knowledge of the patient, family members or other caregivers and what is in the patient's chart. Errors or omission of appropriate wristbands will be corrected immediately and an UOR completed detailing the incident.

   Color-coded wristbands are not removed at discharge. For home discharges, the patient is advised to remove the band at home. For discharges to another facility, the wristbands are left intact as a safety alert during transfer. Receiving facilities should follow their policy and procedure for the banding process.

7. DNR (Do Not Resuscitate)
   The DNR color-coded wristband serves as an alert and does not take the place of an order. DNR orders must be written and verification of advanced directives must occur.

8. Staff Education
   Staff education regarding color-coded wristbands will occur during the new orientation process and updated with any changes to this policy.

Title: **Color-Coded Wristband Use**	
Scope: Nursing Services	Manual: **CPM - Admission, Discharge, Transfer Documentation (ADT)**
Source: Chief Nursing Officer	Effective Date: 12/2008

9. Patient Refusal
   If the patient is mentally competent and refuses to wear the color-coded wristband, an explanation of the benefits of wearing the color-coded wristband and the risks of not wearing the wristband will be provided to the patient. The nurse will reinforce that this is an opportunity to participate in efforts to prevent errors, and it is his/her responsibility as part of the team. The nurse will document in the medical record patient refusals, and the explanation provided by the patient. The patient will be requested to sign a *Patient Refusal to Participate in the Wristband Process* form.

10. Surrogate Decision-maker
    If the patient is not mentally competent, the appropriate surrogate decision-maker will be consulted according to hospital policy.

REFERENCES:

1. TJC CAMCAH 2016, PC.01.02.08
2. TJC CAMCAH 2016, PC.01.03.01
3. CAH State Operations Manual 12/2016, CFR 489.012

CROSS REFERENCE P&P:

1. Advanced Directives
2. Fall Risk Prevention – Perinatal
3. Fall Prevention and Management
4. Sepsis, Emergency Patient Care (Lippincott)

Approval	**Date**
CCOC	7/29/19
Medical Executive Committee	8/6/19
Board of Directors	
Last Board of Directors Review	

Developed: 12/2008 bss/jk
Reviewed: 3/15 bss
Revised: 5/11 jm; 9/12 bss; 12/17 ta; 07/19 jn
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Color-Coded Wristband Use**	
Scope: Nursing Services	Manual: **CPM - Admission, Discharge, Transfer Documentation (ADT)**
Source: Chief Nursing Officer	Effective Date: 12/2008

NORTHERN INYO HOSPITAL

Patient Refusal to Participate in the Wristband Process

Patient sticker

The above-named patient refuses to (check all that apply):
_____ Wear color-coded wristbands.
A member of the health care team has explained the benefits of the use of color-coded wristbands to me. I understand the benefits of the use of color-coded wristbands and the risks of refusing the wristbands and, despite this information, do not give permission for the use of color-coded wristbands in my care.

Title: **Color-Coded Wristband Use**	
Scope: Nursing Services	Manual: **CPM - Admission, Discharge, Transfer Documentation (ADT)**
Source: Chief Nursing Officer	Effective Date: 12/2008

_____ Remove "social cause" wristbands (e.g., charity wristbands).
A member of the health care team has explained the risks of refusing to remove the "social cause" wristbands to me. I understand that refusing to remove the "social cause" wristbands could cause confusion in my care and, despite this information, I do not give permission for the removal of "social cause" wristbands.

Reason provided (if any): _____

_____

_____ _____

Date/Time Signature/Relationship

_____ _____

Date/Time Witness Signature/Job Title

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: %SVHT PG "CVTF 5FTU .D,FTTPO %SVH 1BOFM XJUI "EV	
Scope: CLIA Waived testing staff.	Manual:
Source:	Effective Date:

PURPOSE:
The Mckesson 12-Drug Panel With Adulterants Drugs of Abuse Test is a CLIA Waived Urine Toxicology rapid screening test for simultaneous and qualitative detection of Methamphetamine (MET), Amphetamine (AMP), Cocaine (COC), Morphine (MOP), Marijuana (THC), Benzodiazepines (BZO), Ecstasy/Methylenedioxymethamphetamine (MDMA), Oxycodone (OXY), Barbituates (BAR), Phencyclidine (PCP), Buprenorphine (BUP), Methadone (MTD), and their associated metabolites, in human urine.

POLICY:
1. Refer to "Training and Competency in Point of Care Testing" for NIH Point of Care Policy
2. All new lots or shipments of The Mckesson 12-Drug Panel with Adulterants Drugs of Abuse Test shall be tested with external controls, and monthly thereafter.
3. The Mckesson 12-Drug Panel with Adulterants Drugs of Abuse Test will not be used for Employment or legal drug screening.
4. The Mckesson 12-Drug Panel with Adulterants Drugs of Abuse Test will not be used in any way that violates local, state, or federal toxicology regulations.
5. All testing staff should be able to interpret results by comparing the color of a test strip to a key on the included Color Chart. Staff with color blindness should not perform this test.

INTENDED USE:
The Mckesson 12-Drug Panel With Adulterants Drugs of Abuse Test is intended for use within the Northern Inyo Hospital Medication-Assisted Treatment (MAT) Program to aid providers with determining compliance with Medication use instruction and as a preliminary indicator of possible patient substance abuse. It is only intended for preliminary analytical results and is not appropriate for Employment or Pre-employment Drug Screening. Please see the Limitations section for more details.

PRINCIPLE:
The One Step Multi-Drug Screen Test is an immunoassay based on the principle of competitive binding. Drugs which may be present in the urine specimen compete against their respective drug conjugate for binding sites on their specific antibody. During testing, a urine specimen migrates upward by capillary action. A drug, if present in the urine specimen below its cut-off concentration, will not saturate the binding sites of its specific antibody coated on the particles. The Antibody coated particles will then be captured by the immobilized drug conjugate and a visible colored line will show up in the test line region of the specific drug strip.

The colored line will not form in the test line region if the drug level is above its cut-off concentration because it will saturate all the binding sites of the antibody coated on the particles.

A drug-positive urine specimen will not generate a colored line in the specific test line region of the strip because of drug competition, while a drug-negative urine specimen or a specimen containing a drug concentration less than the cut-off will generate a line in the test region. To serve as a procedural control, a colored line will always appear at the control line region indicating that proper volume of specimen has been added and membrane wicking has occurred.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

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Scope: CLIA Waived testing staff.	Manual:
Source:	Effective Date:

Each test line in the test panel contains mouse monoclonal antibody-coupled particles and corresponding drug-protein conjugates. A goat antibody is employed in each control line.

MATERIALS, EQUIPMENT, REAGENTS AND STORAGE:

Drugs of Abuse Test Mckesson 12-Drug Panel With Adulterants (store between 2-30 degrees C):

- Test Cup
- Procedure Card
- Color Chart card for Adulterant Interpretation
- Desiccants
- Disposable gloves
- Package insert
- Package insert
- Security seals

Alere Professional Cup Urine Drug Controls: Negative, Positive (store between -10 to -20 degrees C or unopened between 2 and 8 degrees C, or opened and refrigerated between 2-8 degrees C for 31 days):

- Positive Control
- Procedure stand
- Negative Control
- Package insert

Not included in kits but required for test:

- Timer
- Aliquot tubes (for freezing urine controls)
- Pipette

PROCEDURE:

1. Standard precautions should be followed when collecting all patient samples. Gloves should be given to patients when collecting urine specimens.
2. External Controls:
   A. External controls should be performed monthly or with each new shipment/lot.
   B. Controls are best stored frozen between -10 and -20 degrees Celsius. They may be stored, unopened, between 2 and 8 degrees Celsius until the expiration date, but the Oxazepam used in the controls may deteriorate with time.
   C. Opened controls may be aliquoted into 1 mL amounts and frozen between -10 and -20 C until the expiration date. Opened controls may be stored between 2 and 8 degrees Celsius for 31 days.
   D. Allow controls to come to room temperature, followed by gentle swirling, before use.
   E. Each control (positive and negative) should be added to a separate testing cup.
   F. If using a short control sample (minimum of 1 mL), pour or pipette control sample into cup, making certain that the bottoms of all imbedded test strips are saturated with control material. Then, screw the lid back onto the testing cup.
   G. Place the cup onto the low volume stand with the test strip portions facing down and the bottom of the cup angled lower than the top.
   H. Testing staff should peel off label to reveal the test result. Read test result at 5 minutes. DO NOT INTERPRET RESULT AFTER 10 MINUTES.
   I. Negative control should yield a result that is negative for all tested substances
   J. Positive control should yield a result that is positive for all tested substances

K. If control results do not match expected outcomes, repeat the test with a new set of controls. If failure continues, contact NIHD lab POCT team for further instruction.
L. No lot or shipment of the Drugs of Abuse Test Cups should be used for patient testing until external controls have passed.

3. Specimen Collection and Preparation:
   A. After taking a Drug of Abuse, it takes a minimum of 2-7 hours for drugs and drug metabolites to appear in urine. It is advisable, therefore, to wait a minimum of 2-7 hours after suspected drug use to collect a urine specimen.
   B. Verify all patient medication use, including OTC drugs and supplements. This can be useful in ruling out false positives.
   C. Ensure patient is able to provide a sufficient quantity of urine. 30 mL is the minimum quantity necessary for patient testing. If the minimum quantity is not provided, the specimen should be discarded and recollected later.
   D. Patient should urinate directly into the urine test cup if the results are to be read immediately, or the specimen may be collected in a sterile urine collection cup if the test will be read later. However, testing the specimen at a later time will invalidate the utility of the Temperature Indicator Strip, which is useful for determining if a patient came to the clinic with another person's urine.
   E. If the provider would like to consider confirmatory testing, a second collection specimen for confirmatory testing should be provided. Please refer to specific Reference Lab requirements for confirmatory testing (eg. Labcorp Test Menu).
4. Patient Testing:
   A. Allow test cup to come to room temperature (15-30 degrees C) prior to test.
   B. Testing staff member should be present near the restroom to receive urine DOA test cup and start the timer.
   C. Tear open foil bag, remove test cup and disposable gloves provided for donor. Label the device with patient information (name and date of birth or Medical Record number, see NIHD specimen collection policy).
   D. After collection is complete, the patient should close the lid and *immediately* return the cup to the testing staff member.
   E. Testing staff should peel off label to reveal test result.
   F. Read Adulterants strip at 2 minutes.
   G. Read urine temperature at 2-4 minutes, if the patient has urinated directly into the testing cup.
   H. Read test result at 5 minutes. DO NOT INTERPRET RESULT AFTER 10 MINUTES.
5. Result interpretation
   A. All results should be considered preliminary.
   B. A preliminary positive test result does not always mean a person took illegal drugs and a negative test result does not always mean a person did not take illegal drugs. There are a number of factors that influence the reliability of drug tests. Certain drugs of abuse tests are more accurate than others.
   C. **Negative**: Two lines appear. One red line should be in the control region (C) and another apparent red or pink line adjacent should be in the test region (Drug/T). This negative result indicates that the drug concentration is below the detectable level. Note, the shade

of red in the test line region (Drug/T) will vary, but it should be considered negative whenever there is even a faint pink line.

D. **Positive**: One red line appears in the control region (C). No line appears in the test region (Drug/T) This positive result indicates that the drug concentration is above the detectable level.

E. **Invalid**: Control line fails to appear. Insufficient specimen volume or incorrect procedural techniques are the most likely reasons for the control line failure. Review the procedure and repeat the test using a new test panel. If the problem persists, discontinue using the lot immediately and contact the Point of Care Team for further instructions.

F. At the physician's discretion, preliminary positive tests can be confirmed by a reference lab. Patient safety and all potential clinical consequences should be taken into account before taking any actions based on preliminary results. See Limitations section for further information.

G. **Adulterant tests (specimen validity tests):** See Color Chart to interpret each result.
   1) **Oxidants (OXI):** Tests for the presence of oxidizing agents such as bleach and peroxide in the urine
   2) **Specific Gravity (S.**G.): Tests for sample dilution. Normal levels for specific gravity will range from 1.003 to 1.030. Specific gravity levels of less than 1.003 or higher than 1.030 may be an indication of adulteration or specimen dilution.
   3) **pH**: tests for the presence of acidic or alkaline adulterants in urine. Normal pH levels should be in the range of 4.0 to 9.0. Values below pH of 4.0 or above 9.0 may indicate the sample has been altered.

H. **Temperature Indicator Strip:**
   1) Green color on temperature indicator strip corresponds to urine temperature.
   2) A urine temperature significantly lower than normal human body temperature should be considered a possible indicator that the patient gave a urine specimen that is not their own if tested immediately after urine collection is performed.
   3) Factors such as ambient temperature and time since collection should be taken into account when determining if urine temperature reflects a recently collected specimen.

LIMITATIONS:

1. The Drugs of Abuse Test Mckesson 12-Drug Panel with Adulterants test cup provides only a qualitative, preliminary analytical result. A secondary analytical method should be used before any result should be considered final. Providers should exercise caution before making clinical decisions based on preliminary results. Gas chromatography/mass spectrometry (GC/MS) is the preferred confirmatory method.
2. There is a possibility that technical or procedural errors, as well as other interfering substances in the urine specimen may cause erroneous results. Please see the package insert included with the test cups for a detailed, but not exhaustive, list of known non-cross-reacting substances, as well as precision, specificity, and sensitivity data.
3. Adulterants, such as bleach and/or alum, in urine specimens may produce erroneous results regardless of the analytical method used. If adulteration is suspected, the test should be repeated with another urine specimen.
4. A positive result does not indicate level of intoxication, administration route, or concentration in urine.

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5. A negative result may not necessarily indicate drug-free urine. Negative results can be obtained when drug is present but below the cut-off level of the test. See the package insert for the cut-off levels for each of the tests.
6. A negative result does not necessarily rule-out recent drug use. Drugs and their metabolites are present in urine for varying lengths of time depending on frequency of drug use and the type of drug being monitored. Frequent drug screening may be necessary to rule out drug abuse.
7. The test does not distinguish between drugs of abuse and certain medications.
8. A positive result might be obtained from certain foods or food supplements.
9. A comprehensive medication list, including supplements and OTC medications, can be useful in ruling out falsely positive results. See the package insert for known cross-reactive substances under "Analytical Specificity."
10. The Drugs of Abuse Test Mckesson 12-Drug Panel with Adulterants test cup can be circumvented through adulteration or substitution. Observed collection can eliminate concerns of adulterants or substitution by preventing a patient from adding substances a urine or substituting another person's urine for their own.

REFERENCES:

1. McKesson Drugs of Abuse Test Cups Multi Drug Panel with Adulterants Product Insert.
2. Substance Abuse and Mental Health Services Administration. *Clinical Drug Testing in Primary Care. Technical Assistance Publication (TAP) 32*. HHS Publication No. (SMA) 12-4668. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012.

CROSS REFERENCE P&P:

1. Training and Competency in Point of Care Testing

Approval	**Date**
CCOC	7/29/19
Medicine / ICU Committee	8/1/19
Medical Executive Committee	8/6/19
Board of Directors	
Last Board of Directors Review	

Developed: 07-22-2019
Reviewed:
Revised:
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: IV Service When NIH IV Room Is Closed	
Scope: Pharmacy, Administration	Manual: Pharmacy
Source: Director of Pharmacy	Effective Date:

PURPOSE:

To delineate the use of an off-site licensed IV room for the continuance of care while the NIHD IV room is not available.

POLICY:

1. Dwayne's Friendly Pharmacy IV room will be used under contract if NIH IV room is not available or closed for any reason.
2. Medications that qualify as immediate use will be mixed in a clean area designated by the Director of Pharmacy, also known as Pharmacist in Charge (PIC).
3. Batched medications, Chemotherapy, PCA, Epidural, TPN and PPN will be mixed at Dwayne's Friendly Pharmacy.
4. Compounded Sterile Products (CSPs) prepared for immediate use must be started on the patient within 1 hour of mixing.
5. Immediate use CSP's do not need to be compounded in an ISO Class 5 environment and garbing and gowning is not required. They will be mixed in a clean area.
6. During mixture for immediate use, only simple transfer of no more than 3 sterile drugs in the manufacturers containers may be involved in the compounding and no more than 2 entries into any one container may occur.
7. A copy of the current IV room license of Dwayne's Friendly Pharmacy will be retained at NIH pharmacy during any time that Dwayne's Friendly Pharmacy IV facility is used under this policy.
8. All personnel that will be mixing at Dwayne's Friendly Pharmacy will be oriented to their facility
9. All ingredients for each CSP will be gathered with the appropriate labels and transported by the NIH employee to Dwayne's Friendly Pharmacy and compounded using the same technique and record keeping as at NIH.

PROCEDURE:

Immediate Use:

1. Pharmacy technicians must work with nursing on the timing of the mixing of these medications.

2. Hand hygiene will be performed prior to mixing: Washing hands, under the fingernails, wrists and up to the elbow for 30 seconds with a facility approved agent and drying hands with a non-shedding disposable towel or sanitizing hands with application of a waterless, alcohol-based hand rub approved by the facility.

3. Follow Aseptic technique.

Title: IV Service When NIH IV Room Is Closed	
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Source: Director of Pharmacy	Effective Date:

4. Clean the preparation area with ~~alcohol prior to each use~~ appropriate agent per Cleaning the Pharmacy Sterile IV Preparation Area. (Clean Room) policy.
5. Place an expiration date of 1 hour on the label.

REFERENCES:
1. ASHP Guidelines on Compounding Sterile Preparations.
2. California Board of Pharmacy (2017). Compounding Regulations Guidance: Title CCR section 1735 et seq. and CCR section 1751 et seq. Retrieved from http://www.pharmacy.ca.gov/publications/compounding_faqs.pdf

CROSS REFERENCE POLICY:
1. Cleaning the Pharmacy Sterile IV Preparation Area. (Clean Room)

Committee Approval	**Date**
CCOC	7/9/19
Infection Control Committee	5/28/19
Pharmacy and Therapeutics	6/20/19
Medical Executive Committee	
Board of Directors	
Board of Directors Last Review	

Developed: 07/19
Revised:
Reviewed:
Supercedes:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Medication Dosing in Renal Failure	
Scope: Pharmacy	Manual: Pharmacy
Source: Director of Pharmacy	Effective Date: 12/15/17

PURPOSE:
To reduce medication related toxicity and adverse effects in patients with renal insufficiency/failure by making appropriate dose adjustment on renally cleared medications.

POLICY:

1. Pharmacists are authorized by the medical staff to adjust the dosages of renally eliminated medications based upon creatinine clearance rates calculated for each patient. This will apply to all medications besides chemotherapy medications which will be handled in a different manner.

PROCEDURE:

1. Upon receipt of an order for a medication that is eligible for dose adjustment, the pharmacist will determine if the ordered dose and frequency is appropriate based on estimated creatinine clearance.
2. The pharmacist will use the creatinine level and compute CRCL using Cockcroft & Gault modified equation ~~clearance that is provided by the computer system to determine renal function. The computer system uses appropriate renal function estimators for the population that the patient fits in. Majority of patient's renal function is determined by the Cockcroft-Gault equation. If the pharmacist determines another estimate for creatinine clearance is more appropriate they will use that estimate for the dose adjustment~~.
3. Appropriate dosing of the medication will be determined based on the renal dose adjustment section of product package insert or most up to date version of Lexicomp.
4. If the ordered dose of the medication is not appropriate, the pharmacist is allowed to discontinue the current order and reorder the medication at the dose defined by the above references.
5. If the medication is contraindicated based on renal function, the pharmacist is responsible for contacting the provider to suggest alternatives.
6. If the original ordered dose is not appropriate for the indication, the pharmacist must contact the provider to recommend alternative dosing.
7. The pharmacist will monitor renal function throughout patients stay in the hospital. If renal function changes throughout the stay, appropriate recommendations will be made to physician for changes in renally cleared medications.

REFERENCES:

1. Dowling, T.C., Matzke, G.R., Murphy, J.E., & Burckart, G. J. (2010). Evaluation of renal drug dosing: prescribing information and clinical pharmacist approaches. *Pharmacotherapy* (30): 776-86. (LOE 8)

CROSS REFERENCE POLICY:
1. Pharmacist Clinical Interventions