Northern Inyo Hospital

June 17 2015 Regular Meeting

June 17 2015 Regular Meeting - June 17 2015 Regular Meeti

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

June 17, 2015 at 5:30 p.m.

In the Northern Inyo Hospital Board Room at 2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 p.m.).
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 two minutes each.)*

Consent Agenda (action items)

3. Approval of minutes of the May 13 2015 regular meeting
4. Approval of financial and statistical reports for the month of April 2015

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5. Chief Executive Officer's Report; Victoria Alexander-Lane
   - A. Physician on boarding
   - B. LAFCO update
   - C. CMO Visit – Role of CMO
   - D. RHC, a medical home
   - E. Transitions in care
   - F. Telemedicine update
   - G. Leadership training
   - H. Process Management
   - I. IT Strategy
   - J. Cardinal Village Resort
   - K. Community Relations
6. Chief of Staff Report; Mark Robinson, M.D.
   - A. Medical Staff privileging, credentialing, and advancements (*action items*):
     1. Advancement of Felix Karp, M.D. from Temporary Locums to Provisional Active Staff with clinical privileges as requested
     2. Advancement of Matthew Wise, M.D. from Provisional Active Staff to Active Staff with clinical privileges as requested
     3. Granting of Pelvic Radiology privileges as requested commensurate with current practice to Keith Shonnard, M.D.

B. Acceptance of the Medical Staff resignations of Sudhir Kakarla, M.D. and Kristin Collins, D.O. (*action items*).

C. Hospital wide Policy and Procedure approvals (*action items*):

1. *Endo Venous Laser Treatment*
2. *Malignant Hyperthermia Cart Check*
3. *Shoulder Arthroscopy 3 Point Distraction System*
4. *Surgery Tissue/Bone Graft "Look Back" Policy*
5. *Bone Graft Tissue Bank*
6. *Utilization Review Plan*
7. *Organ/Tissue/Eye Donation*

7. Chief Nursing Officer Report (*information item*).
8. Chief Performance Excellence Officer Report (*information item*).
9. New Business

A. Approval of Fiscal year 2015/2016 annual budget (*action item*).

B. Northern Inyo Healthcare District 401(a) Plan Amendment 2 (*action item*).

C. Mammography Upgrade (*action item*).

D. Floor Waxing Proposal, *Just Do Right Janitorial* (*action item*).

E. Approval of Appropriations Limit for 2015/2016 fiscal year, Resolution #15-01 (*action item*).

F. Microsoft Licensing renewal (*action item*).

G. Proposed update to current employee discount policy (*action item*).

H. Hospitalist Contract Addendum, Joy Engblade, M.D. (*action item*).

I. Microsoft True-up cost approval (*action item*).

10. Reports from Board members (*information items*).
11. Adjournment to closed session to/for:

A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*).

B. Discussion of potential litigation *(Government Code section 54956(d)(2*)).

C. Confer regarding action filed against Northern Inyo Healthcare District and other Defendants (*Government Code Section 54956.9(a)*).

12. Return to open session, and report of any action taken in closed session.
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.

CALL TO ORDER	The meeting was called to order at 5:30 pm by M.C. Hubbard, President.
PRESENT	M.C. Hubbard, President Denise Hayden, Vice President D. Scott Clark, M.D., Secretary Peter Watercott, Treasurer John Ungersma, M.D., Member at Large
ALSO PRESENT	Victoria Alexander-Lane, Chief Executive Officer Mark Robinson M.D., Chief of Staff Sandy Blumberg, Executive Assistant
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Hubbard stated 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. No comments were heard.
CONSENT AGENDA	Ms. Hubbard called attention to the consent agenda for this meeting, which contained the following items: - Approval of minutes of the April 7 2015 special meeting - Approval of minutes of the April 15 2015 regular meeting - Approval of financial and statistical reports for the month of March, 2015 It was moved by John Ungersma M.D., seconded by D. Scott Clark M.D., and unanimously passed to approve the proposed consent agenda items as presented.
CHIEF EXECUTIVE OFFICER'S REPORT PHYSICIAN RECRUITMENT	Chief Executive Officer Victoria Alexander-Lane reported that Martha Kim M.D.; Louisa Salisbury M.D.; and Allison Robinson M.D. will come on board at Northern Inyo Hospital (NIH) in the next several months. She additionally reported that Tomi Bortolazzo M.D. submitted her resignation effective July 31, 2015, and the hospital will recruit for a replacement urologist. She also noted that management is in discussion with potential Rural Health Clinic (RHC) director candidates and a potential Chief Medical Officer (CMO) candidate.
LAFCO UPDATE	Ms. Alexander-Lane additionally reported the Inyo County Local Agency Formation Commission (LAFCO) has corresponded with Southern Mono Healthcare District in regard to their plan to open a medical clinic within the boundaries of the Northern Inyo Healthcare District. She explained that the services Southern Mono intends to offer here are not needed, and are already available to area residents at Northern Inyo Hospital.
NIH FOUNDATION UPDATE	Ms. Lane also stated that expansion of the Northern Inyo Hospital Foundation is progressing well, and the group is engaged in discussing new projects and grant applications for education and unmet healthcare needs in this community. One of the Foundation's interests is in

developing transportation resources for area residents who have no way to get to and from medical appointments and services.

RADIOLOGY DEPARTMENT ACR ACCREDIDATION

NIH Director of Diagnostic Imaging Patty Dickson reported the Diagnostic Imaging Department recently passed its' full American College of Radiology (ACR) accreditation survey, with no violations or recommendations for improvement being noted.

STOP LOSS CLAIMS

Ms. Alexander-Lane reported that NIH employee health insurance expenses remain high, and that 10 or more people enrolled in the hospital's self-insured health plan have surpassed the stop-loss limit during the last several months.

CONTRACT DISCUSSIONS

Ms. Lane also reported preliminary contract renewal discussions are underway with the Hospital's Emergency Department physicians, and with the anesthesiologists as well.

ACHD TRUSTEE OF THE YEAR

Ms. Alexander-Lane additionally reported that District Board member John Ungersma M.D. was recently awarded designation as the Association of California Healthcare Districts (ACHD) Trustee of the Year, for the State of California. Ms. Alexander-Lane and members of the Board acknowledged Dr. Ungersma for his many years of dedicated service and advocacy on behalf of residents of this District and the State of California.

CHIEF OF STAFF REPORT

Chief of Staff Mark Robinson M.D. reported following careful review, consideration, and approval by the appropriate committees, the Medical Executive Committee recommends approval of the following hospital wide policies and procedures:

1. Cardiopulmonary – Stress Echo procedure
2. Cardiopulmonary – Stress Echo

POLICY AND PROCEDURES APPROVALS

It was moved by Doctor Clark, seconded by Doctor Ungersma, and unanimously passed to approve both policies and procedures as presented.

MEDICAL STAFF ADVANCEMENT AND BYLAWS AMENDMENT

Doctor Robinson also reported following careful review and consideration the Medical Executive Committee recommends Board approval of the following:

- Advancement of Physician Assistant Colleen McEvoy's proctoring period based upon Doctors Collins' and Helvie's reviews of Ms. McEvoy's charts
- Approval of a proposed *Telemedicine Bylaws Amendment* to the NIH Medical Staff Bylaws

It was moved by Doctor Clark, seconded by Doctor Ungersma and unanimously passed to approve the Medical Staff advancement and the Telemedicine Medical Staff Bylaws Amendment as presented.

CHIEF NURSING OFFICER REPORT

Chief Nursing Officer Kathy Decker provided an update on nursing department union membership; leaves of absence; hiring and recruitment; and also reported that Emergency Department RN Diane Stevens recently received the Daisy Award for excellence in nursing.

PERFORMANCE EXCELLENCE REPORT

Chief Performance Excellence Officer Maria Sirois reported the following:

- An NIH staff member recently filed a complaint with the office of Occupational Safety and Health Administration (OSHA) in regard to the Emergency Department (ED) flooring replacement project
- The kickoff meeting for this year's Leap Frog project has taken place and the initial project team meeting has been held
- The Hospital's first phase of Lean Six Sigma training (for waste reduction and efficiency improvement) is nearly complete
- The Hospital has recently appointed Ms. Lorie Thompson to function as Veterans Services Liaison

NEW BUSINESS

AMENDMENTS (2) TO THE DISTRICT DEFINED BENEFIT RETIREMENT PLAN

Ms. Alexander-Lane called attention to two proposed Amendments to the Hospital District Defined Benefit Retirement Plan. Directors Watercott and Hayden exited the meeting at this time due to a conflict of interest. Ms. Alexander-Lane noted that the first Amendment is needed in order to bring the existing Plan back into IRS compliance; and the second amendment allows for re-negotiating the Plan on behalf of union members. It was moved by Doctor Ungersma, seconded by Doctor Clark and passed by Board members present to approve both Amendments to the Hospital District Defined Benefit Retirement Plan as presented (with Directors Hayden and Watercott being absent from the vote). Following the vote, Directors Watercott and Hayden returned to the meeting.

DRAGON SOFTWARE PURCHASE

Chief Information Officer Leo Freis called attention to a capital expenditure request to purchase Dragon software licenses and training for hospital transcription. Mr. Freis explained that the hospital's last remaining transcriptionist will be moving out of the area, and this would be an appropriate time to switch to voice recognition transcription which would save the hospital approximately $140,000 annually in transcription costs. It was moved by Mr. Watercott, seconded by Denise Hayden, and unanimously passed to approve the purchase of Dragon transcription software licenses and training as presented.

TISSUE PROCESSOR PURCHASE

Mr. Freis also called attention to a request for early replacement of the hospital's tissue processor, which recently broke. Because of its age the equipment can no longer be serviced by the company that manufactured it. It was moved by Mr. Watercott, seconded by Doctor Ungersma, and unanimously passed to approve the purchase of a new tissue processor as requested.

BOARD MEMBER REPORTS	Ms. Hubbard asked if any members of the Board of Directors wished to report on any items of interest. Doctor Ungersma reported on the ACHD meeting that was recently held in Monterey, California, stating that in-depth discussion on the Affordable Care Act took place.
ADJOURNMENT TO CLOSED SESSION	At 6:48 pm Ms. Hubbard announced the Board of Directors would adjourn to closed session to/for: A. Hear reports on the hospital quality assurance activities from the responsible department head and the Medical Staff Executive Committee (*Section 32155 of the Health and Safety Code, and Section 54962 of the Government Code*). B. Discussion of potential litigation (Government Code section 54956(d)(2)).
RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN	At 8:04 pm the meeting returned to open session. Ms. Hubbard reported that the Board took no reportable action.
ADJOURNMENT	The meeting was adjourned at 8:05 pm.

_____
M.C. Hubbard, President

Attest: _____
D. Scott Clark, M.D., Secretary

BUDGET VARIANCE ANALYSIS

Apr-15 Fiscal Year Ending June 30, 2015

Year to date for the period ending April 30, 2015

891	or	36%	more IP days than in the prior fiscal year
$ 4,075,503	or	13.44%	over budget in IP Ancillary Revenue and
$ 3,246,072	or	4.9%	over budget in OP Revenue resulting in
$ 7,321,575	or	7.6%	over budget in gross patient revenue &
$ (2,668,653)	or	-4.2%	under budget in net patient revenue

Year-to-date Net Revenue was	$	60,342,777
Total Operating Expenses were:	$	55,422,006

for the fiscal year to date

$ (1,927,211)	or	0.0%	under budget. Wages and Salaries were
$ (1,759,799)	or	-8.9%	under budget and Employee Benefits
$ 1,411,266	or	10.7%	over budget.
		81%	Employee Benefits Percentage of Wages

The following expense areas were also over budget for the year for reasons listed:

$ 1,411,266	or	10.7%	Employee Benefits due to funding of Defined Contribution Plan & extremely high Health Claims
$ 1,038,260	or	54%	Interest Expense over budget due to Accretive Interest on Capital Appreciation Bonds

Other Information:

$ 5,521,379		Operating Income, less
$ (4,855,251)		loss in non-operating activities created a net income of;
$ 666,128	$ (580,625)	under budget.
	42.09%	Contractual Percentages for Year and
	34.96%	Budgeted Contractual Percentages including
$ 601,855	in prior year cost report settlement activity for Medicare & Medi-Cal	

Non-Operating actives included:

$ (3,792,072) loss	$ 864,391	under budget in Medical Office Activities & Over Budget on Interest Expense
$ 276,823	$ (151,873)	under budget in 340B Pharmacy Activity

Contractual Percentage Information

Month Percentage	Year Percentage	
44%	42%	Our Interim Cost Report to Medicare resulted in a payable to Medicare of $2 Million which is reflected in the higher contractual percentage

Northern Inyo Hospital
Balance Sheet
Period Ending April 30, 2015

Current Assets:	**Current Month**	**Prior Month**	**Change**
Cash and Equivalents	3,839,869	4,564,180	(724,311)
Short-Term Investments	9,741,050	8,735,540	1,005,510
Assets Limited as to Use	-	-	-
Plant Replacement and Expansion Fund	2	2	-
Other Investments	978,712	978,712	-
Patient Receivable	47,080,153	46,803,175	276,978
Less: Allowances	(36,139,967)	(36,212,583)	72,616
Other Receivables	(287,517)	126,813	(414,330)
Inventories	3,849,604	3,731,193	118,411
Prepaid Expenses	1,305,464	1,305,280	185
Total Current Assets	**30,367,370**	**30,032,311**	**335,059**
Internally Designated for Capital Acquisitions	1,033,731	1,033,722	8
Special Purpose Assets	319,336	833,873	(514,538)
Limited Use Asset; Defined Contribution Pension	400,000	400,000	-
Revenue Bonds Held by a Trustee	2,840,174	2,678,429	161,746
Less Amounts Required to Meet Current Obligations	-	-	-
Assets Limited as to use	**4,593,240**	**4,946,024**	**(352,784)**
Long Term Investments	1,452,143	1,452,143	-
			-
Property & equipment, net Accumulated Depreciation	83,377,276	83,565,085	(187,809)
Unamortized Bond Costs	-	-	-
			-
Total Assets	**119,790,029**	**119,995,562**	**(205,534)**

Northern Inyo Hospital
Balance Sheet
Period Ending April 30, 2015

Liabilities and Net Assets			
Current Liabilities:			
Current Maturities of Long-Term Debt	163,456	244,643	(81,187)
Accounts Payable	1,023,288	1,385,528	(362,240)
Accrued Salaries, Wages & Benefits	4,845,316	4,602,272	243,044
Accrued Interest and Sales Tax	436,078	775,065	(338,987)
Deferred Income	88,832	133,248	(44,416)
Due to 3rd Party Payors	2,941,829	2,207,359	734,470
Due to Specific Purpose Funds	-	-	-
Total Current Liabilities	**9,498,799**	**9,348,114**	**150,684**
Long Term Debt, Net of Current Maturities	50,353,007	50,353,007	-
Bond Premium	1,145,807	1,151,404	(5,597)
Accreted Interest	7,992,827	7,882,278	110,549
Total Long Term Debt	**59,491,640**	**59,386,689**	**104,952**
Net Assets			
Unrestricted Net Assets less Income Clearing	49,814,126	49,810,987	3,139
Temporarily Restricted	319,336	833,873	(514,538)
Net Income (Income Clearing)	666,128	615,999	50,129
Total Net Assets	**50,799,590**	**51,260,859**	**(461,269)**
Total Liabilities and Net Assets	**119,790,029**	**119,995,662**	**(205,633)**

NORTHERN INYO HOSPITAL
STATEMENT OF OPERATIONS (new format)
for period ending April 30, 2015

	ACT MTD	BUD MTD	VARIANCE	ACT YTD	BUD YTD	VARIANCE
Unrestricted Revenues, Gains & Other Support						
Inpatient Service Revenue						
Routine	678,619	628,346	50,273	7,900,298	6,367,248	1,533,050
Ancillary	2,319,659	2,363,775	(44,116)	26,495,343	23,952,890	2,542,453
Total Inpatient Service Revenue	2,998,277	2,992,121	6,156	34,395,641	30,320,138	4,075,503
Outpatient Service Revenue	7,262,324	6,567,886	694,438	69,800,652	66,554,580	3,246,072
Gross Patient Service Revenue	10,260,601	9,560,007	700,594	104,196,293	96,874,718	7,321,575
Less Deductions from Revenue						
Deductions	190,959	310,801	(119,842)	2,349,082	3,149,451	(800,369)
Contractual Adjustments	4,623,613	3,030,969	1,592,644	42,106,290	30,713,837	11,392,453
Prior Period Adjustments *	(284,140)	-	(284,140)	(601,855)	-	(601,855)
Total Deductions from Patient Service Revenue	4,530,432	3,341,770	1,188,662	43,853,516	33,863,288	9,990,228
Net Patient Service Revenue	5,730,169	6,218,237	(488,068)	60,342,777	63,011,430	(2,668,653)
Other revenue	57,792	19,799	37,993	600,608	200,642	399,966
Total Other Revenue	57,792	19,799	37,993	600,608	200,642	399,966
Expenses:						
Salaries and Wages	1,791,275	1,944,142	(152,867)	17,940,825	19,700,624	(1,759,799)
Employee Benefits	1,241,681	1,302,837	(61,156)	14,613,343	13,202,077	1,411,266
Professional Fees	629,329	564,819	64,510	5,473,323	5,723,497	(250,174)
Supplies	507,210	561,835	(54,625)	5,064,257	5,693,269	(629,012)
Purchased Services	262,310	325,628	(63,318)	3,065,697	3,299,685	(233,988)
Depreciation	407,949	401,199	6,750	4,015,922	4,065,481	(49,559)
Bad Debts	234,625	214,617	20,008	2,036,899	2,174,786	(137,887)
Other Expense	301,652	344,389	(42,737)	3,211,740	3,489,798	(278,058)
Total Expenses	5,376,032	5,659,466	(283,434)	55,422,006	57,349,217	(1,927,211)
Operating Income (Loss)	411,929	578,570	(166,641)	5,521,379	5,862,855	(341,476)
Other Income:						
District Tax Receipts	44,416	43,808	608	444,160	443,919	241
Tax Revenue for Debt	85,704	84,530	1,174	857,040	856,573	467
Partnership Investment Income		-	-		-	-
Grants and Other Contributions Unrestricted	100,460	7,966	92,494	156,942	80,719	76,223
Interest Income	13,380	11,212	2,168	136,712	113,617	23,095
Interest Expense	(292,030)	(188,605)	(103,425)	(2,949,451)	(1,911,191)	(1,038,260)
Other Non-Operating Income	5,118	2,766	2,352	14,595	28,028	(13,433)
Net Medical Office Activity	(324,586)	(459,520)	134,934	(3,792,072)	(4,656,463)	864,391
340B Net Activity	5,739	42,305	(36,566)	276,823	428,696	(151,873)
Non-Operating Income/Loss	(361,800)	(455,538)	93,738	(4,855,251)	(4,616,102)	(239,149)
Net Income/Loss	50,129	123,032	(72,903)	666,128	1,246,753	(580,625)

NORTHERN INYO HOSPITAL
OPERATING STATISTICS
for period ending April 2015

		FYE 2015	FYE 2014		
	Month to Date	Year-to-Date	Year-to-Date	Variance from PY	
Licensed Beds	25	25	25		
Total Patient Days with NB	306	3,391	2,500	891	36%
Swing Bed Days	84	698	99	599	
Discharges with NB	98	1,051	924	127	
Days in Month	30	304	304		
Occupancy	10.20	11.15	8.22	3	
Average Stay (days)	3.12	3.23	2.71	1	
Hours of Observation (OSHPD)*	767	5,387	5,407	(20)	
Observation Adj Days	32	224	225	(1)	
ER Visits (OSHPD)	521	6,633	6,471	162	
Outpatient Visits (OSHPD)	3,191	31,613	32,036	(423)	
IP Surgeries (OSHPD)	19	222	245	(23)	
OP Surgery (OSHPD)	97	896	825	71	
Worked FTE's	292.00	299.00	314.00	(15)	
Paid FTE's	324.00	339.00	356.00	(17)	
Payor %					
Medicare		42%	43%	-1%	
Medi-Cal		21%	17%	5%	
Insurance, HMO & PPO		34%	36%	-2%	
Indigent (Charity Care)		0.4%	1%	-1%	
All Other		2%	3%	-1%	
Total		100%	100%		

***Observation Hours have been corrected for the year**

Investments as of 4/30/2015

ID	Purchase Date	Maturity Date	Institution	Broker	Rate	Principal Invested
1	15-Apr-15	01-May-15	LAIF (Walker Fund)	Northern Inyo Hospital	0.28%	323,344.36
3	15-Apr-15	01-May-15	Local Agency Investment Fund	Northern Inyo Hospital	0.28%	9,317,705.95
4	20-May-10	20-May-15	First Republic Bank-Div of BOFA FN	Financial Northeaster Corp.	3.10%	100,000.00
				Short Term Investments		9,741,050.31
5	16-Apr-14	15-Oct-16	Wachovia Corp New Note	Multi-Bank Service	1.38%	552,142.50
6	13-Jun-14	13-Jun-18	Synchrony Bank Retail-FNC	Financial Northeaster Corp.	1.60%	250,000.00
7	28-Nov-14	28-Nov-18	American Express Centurion Bank	Financial Northeaster Corp.	2.00%	150,000.00
8	02-Jul-14	02-Jul-19	Barclays Bank	Financial Northeaster Corp.	2.05%	250,000.00
9	02-Jul-14	02-Jul-19	Goldman SachsBank USA NY CD	Financial Northeaster Corp.	2.05%	250,000.00
				Long Term Investments		$1,452,142.50
				Total Investments		$11,193,192.81
2	15-Apr-15	01-May-15	LAIF Defined Cont Plan	Northern Inyo Hospital	0.28%	400,332.00

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending June 30, 2015
As of April 30, 2015

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES		AMOUNT
FY 2011-12	Paragon Physician Documentation Module		111,826 *
FY 2012-13	Paragon Rules Engine/Meaningful Use Stage 2 QeM	Plus annual fees	67,390 *
FY 2013-14	Caldwell Easy III	EEG	50,917
	Athrex Orthopedic Equipment & Instrumentation	Surgery	70,010 *
	Philips Monitors	Infusion Unit	88,247 *
	Blood Gas Analyzer Upgrade	Laboratory	14,687
	Stress Equipment	EKG	39,044 *
	5500 HD Resting ECG System	EKG	29,654 *
	GE OEC 9900 C-Arm	Radiology	163,673 *
	Olympus 3-D Laparascopic Cameras and Scopes	Surgery	487,327 *
	Triad Energy Platform Also on Capital Expenditures	Surgery	49,131 *
	AMOUNT APPROVED BY THE BOARD IN THE PRIOR FISCAL YEARS TO BE EXPENDED IN THE CURRENT FISCAL YEAR		1,171,906
FY 2014-15	Radio Frequent Ablation Hardware		36,580
	Flooring Replacement; ED Corridor & Sterile Pack, Clean Up and Decontamination		195,820
	Dragon Voice Recognition		36,963
	VIP-6 Tissue Processor		80,054
	AMOUNT APPROVED BY THE BOARD IN THE CURRENT FISCAL YEAR TO BE EXPENDED IN THE CURRENT FISCAL YEAR		349,417
	Year-to-Date Board Approved Budgeted Capital		442,269 *
	Amount Approved by the Board in Prior Fiscal Years		

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending June 30, 2015
As of April 30, 2015

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES	AMOUNT
	to be Expended in the Current Fiscal Year	1,171,906
	Amount Approved by the Board in the Current Fiscal Year to be Expended in the Current Fiscal Year	349,417
	Year-to-Date Board-Approved Amount to be Expended	
	Year-to-Date Administrator-Approved Amount	169,652 *
	Actually Expended in Current Fiscal Year	1,515,643 *
	Year-to-Date Completed Building Project Expenditures	219,025 *
	TOTAL FUNDS APPROVED TO BE EXPENDED	1,904,320
	Total-to-Date Spent on Incomplete Board Approved Expenditures	

Reconciling Totals:

Actually Capitalized in the Current Fiscal Year Total-to-Date	1,904,320
Plus: Lease Payments from a Previous Period	0
Less: Lease Payments Due in the Future	0
Less: Funds Expended in a Previous Period	0
Plus: Other Approved Expenditures	0
ACTUAL FUNDS APPROVED IN THE CURRENT FISCAL YEAR TOTAL-TO-DATE	1,904,320
Donations by Auxiliary	
Donations by Hospice of the Owens Valley	0
+Tobacco Funds Used for Purchase	0
	0

*Completed Purchase
(Note: The budgeted amount for capital expenditures for all priority requests for the fiscal year ending June 30, 2015, is $3,725,006 coming from existing hospital funds.)

**Completed in prior fiscal year

Northern Inyo Hospital
CAPITAL EXPENDITURES APPROVED BY BOARD DURING BUDGET PROCESS
Fiscal Year Ending June 30, 2015
As of April 30, 2015

Item	Department	Amount	Month Total	Grand Total
Fabius GS Pemium	Anesthesiology	39,571		
Fabius GS Pemium	Anesthesiology	39,571		
IE33 Ultrasound System	ECHO	95,501		
Hobart Dry Disposer	Dietary	2,359		
VPAP	Respiratory Therapy	3,229	180,231	
As of Month Ending April 30, 2015				442,269

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending June 30, 2015
As of April 30, 2015

Administrator-Approved Item(s)	Department	Amount	Month Total	Grand Total
As of Month Ending February 28, 2015				**166,958**
Canon iR Advance 400iF	Medical Records	2,695	2,695	
As of Month Ending April 30, 2015				**169,652**

NORTHERN INYO HOSPITAL
Northern Inyo County Local Hospital District
150 Pioneer Lane, Bishop, California 93514

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

TO: NICLHD Board of Directors
FROM: Mark Robinson, MD, Chief of Medical Staff
DATE: June 2, 2015

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 NICLHD Board of Directors:

1. Advancement from Temporary Locums of Felix Karp, MD to Provisional Active Staff with clinical privileges as requested. This recommendation is made consequent to careful review of the applicant's applications and supporting documentation. (Action)
2. Advancement from Provisional Active Staff of Matthew Wise, MD to Active Staff with clinical privileges as requested. This recommendation is made consequent to careful review of the applicant's applications and supporting documentation. (Action)
3. Acceptance of the resignations of Sudhir Kakarla, MD and Kristin Collins, DO. (Action)
4. Granting of Pelvic Radiology privileges as requested commensurate with current practice to Dr. Keith Shonnard. Dr. Shonnard accidentally omitted said privilege due to clerical oversight. (Action)
5. Approval of the following policies/procedures, which have been reviewed and recommended by appropriate Medical Staff committees:

    i. *Endo Venous Laser Treatment (Action)*
    ii. *Malignant Hyperthermia Cart Check (Action)*
    iii. *Shoulder Arthroscopy 3 Point Distraction System (Action)*
    iv. *Surgery Tissue/Bone Graft "Look Back" Policy (Action)*
    v. *Bone Graft Tissue Bank (Action)*
    vi. *Utilization Review Plan (Action)*
    vii. *Organ/Tissue/Eye Donation (Action)*

_____
Mark Robinson, MD

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Endo Venous Laser Treatment**	
Scope: Surgery	Department: **Invasive Procedures, Operative, Preparation and Post Op (OOP), Surgery**
Source: DON Perioperative Services	Effective Date:

PURPOSE:
To ensure the safe performance of endo-venous laser treatment utilizing the Diomed Laser.

POLICY:

- Only authorized physicians knowledgeable and trained in the function and use of the Diomed Laser may perform surgical procedures utilizing the laser.
- Personnel and patients must wear safety goggles specific for the Diomed Laser while the laser is in use.
- The key to the laser must be removed and stored in the laser cart cabinet whenever the laser is not in use to prevent accidental firing or loss. The remote interlock bypass safety device located in the rear of the unit will stay in place at all times.
- The laser must be stored at temperatures between 32 degrees F and 140 degrees F. If stored at temperatures below 59 degrees F for a period of time, the laser requires up to 12 hours acclimatizing prior to operation. Laser will not operate at temperatures below 59 degrees.
- Only authorized personnel must service the laser.

PROCEDURE:

ASSEMBLE EQUIPMENT:

1. Collect necessary supplies per procedure card
2. Choose fiber wire specific for the Diomed Laser
3. Cart with laser and foot pedal to appropriate surgical suite
4. Goggles specific for Diomed Laser
5. Occlusive covers for window and doors of operating room.
6. Laser Specific Warning signs for doors of operating room.

START UP AND SELF TEST

1. Place Occlusive covers on operating room doors and windows to prevent laser penetration.
2. Make sure Laser Specific Warning Signs are on the outside of the operating doors.
3. Make sure all personnel and patient wear safety goggles when laser is in active mode.
4. Place the laser cart within 6 feet of the operating room table.
5. Connect the electrical power cord to the main power outlet.
6. Make sure footswitch is connected to the footswitch socket (line up red dots and insert).
7. Turn on power switch located on back of machine
8. Turn on laser with key switch on front of unit; the system will perform a self-test function to ensure the the unit is operating correctly. Make sure all the **LED** segments for **Power, Pulse** and **Interval are** illuminated
9. Connect the optical fiber to the laser aperture located on the right side of the unit as you are looking at it, ensuring that the SMA-905 connector is screwed "finger tight".
10. Highlight "**fiber**" press **Select**. Press **Select** to confirm the selection.

Title: **Endo Venous Laser Treatment**	
Scope: Surgery	Department: **Invasive Procedures, Operative, Preparation and Post Op (OOP), Surgery**
Source: DON Perioperative Services	Effective Date:

11. System will automatically go to **STANDBY** mode, with a default setting of continuous operating mode and 10W power.
12. If a non-contact fiber has been selected, select "calibration" from the Main Menu screen and follow the on-screen instructions to calibrate the fiber.
13. After calibration has been carried out successfully, set the Operating Mode. Pulse length and Pulse Interval or Fluency as required for the particular treatment per physician order.
    a. **Select Mode:**
    Continuous, Pulse or Repeat Pulse
    Rotate knob to increase or decrease the pulse duration in pulse and repeat pulse modes as per
    Fiber Mode
    0.1 to 9.9 seconds in 0.1 second increments in single pulse mode.
    0.1 to 1.0 seconds in 0.1 second increments in repeat pulse mode.
    b. **Select Power:**
    Rotate the knob to increase or decrease the output power in all operating modes:
    Fiber Mode
    0.5W to 5W in 0.5W increments
    c. **Interval:**
    Rotate the knob to increase or decrease the interval between the pulses in the repeat pulse mode:
    Fiber Mode
    0.1 to 1 seconds in 0.1-second increments
14. To start treatment and delivery of laser energy, press **READY/STANDBY**, wait for the Laser to enter **READY** mode and depress the footswitch. An audible warning will be heard during laser irradiation.
15. Note that the red aiming beam will automatically turn on once the laser has been set to READY. There is a brief delay before the aiming beam illuminates.
    NOTE: The Diomed Laser will automatically return to **STANDBY if treatment is paused for 3 minutes.**
16. To turn the Diomed laser off, turn the key switch and remove the key, and store in designated location.
17. Document Laser energy and pulses and time on patient record.
18. Dispose of used laser fiber wire in sharps container.
19. The designated Laser Nurse must remain in the location of the laser machine and be prepared to place the laser in **standby** when the fiber wire reaches the exit area to be sure the laser is inactivated before removal from the vein.
20. The designated Laser Nurse will complete the Laser Safety Checklist. The original of this form will remain in the patient chart, a copy will be placed in the Laser Log located in the Surgery Clerk office following the procedure.

AFTER USE OF LASER MACHINE:

1. Wipe outside of laser machine with hospital approved disinfectant including foot pedal.
2. The Laser Nurse should replace laser goggles in appropriate cases and store in laser cart to prevent inadvertent scratches or damage to goggles.
3. **Remove Key from laser** and store in designated location.
4. Remove laser signs and window coverings and store in appropriate location.
5. Return Laser Cart to appropriate location.
6. Restock used fiber wires as needed

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Endo Venous Laser Treatment**	
Scope: Surgery	Department: **Invasive Procedures, Operative, Preparation and Post Op (OOP), Surgery**
Source: DON Perioperative Services	Effective Date:

ERROR MESSAGES:

If an error message is displayed, refer to section 27 page 63 in the Laser manual. (Located on laser cart).

EMERGENCY SWITCH:
To shut down the laser immediately in case of emergency, press the RED BUTTON located on the front panel of main enclosure. After emergency switch activation, the key switch must be used to restart the system.

PRECAUTIONS:

1. Laser beam can be hazardous to the eye. Everyone in room must wear approved Goggles for specific laser.
2. Window and doors must be covered with darkened coverings.
3. Warning signs must be posted on outside of operating room doors.
4. Avoid skin exposure to direct or scattered radiation.
5. Sterile water will be available on the sterile field.
6. The Laser Footpedal will be placed by the physician's foot as close to the time of actual use as possible and no other footpedals will be in the vicinity of the Laser Footpedal.
7. Keep laser key in designated location when not in use- DO NOT LEAVE IN LASER.

SPECIAL CONSIDERATIONS:

Approval	**Date**
CCOC	4/2015
Surgery-Tissue committee	4/22/15
Medical Executive Committee	6/2/15
Board of Directors	6/17/15

INDEX: Diomed Laser/ Laser Diomed/ Endovenous Laser Treatment
Revised 1/2015 VK

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Malignant Hyperthermia Cart Check**	
Scope: **Nursing Services, Anesthesia, Emergency Dept, ICU/CCU, Medical Staff, Medical/Surgical, Nursing Administration, OB/Gyn, Outpatient, PACU, Pharmacy Services**	Manual: Clinical Practice
Source: DON Perioperative Services	Effective Date: 12/1/13

Purpose:

To insure availability of all drugs, equipment, and supplies necessary to initiate advanced life-support measures in a malignant hyperthermia crisis.

Policy:

1. One Malignant Hyperthermia cart will be kept in the Emergency Department for usage throughout Northern Inyo Hospital.
2. The Malignant Hyperthermia cart will be checked daily for outdates by the Emergency Department staff.
3. A listing of all Malignant Hyperthermia medications with drug outdates will be maintained by Pharmacy.
4. A listing of all supplies will be maintained by the Emergency Manager.
5. The Emergency Department staff checking the cart will be responsible for replacing expired supplies prior to the expiration date.
6. The Pharmacy staff will be responsible for replacing expired medications prior to expiration.
7. The Malignant Hyperthermia cart contents and QAPI will be overseen by the Resuscitation Committee.

Procedure:

1. An assigned Emergency Department staff member will check the Malignant Hyperthermia cart Monday through Sunday. (see attachment).
2. The Surgery Department staff / House Supervisor will use the Malignant Hyperthermia cart checklist (see attachment to check off the following):
    a. The 2 drawers will be checked for an intact lock.
    b. The refrigerator will be checked for an intact lock.
    c. The refrigerator will be plugged into a red outlet.
    d. The refrigerator temperature will be checked and recorded daily on Temperature Documentation sheet (see attachment 3).
        i. Action will be taken for any Temperature outside of range including notification of Pharmacy and Biomed.
    e. The Emergency Department staff will double check the pharmacy medication expiration dates.
        i. If ready to expire, notify Pharmacy.
    f. Supply equipment expiration dates will be reviewed on the Malignant Hyperthermia cart supply/equipment/medication list.
        i. Any supply/equipment due to expire will be replaced with the same item that is not outdated and the checklist expiration date is to be updated with the new expiration date.
    g. All external contents of cart (side and back) will be checked using the supply/equipment/ medication checklist and verified daily.
3. The Pharmacy will be responsible for maintaining all pharmaceuticals in the Malignant Hyperthermia cart.
    a. This includes the drugs on the Equipment/Supply/Drugs Malignant Hyperthermia Cart set up list.

Title: **Malignant Hyperthermia Cart Check**	
Scope: **Nursing Services, Anesthesia, Emergency Dept, ICU/CCU, Medical Staff, Medical/Surgical, Nursing Administration, OB/Gyn, Outpatient, PACU, Pharmacy Services**	Manual: Clinical Practice
Source: DON Perioperative Services	Effective Date: 12/1/13

b. Drugs to be included on the Malignant Hyperthermia Cart supplies/equipment shall be reviewed by the Resuscitation Committee then P&T Committee Annually.

4. Any request for change in the Malignant Hyperthermia Equipment/Supply/Drugs list shall be reviewed by the Resuscitation Committee.
5. The Malignant Hyperthermia Hotline may be called 24/7 at 1-800-644-9737 to manage a Malignant Hyperthermia crisis or view the crisis page on MHAUS.
6. Ice is available from all ice machines and ice machines in the first floor satellite kitchen.

Reference:

1. MHAUS (2013), http://www.mhaus.org/healthcare-professionals/be-prepared. FAQ's: Stocking a Malignant Hyperthermia Cart

Cross Reference P&P:

1. **Malignant Hyperthermia**
2. **Crash Cart**

Developed: 05/29/2013
Reviewed:
Revised: 10/16/2013

Approval	**Date**
Resuscitation Committee	11/2013
Surgery Tissue Committee	6/2/15
Medical Executive Committee	6/2/15
Board of Directors	6/17/15

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Shoulder Arthroscopy 3 Point Distraction System**	
Scope: Surgery	Manual: **Activity, Muscle Skeletal, Rest and Orthopedic (MAO), Surgery**
Source: DON Perioperative Services	Effective Date: TBD

PURPOSE:

The 3 Point Shoulder Distraction System maintains the patient's arm in optimum position for arthroscopic procedures.

POLICY:

This procedure shall be followed during shoulder arthroscopies utilizing the distraction device by perioperative staff under the direction of the operating surgeon.

EQUIPMENT:

Shoulder traction device and weights from 5-12#
Sterile STaR Sleeve
Vacuum beanbag support
Axillary roll available
Pillows
Safety Straps

Guidelines:

Position the patient using standard of care for the patient in the lateral decubitus position. Care should be taken to avoid excessive traction, as transient neuropraxia, presumably due to excessive strain on the brachial plexus has been reported.

Age specific considerations: Be cautious with elderly patients who have fragile skin.

PROCEDURE:

After patient is properly positioned on the surgery table, the 3-Point Shoulder Distraction System (AR-1600M) is positioned with the base of the assembly at the foot of the table opposite the operative shoulder on a standard "Clark rail" to allow abduction and flexion of the operative shoulder.

After the patient is properly prepped and draped, the sterile STaR Sleeve is measured and trimmed to fit by the surgeon. The reference position is neutral with the thumb facing the opening of the Star Sleeve and with the heel of the hand inside the sleeve. The foam overlaps one over the other protecting the superficial branch of the radial nerve. Cinch the wrist snugly with the straps. Do not pull remaining straps excessively tight to avoid compressing the median nerve. Attach the S hook to the D Ring. The D Ring is located where the white and yellow cables are permanently jointed into a circular ring like device.

Traction is placed through a suspended pulley system using 5-8-10 or 12 lb weights depending on the size of the patient, type of traction to be used, and doctor's specification.

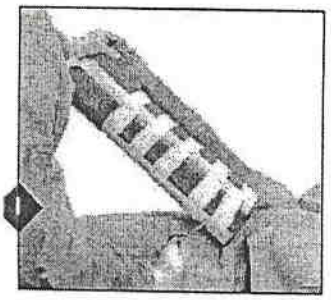
Surgeon will adjust the distraction device as needed. Weights are applied by circulator as directed by the surgeon. Adjustments to the distraction device during the procedure will be completed by the circulator as directed by the surgeon.

Use of the distraction device will be documented in the operative record.

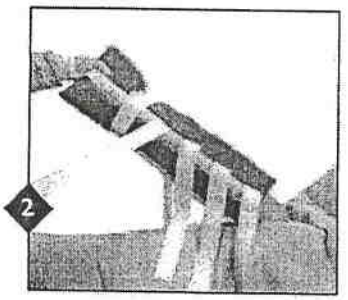
NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Shoulder Arthroscopy 3 Point Distraction System**	
Scope: Surgery	Manual: **Activity, Muscle Skeletal, Rest and Orthopedic (MAO), Surgery**
Source: DON Perioperative Services	Effective Date: TBD

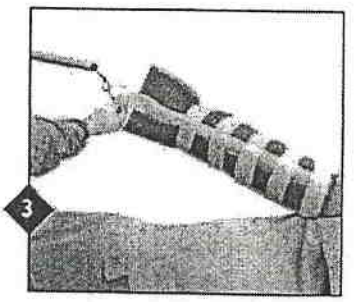
Directions for Use



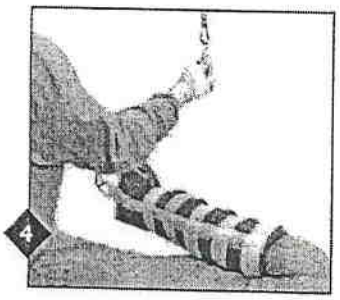
Measure the sleeve against the patient's arm so that the wrist and hand are positioned at the distal end of the sleeve. Trim the sleeve to extend no less than two inches inferior to the greater tuberosity.



Either wrap the supplied Coban™ wrap around the sleeve distal-to-proximal or open the Velcro straps and wrap them around the sleeve distal-to-proximal.

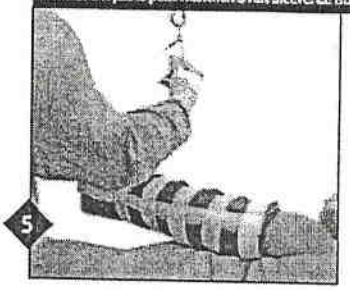


Attach the hook and cable (YELLOW) from the distal traction arm to the metal triangular ring on the end of the sleeve. Apply traction weights to the distal traction cable and position the traction arm for the optimum angle.



Hang a sterile S-hook from the clip of the horizontal traction cable (RED). If used, hang the traction scale from the horizontal traction cable (RED) and place the other sterile S-hook on the distal end of the scale.

The following directions do not apply to the Short STaR Sleeve. Die folgenden Anweisungen gelten nicht für die kurze STaR™ Armmanschette. Les instructions suivantes ne concernent pas le petit manchon STaR Sleeve. Le istruzioni seguenti non riguardano la guaina corta STaR™. Estas instrucciones no se aplican a la manga corta STaR Sleeve.



Place the triangular ring of the rotation control strap on the S-hook so that the strap hangs down.

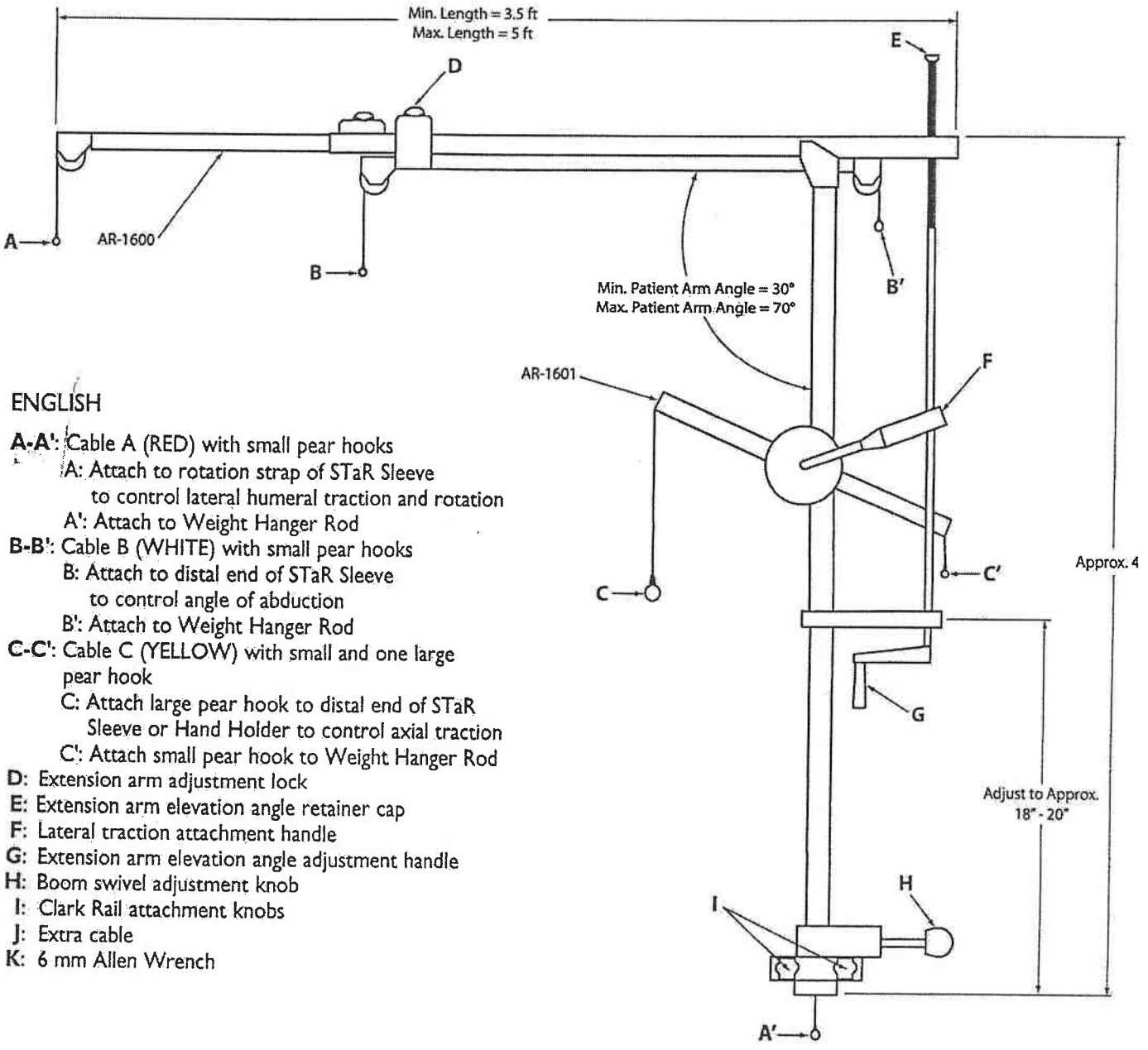
Open and straighten the rotation control strap. Attach the blue end underneath the sleeve. Pass the white end under the opposite side of the arm and affix it to the rotation control strap. Secure the full length of the upper portion of the strap to itself.

To control internal and external rotation during the procedure, loosen the Velcro strap, rotate the arm, and retighten the strap.

NOTE: Use the second sterile S-hook to maintain sterility if the rotation control strap is detached from the unsterile horizontal traction cable and needs to be reattached during the same surgical procedure.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Shoulder Arthroscopy 3 Point Distraction System**	
Scope: Surgery	Manual: **Activity, Muscle Skeletal, Rest and Orthopedic (MAO), Surgery**
Source: DON Perioperative Services	Effective Date: TBD



ENGLISH

A-A': Cable A (RED) with small pear hooks
- A: Attach to rotation strap of STaR Sleeve to control lateral humeral traction and rotation
- A': Attach to Weight Hanger Rod

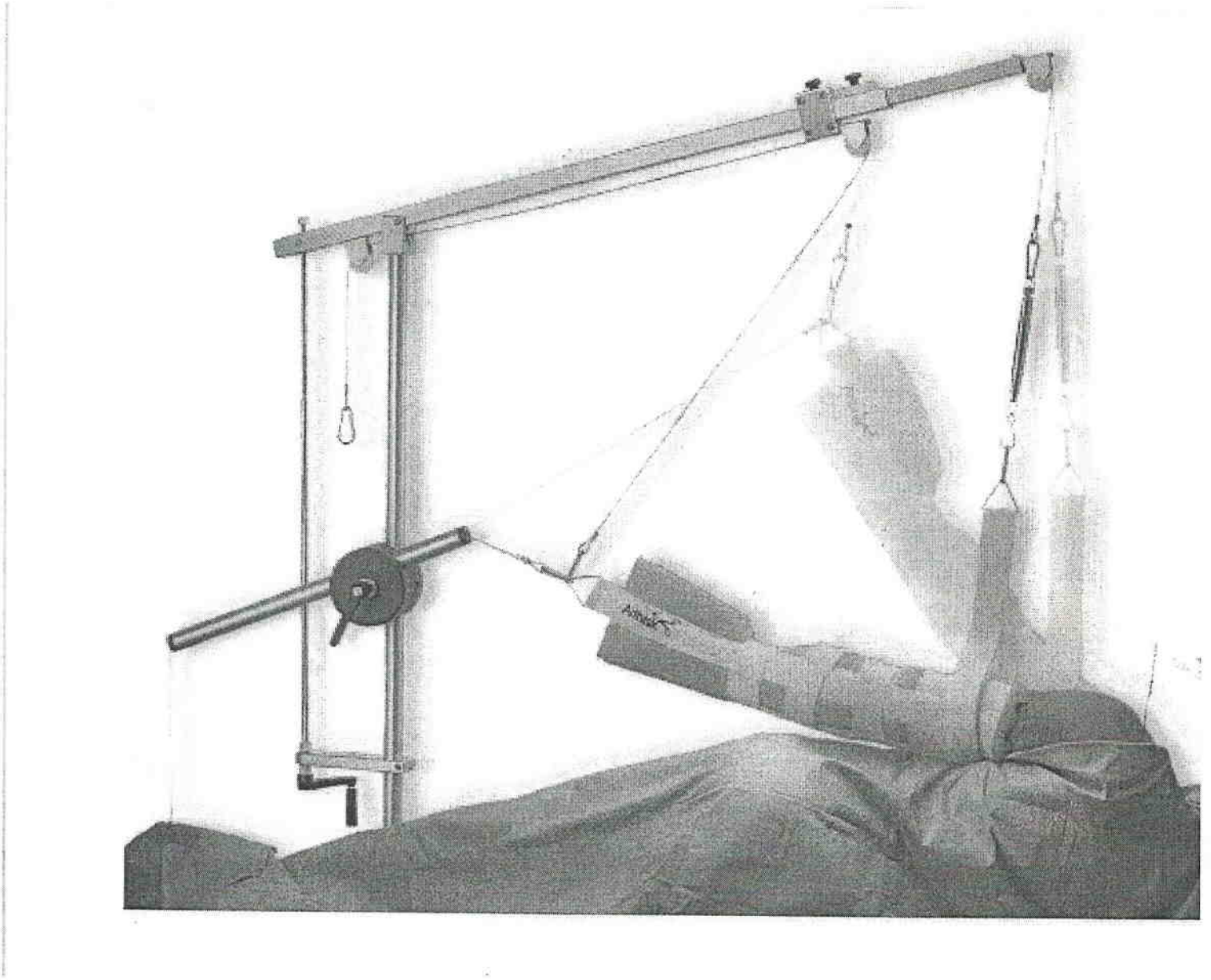
B-B': Cable B (WHITE) with small pear hooks
- B: Attach to distal end of STaR Sleeve to control angle of abduction
- B': Attach to Weight Hanger Rod

C-C': Cable C (YELLOW) with small and one large pear hook
- C: Attach large pear hook to distal end of STaR Sleeve or Hand Holder to control axial traction
- C': Attach small pear hook to Weight Hanger Rod

D: Extension arm adjustment lock
E: Extension arm elevation angle retainer cap
F: Lateral traction attachment handle
G: Extension arm elevation angle adjustment handle
H: Boom swivel adjustment knob
I: Clark Rail attachment knobs
J: Extra cable
K: 6 mm Allen Wrench

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Shoulder Arthroscopy 3 Point Distraction System**	
Scope: Surgery	Manual: **Activity, Muscle Skeletal, Rest and Orthopedic (MAO), Surgery**
Source: DON Perioperative Services	Effective Date: TBD



NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Shoulder Arthroscopy 3 Point Distraction System**	
Scope: Surgery	Manual: **Activity, Muscle Skeletal, Rest and Orthopedic (MAO), Surgery**
Source: DON Perioperative Services	Effective Date: TBD

REFERENCE:

1. *AORN Perioperative Standards and Recommended Practices*. (2014). Denver, CO, p. 491-492
2.. Alexander's Care of the Patient in Surgery. Thirteenth Edition. (2007). Mosby Inc., St. Louis, Missouri p. 155-156
3. Arthrex Shoulder and Elbow Repair and Reconstruction Technology. (2015). Arthrex Inc., Naples, Florida, p. 33
4. Arthrex 3-Point Shoulder Distraction System (AR-1600M) Assembly Instructions. (2010). Arthrex Inc., Naples, Florida, p. 1-3
5. Arthrex Shoulder Traction and Rotation STaR Sleeve Assembly Instructions. (2005). Arthrex Inc., Naples, Florida, p. 1-2
6. Snyder, S. (Presenter).(2015). *Arthrex 3-Point Shoulder Distraction System and STaR Sleeve Video* [VCD-1041]. Arthrex Inc. Rev. date 5/17/00

CROSS REFERENCES: Shoulder Arthroscopy 3 Point Distraction System, Shoulder Distraction Device, Distraction Device Shoulder

Approval	Date
CCOC	4/2015
Surgery Tissue Committee	4/22/15
Medical Executive Committee	6/2/15
Board of Directors	6/17/15

Developed: 1/03
Reviewed: 3/15
Revised: 3/15, 1/03 4/2015 BS
Supercedes: Shoulder Arthroscopy Traction Device

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Surgery Tissue / Bone Graft "Look Back" Policy**	
Scope: Surgery/Infection Control/Risk Management	Department: **Infection Control- Patient Care (ICP), Surgery**
Source: DON Perioperative Services	Effective Date: TBD

PURPOSE:

To ensure that tissue or bone graft recipients are notified in the event that the hospital is notified that a particular lot of tissue or bone was potentially contaminated with Human Immunodeficiency Virus (HIV), Human T-Lymphotropic Virus I-II (HTLV I-II), Viral hepatitis or other infectious agents known to be transmitted through bone/tissue.

To ensure that recipients are provided with information regarding testing, treatment and counseling.
To ensure that recipients are provided with information regarding the potential for transmission of infection to others.

POLICY:

If a patient has an infection or other identified health problem that could potentially be related to a bone/tissue implant, the Infection Control Officer/Safety Risk Manager will be notified, a Quality Review Report and Look Back Report will be completed and the appropriate bone/tissue bank will be notified of the nature of the problem, the type of bone/tissue used and the specific identification number associated with the bone/tissue. The Bone/Tissue Bank log will be reviewed for any additional bone/tissue from the same donor and it will be quarantined until appropriate investigative measures have approved its release or return to the appropriate bone/tissue bank.

If an individual has received potentially infectious tissue/bone from a donor who has tested positive for HIV or HCV since the time of donation, Northern Inyo Hospital (NIH) will initiate the "Look Back" policy, as soon as it is notified of the fact.

PROCEDRE:

1. Upon notification by fax and/or letter by the Bone/Tissue Bank to the Pathology Director and or Perioperative Director of Nurses at Northern Inyo Hospital that a potentially infectious tissue/bone product has been issued to the NIH Tissue/Bone Bank, the Pathology Director and or Perioperative Director of Nurses or their designee will immediately determine the disposition of the tissue/bone product.
2. If the product is present in the Surgery Bone/Tissue inventory, the assigned investigator will:
    A. Isolate the product and return it to BoneTissue Bank.
    B. Document the return in the Disposition Log.
    C. Complete a Look Back Report and Quality Review Report and have both documents signed by the Perioperative Director of Nurses and or Pathologist.
    D. File one copy of the Look Back report in the Laboratory and give one copy to the Safety/Risk Manager.
3. If the product has been implanted, the assigned investigator will:
    A. Complete the Look Back Report and Quality Review Report and will have both documents signed by the Perioperative Director of Nurses and/or Pathologist.
    B. File one copy of the of the Look Back report in the Perioperative Department, one copy with the Laboratory Manager, and give one copy to the Safety/Risk Manager.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Surgery Tissue / Bone Graft "Look Back" Policy**	
Scope: Surgery/Infection Control/Risk Management	Department: **Infection Control- Patient Care (ICP), Surgery**
Source: DON Perioperative Services	Effective Date: TBD

4. Upon notification, the Safety Officer/Risk Manager will:
   A. Make at least three attempts by a notification letter sent via certified mail to notify the attending physician and request that the physician immediately notify the individual of the need for testing, treatment and/or counseling.
   B. If the physician is unable or unwilling to notify the client, the Safety Officer will make three attempts to notify the client of the need for testing, treatment and/or counseling by letter sent via certified mail.
   C. Notification attempts will be documented on the Look Back report that was filed in the Laboratory.
   D. If the hospital is notified that a state court has declared the recipient legally incompetent, notice must be given to the legal representative of the client.
5. The timeframe for notification is as follows:
   A. HIV Look Back – complete within eight weeks
   B. HCV Look Back - complete within twelve weeks

Record Retention of all Look Back documents will be for at least ten years from the date of notification and will be accessible for retrieval within five working days.

References:

1. TJC (TS.03.03.01)Ca/CAH Functional Chapter Tissue

Committee Approval	**Date**
CCOC	4/2015
Surgery/Tissue Committee	4/22/15
Medical Executive Committee	6/2/15
Board of Directors	6/17/15

Revised 4/2015 BS
Reviewed 8/11 BS
Supercedes

Index Listings: Look Back - Bone/Tissue Graft; Bone/Tissue Graft - Look Back

Look Back Report

Tissue/Bone Bank

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Surgery Tissue / Bone Graft "Look Back" Policy**	
Scope: Surgery/Infection Control/Risk Management	Department: **Infection Control- Patient Care (ICP), Surgery**
Source: DON Perioperative Services	Effective Date: TBD

Date of Notification _____ Tissue/Bone Product _____

Reported by _____ Graft #/Exp _____

Purpose of Notice _____

_____

Graft Disposition:

_____ Tissue in Stock Date Quarantined _____ Date Returned to Tissue Bank _____

_____ Tissue Released Date Released _____

_____ Tissue Implanted Recipient _____

MR# _____ Date Implanted _____

Recipient _____

Date Transferred _____

_____

Director of Tissue Bank Service Date

_____

Safety/Risk Manager Date

Recipient's Physician of Record _____

Attempts to Notify

_____

Outcomes _____

_____

_____

Safety/Risk Manager Date

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Bone Graft Tissue Bank**	
Scope: Surgery, Materials Management	Department: **Invasive Procedures, Operative, Preparation and Post Op (OOP), Surgery**
Source: DON Perioperative Services	Effective Date: 11/16/2005

PURPOSE:
To ensure safe receipt, storage and preparation of freeze-dried and fresh-frozen human tissue or bone allograft for patient use.

POLICY:

1. All Tissue stored in this Tissue Bank will be purchased from a Tissue Bank Licensed in the State of California and a record of their donor screening and testing will be maintained.
2. The Perioperative Director of Nurses will be responsible for the tissue bank.
3. Freeze Dried Bone/Tissue Grafts will be stored in a designated area and maintained at ambient temperature of 15 degrees Celsius to 30 degrees Celsius, but not frozen. Temperature will be monitored and recorded daily.
4. Fresh Frozen Tissue Grafts shall be maintained in a designated bone freezer at -40 degrees Celsius to -86 degrees Celsius for long term storage; and between – 20 degrees to – 40 degrees Celsius for short term storage (fewer than six months)
5. Refrigerated grafts (Graft Jacket) will be maintained in designated refrigerator at 1degree to 10 degrees Celsius or 34 degrees to 50 degrees Fahrenheit per manufacturer information.
6. Refrigerator and Freezer units will be monitored and daily temperature checks recorded have annual calibration checks and have an alarm system that is continuously monitored and sounds when the temperature is not within the acceptable range. Freezer will be maintained on an emergency power system.
7. In case of a malfunction in the Freezer when the perioperative unit is closed, the nursing supervisor will receive a text message and they will notify the Biomedical Engineer on call and perioperative management personnel or Nurse on call. The integrity of the tissue will be evaluated and if necessary the tissue will be stored on dry ice or in the laboratory blood bank freezer until the problem is resolved.
8. Malfunction of refrigerator or freezer will be documented and tissue monitored to prevent compromise.
9. If malfunction of freezer and Tissue/Bone needs to be relocated to another freezer or stored temporarily:
    - Notify the laboratory for the need to add the frozen tissue/bone to their sub zero freezer.
    - Frozen Tissue/Bone may be transported in an ice chest with enough dry ice to touch the grafts on all four sides.
    - Use appropriate gloves suitable to keep from damaging your hands when handling the frozen tissue.
    - The tissue/bone in the ice chest will be transported to the laboratory for storage until the problem with the surgery tissue/bone freezer has been repaired and has met the appropriate temperature to maintain the integrity of the tissue/bone.
    - The tissue/bone will be transported back in an ice chest with enough dry ice to touch the tissue/bone on all four sides.
    - Tisseel (frozen pre-filled syringes) may also be transported in an ice chest with enough dry ice to maintain their integrity as noted above.
10. If tissue needs to be quarantined, affected tissue will be maintained in a colored plastic bag and segregated from all other tissue.
11. Restricted access to Tissue Banks is required to verify the safety and security of tissues.
12. All tissue will be entered into Tissue Log Book with appropriate information upon arrival (see procedure below).
13. Thawing and graft preparation will be done in accordance with package instructions and physician order.
14. The Tissue/Bone Bank Log will be reviewed weekly for accuracy by designated personnel.

Title: **Bone Graft Tissue Bank**	
Scope: Surgery, Materials Management	Department: **Invasive Procedures, Operative, Preparation and Post Op (OOP), Surgery**
Source: DON Perioperative Services	Effective Date: 11/16/2005

15. Perioperative staff responsible for receiving, removing, or logging any of the bone/tissue must have completed training and validation for the Bone / Tissue Bank.
16. There will be a tracer audit completed annually to ensure compliance with policy and procedure, noting any changes needed to meet 100% compliance.

PROCEDURE:

Weekly Bone/Tissue Bank Maintenance Check by assigned personnel

Tissue/Bone Freezer

- Freezer is secure and lock is in place
- Temperature is maintained at least -40 degrees Celsius
- Vent Filter is clean and free from lint
  (if needed rinse, pat dry with towel, air dry and replace)
- Daily temperature log is completed and graft is functioning properly

Freeze Dried Tissue Bank (stainless cart)

- Bank is secure and doors are closed
- Temperature is maintained at ambient temperature 15 degrees Celsius to 30 degrees Celsius
- Temperature chart is functioning properly and is documenting temperature of cart
- Cart is clean and free from clutter

Tissue/Bone Bank Log:

- Review log for accurate and complete documentation

Log In

- Date received
- Time received
- Tissue Bank
- Donor ID number
- Appropriate Log for Tissue/Bone type
- Expiration date
- Integrity "Met"
- Temperature
- Initials

Log Out

- Storage temperature
- Disposition of tissue/graft
- Date of disposition
- Patient hospital number
- Surgeon
- Implant record returned
- Reconstitution fluids and expiration date

Title: **Bone Graft Tissue Bank**	
Scope: Surgery, Materials Management	Department: **Invasive Procedures, Operative, Preparation and Post Op (OOP), Surgery**
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- Initials of person who completed the documentation

If documentation is incomplete or not accurate notify Perioperative Nursing Coordinator and person responsible for correction/completion.

Fresh Frozen Tissue Graft – Receipt and Storage:

1. At the time of scheduling a case, the Operating Room Clerk, shall notify the Surgical Nurse Coordinator or her designee of the need for a bone allograft. The Operating Room Clerk makes a note in the "notes" or "tasks" section in Operating Room Management Scheduling procedure notes. This information will print out on the surgery schedule alerting personnel of the need for an allograft. The need for an allograft also is printed out in the "notes"/"tasks" section on the physician case card for the procedure which is printed out the day prior to the surgical procedure. The Surgical Nurse Coordinator or her designee will ensure that the appropriate graft is in the inventory and available for use on designated day.
2. The designated freezer will contain a minimal consignment of fresh frozen bone. If desired graft is not stored in this freezer, the tissue bank will be called at least two days prior to the scheduled surgery to confirm proper shipment date and time. The allograft will be scheduled to arrive in time to perform the surgical procedure.
3. The bone graft shall be ordered from and the delivery scheduled with the tissue bank of choice. Fresh Frozen Grafts shall be shipped by Overnight Carrier.
4. Purchasing shall be notified of the expected arrival time and shall be given instructions to immediately deliver the package to Surgery due to the strict temperature requirements.
5. Storage requirements: Refer to Manufacturer requirements.
   a. Freeze dried ambient temperature 15 degrees Celsius to 30 degrees Celsius.
   b. Fresh Frozen -40 degrees Celsius to -86 degrees Celsius (laboratory/surgery sub zero freezer)
   c. Shoulder graft 36 degrees to 50 degrees Fahrenheit (2.2 degrees Celsius to 10 degrees Celsius) to be stored in the designated refrigerator in the perioperative unit.

Fresh Frozen Tissue Graft – Preparation:

Remove desired graft from freezer immediately prior to use as requested by surgeon:

- **Always refer to graft information included with graft prior to preparation.**

1. Remove the outer clear plastic pouch. This may performed by using scissors and cutting along any border seam of the outer pouch. Use caution to avoid cutting the peel pouch. **Once the outer pouch has been compromised, the allograft shall be transplanted or discarded.**
2. Utilizing sterile technique, open peel pouch and pass sterile inner plastic pouch onto the sterile field.
3. With sterile scissors, open inner sterile plastic pouch and place contents into a sterile basin with thawing solution. **Thaw grafts quickly in warm solution 37 to 40 degrees Celsius (98.6 to 104 degrees Fahrenheit)** containing antibiotics if the surgeon's preference. **(DCI'S recommends culturing of the allograft at this time, immediately prior to implantation).**

- **Allow at least 30 minutes for the graft to fully thaw. Once thawed, all frozen allografts must be used immediately or discarded. Thawed allografts may not be returned to DCI or the Tissue/Bone Freezer.**

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- **DCI'S grafts are processed using some or all of the following agents; Bacitracin, Polymyxin B Sulfate, Allowash, Alcohol, or Hydrogen Peroxide. Although the tissue was rinsed with sterile water or sterile saline throughout the processing procedure, traces of the medication and chemicals may remain.**

FREEZE DRIED TISSUE/BONE ALLOGRAFT:

Freeze dried bone/tissue graft will be reconstituted if necessary per **bone bank instruction specific for each type of tissue/bone graft. (See literature supplied with each type of tissue/bone graft).**

DCI'S Bone Bank Rehydration:

1. Remove the clear plastic, tamper resistant seal or aluminum tear ring. Once seal has been broken the tissue shall be either transplanted or discarded.
2. Utilizing sterile techniques, twist open and remove the screw cap, or remove the protective disk from the bottle.
3. Prepare the top surface of the stopper with alcohol or other germicidal agent and allow to dry.
4. Using a sterile syringe and needle, inject a sufficient quantity of the normal physiologic solution to cover the allograft.
5. Allow the allograft adequate time to fully rehydrate prior to use. **Generally, morsellized allografts and soft tissue allografts require 30 minutes for complete rehydration. Cortical bone and allografts that require further shaping and/or drilling should be rehydrated for a minimum of 4 hours.** Once rehydrated, allografts must be used immediately or discarded. **Rehydrated allografts may not be returned to DCI.**
6. At the time of surgery, aseptically complete vacuum release from bottle and remove sterile stopper.
7. Transfer the contents to a sterile back table. The graft may be rehydrated on the back table in a sterile basin by transferring the graft in the dehydrated state using sterile technique.
8. DCI'S recommends culturing of allograft at this time, immediately prior to transplant.

ALLO SOURCE Graft Preparation:

- **Always refer to graft information included with graft prior to preparation.**

1. To reconstitute cancellous products, crushed bone, ground bone, place graft in sterile basin and cover with sterile isotonic solution for a minimum of 30 minutes.
2. To reconstitute tricortical wedges, struts, cortical products, place graft in a sterile basin and cover with sterile isotonic solution for a minimum of 2 hours.
3. **Refer to manufacture literature for further information.**

MTF (Musculoskeletal Transplant Foundation) Graft Preparation:

- **Always refer to graft information included with graft prior to preparation.**

The decision to rehydrate MTF freeze-dried bone prior to transplantation should be based upon the surgeon's preference. Bone chips, powders and granules do not need to be rehydrated prior to use. For tissues that are to be cut, shaped, drilled or used for weight bearing purposes, excessive forces should

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not be applied to the lyophilized bone during manipulation or upon implantation. For ease of handling, it is recommended that freeze-dried soft tissue (tendon and ligaments) be rehydrated prior to use.

1. Allograft tissue should be maintained in an aseptic environment at all times to prevent the possibility of contamination.
2. It is common surgical practice to rehydrate freeze-dried tissue in an acceptable sterile irrigant such as normal saline or lactated ringer's solution. Antibiotics may be used with the irrigant according to the surgeon preference.
3. Patient sensitivity to the antibiotics used to rehydrate allograft tissues should be checked prior to use. Concentration of antibiotic solutions should be less than normally indicated for IV administration.
4. Use new solutions for **each allograft**.
5. Sufficient solution should be prepared to completely cover the tissue.
6. Tissue that is rehydrated for more than two hours should be stored at 4 degrees Celsius to 8 degrees Celsius (39.2 Fahrenheit to 46.4 Fahrenheit).
7. Tissues should be implanted or discarded within 24 hours of opening the final tissue container provided the allograft tissue is maintained in an aseptic environment.

DOCUMENTATION:

1. Record the following information in patient's medical records:
   a. The date and time of thawing.
   b. Product description including the sticker provided by manufacturer.
   c. Expiration date of tissue.
   d. Unique identification number noted on graft packaging.
   e. Time of implantation.
   f. Cutting or shaping performed on graft.
   g. Solution type and lot number for reconstitution of graft.
   h. Use of antibiotics and their concentration.
   i. Culture of graft if ordered by surgeon.
   j. Any other relevant information.
   k. Signature of the person recording the information.
2. Records must be retained for minimum of 10 years
3. Daily temperature chart must be kept for 10 years

LOGGING IN TISSUE:

Integrity of packaging is "Met" by the following criteria:

- The package is visually inspected for any signs of damage.
- The package is in intact with no signs of damage or tears.
- The package is clean and free from debris.
- The freeze dried package has maintained its temperature during transport.
- The frozen tissue/bone was maintained with enough dry ice to support the desired temperature of -40 degrees Celsius during transport.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

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Source: DON Perioperative Services	Effective Date: 11/16/2005

All Tissue/Bone Graft material will be logged in upon arrival and monitored for:

1. Make sure the tissue is logged on appropriate form for the tissue type
2. Date of arrival
3. Time of arrival
4. Tissue Bank Name
5. Identification number (donor ID number)
6. Expiration date
7. Packaging integrity "Met" upon arrival
8. Temperature
9. Initials of person logging in graft

LOGGING OUT TISSUE/BONE:

1. Temperature
2. Disposition of graft
   - Implanted
   - Disposed of and how – Tissue bank must be notified of disposition of bone/tissue even if disposed of due to expiration or contamination
   - Returned to Company
3. Date
4. Patient hospital number
5. Surgeon
6. Implant record returned
7. Reconstitution solutions
8. Initial of the person signing out the graft

References:
TJC: TS.03.01.01, TS.03.02.01, TS.03.03.01 CACAH Functional Chapter: Transplant Safety

Committee Approval	Date
CCOC	4/2015
Surgery-Tissue Committee	4/22/15
Medical Executive Committee	6/2/15
Board of Directors	6/17/15

Revised: 3-07-09, 04-2015BS
Reviewed 2-14-11
Supercedes 02/01

Index Listings: Bone Graft Tissue Bank, Tissue Bank

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Bone Graft Tissue Bank**	
Scope: Surgery, Materials Management	Department: **Invasive Procedures, Operative, Preparation and Post Op (OOP), Surgery**
Source: DON Perioperative Services	Effective Date: 11/16/2005

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Utilization Review Plan**	
Scope: Hospital Wide	Manual: Case Management, Utilization Review
Source: DON Case Management	Effective Date:

PURPOSE:

The purpose of this plan is to identify the elements of a comprehensive utilization review management plan which is necessary to satisfy Medicare Conditions of Participation. This plan is coordinated to support Northern Inyo Hospitals (NIH) mission and vision by collecting and reviewing data that assures the appropriate allocation of hospital resources and specifically monitoring the necessity for appropriateness of hospitalization extended length of stay and the quality of this interaction. This plan provides framework for addressing under and over utilization of resources as well as the review of treatment to determine that the care provided meets professionally recognized standards of care.

POLICY:

1. NIH's UR plan applies to all patients regardless of payment source and all admissions are reviewed in accordance with federal and state regulations governing Utilization review.
2. Findings and recommendations of the Utilization Review Committee are reported to the Medical Executive Committee. Additional issues can be referred to Billing Coding Compliance Committee.
3. The UR plan shall be reviewed and evaluated by the Utilization Review Committee and the Medical Executive Committee at least once a year and revised as needed.

DEFINITIONS:

1. **Utilization Management Plan** means the organizational plan that contains the essential requirements for the establishment and implementation of a utilization management process to ensure the quality, appropriateness and efficiency of care and resources furnished by the facility and medical staff. The purpose of this plan is to ensure that patients at Northern Inyo Hospital receive medically necessary and appropriate care at the appropriate time and in the appropriate setting.
2. **INTERQUAL Criteria** means clinical decision support guidelines licensed for use by hospitals to evaluate the appropriateness of medical interventions and level of care based on clinical criteria and standards.
3. **Secondary Review** means a clinical review performed by a physician member of the Utilization Review Committee or a Physician Advisor when INTERQUAL guidelines suggest a different patient status or level of care than that ordered by the patient's Physician and/or a potential quality concern.

PROCEDURE:

Overview:

A developed plan that contains

- Delineation of responsibilities and authority of personnel for conducting internal utilization review.
- Establishes procedures to review the medical necessity of admissions, extended stays, and professional services, and appropriateness of settings.
- Establish procedures for coverage determinations, denials, appeals, and peer review within the organization.
- Establishes reporting, corrective action and documentation requirements for the utilization management process.

Plan Requirements

- Commitment and cooperation from the hospital administration and Medical/Hospital staff.
- Objective Review Criteria
- Maintenance of appropriate data
- Integration of UR findings into quality improvement activities
- Patient record access appropriate for Utilization review

Composition – See ***Medical Staff bylaws***

- The Utilization Review committee is a standing committee of the medical staff and is responsible to the Medical Staff Executive Committee. The committee shall comprise two or more physicians and other practitioners to perform the utilization management function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in 482.12(c) (1). The Utilization Review and Medical Records Committee shall consist of at least 4 active staff members selected on a basis that will ensure insofar as feasible, representation of the services and the major clinical specialties which are routinely practiced by Practitioners at Northern Inyo Hospital.
    - The Quality Improvement Coordinator, the Utilization Review/Infection Control Coordinator, the Director of Nursing, Billing Department Supervisor, Director of Medical Records, DRG Coordinator, the Hospital's Patient Representative, and Social Service Director shall serve as Ex Officio non-voting members.
- The UR committee may be supported by representatives from Case Management and Administration, but only physicians and other practitioners are members for regulatory purposes.
- No person with a direct financial interest may participate in reviews conducted by the Committee.

Meetings

- The UR committee shall meet as a separate and distinct committee with its own agenda and minutes. The committee shall meet as often as necessary to accomplish primary functions, but no fewer that quarterly.
- Committee minutes shall be maintained according to hospital policy and include the date/time of the meeting, attendees, standard reports, action item follow-up, focused reviews, audits, and action to be taken. The minutes shall exclude patient or physician names.

Standard Reports

- Length of Stay
- Avoidable Days
- Appeal Outcomes
- Denials
- INTERQUAL review results (Cases or number of days that do not satisfy criteria for admission, continued stay and/or level care, and secondary reviews results)
- # of Admission Hospital Issued Notice of Non-coverage (HINN) letters issued
- Observation information, including the number of observation stays converted to inpatient, average length of stay (hours) and the number exceeding 48 hours.
- Condition Code 44

Authority and Responsibility

- **UR (Case Management) Committee Chair**

- Assigns responsibility for medical necessity secondary review process
- Evaluates the effectiveness of utilization management activities
- Reports evaluation results and/or issues to appropriate committees.

➢ **Utilization Review Committee**

- Provides oversight to assure that health care furnished at Northern Inyo Hospital is consistent with professionally recognized quality standards.
- Provides oversight to assure consistently appropriate and medically necessary treatment for patients.
- Evaluates and acts upon peer review information related to medical necessity, appropriateness of treatment and quality of care.
- Provides for confidentiality of the peer review process and findings.
- Provides focused review and reporting mechanisms or identified utilization management problems
- Arrange for two or more appropriate practitioners to perform UR functions
- Schedule meetings with appropriate minutes and committee activity.
- Provides annual review, evaluation and approval of the plan by both the UR and Medical Executive Committee.

➢ Duties: The Utilization Review and Medical Records Committee shall perform the following functions:

- Delineate the scope of utilization review provided within the hospital
- Develop critical indicators to be used as screening devices in reviewing the utilization of Hospital Services.
- Establish thresholds used to trigger physician review.
- After cases have been isolated using the critical indicators, evaluate the quality and appropriateness of care administered and identify areas for improvement.
- Review patient care services to ascertain if quality care within the standards of the Hospital and Medical Staff is being provided in the most cost-effective manner, address overutilization, underutilization, and inefficient scheduling of care and resources.

➢ **Case Management Staff**

- **Director**: The Director of Case Management, under the direction of the Utilization Review Committee, has responsibility for the following activities:
  - Delegates responsibilities to appropriate personnel to ensure coverage for determining appropriate patient status.
  - Provides guidance to the medical staff and hospital personnel regarding medical necessity criteria and appropriate service determinations
  - The process of measuring and assessing the use of professional care, services, procedures, and facilities, including the medical necessity and appropriateness of:
    - Necessity of admission
    - Level of care
    - Appropriate utilization of resources
    - Continued stay
    - Discharge/post hospital referrals
    - Readmissions
    - Performance improvement team activities to improve systems and processes associated with inefficient or inappropriate delivery of care and services.
- **Case Manager (the role is titled Assistant Director of Nursing):**

- Reviews medical record documentation to obtain information necessary for UR determinations
- Screens patients from time of admission for potential discharge and aftercare needs
- Applies utilization review criteria objectively regarding level of care using INTERQUAL guidelines on all admissions and continued stays regardless of payer.
- Reviews all continued stays and addresses all concerns with attending physician/hospitalist
- If admission criteria are not satisfied, the reviewer shall contact the attending physician for additional information. If additional information is provided to support the admission satisfies admission criteria, the admission shall be approved.
  - If additional information is not provided or the case still fails to satisfy admission criteria, an alternate level of care (ALOC) shall be discussed with the attending physician. If the attending physician agrees that an ALOC is appropriate, the Case Manager shall facilitate the transfer. If the attending does not agree to transfer to an ALOC, the case shall be referred for secondary review.

- **Secondary Review Process**
  - When an admission or continued stay case is referred by the Case Manager to a member of the committee for secondary review, the reviewer shall review the case based on the documentation in the medical record and discussions with the attending physician in order to determine medical judgment. Secondary review determinations shall be documented and supported with clinical rationale.
  - If the physician member of the UR committee determines that an admission or a continued stay is not medically necessary, the Case Manager will be contacted and provided instructions on the appropriate level of care. Any determination to transfer a patient from the inpatient level of care to the observation level of care resulting from the secondary review process must involve a physician of the UR committee and must also comply with the requirements of Condition Code 44.
  - If the UR committee or designee decides that continued stay in the hospital is not medically necessary, the designee must give written notification to the hospital, the patient, and the practitioner responsible for the care no later than two (2) days after the determination. (*See Hospital Coverage Notices for Medicare Inpatients*)

REFERENCES:

1. A-0308
   a. **§482.30 Condition of Participation: Utilization Review**
2. A-309
   a. **§482.30(a) Standard: Applicability**
3. A-0310
   a. **§482.30(b) Standard: Composition of Utilization Review Committee**
4. A-0311

Title: **Utilization Review Plan**	
Scope: Hospital Wide	Manual: Case Management, Utilization Review
Source: DON Case Management	Effective Date:

   a. **§482.30(c) Standard: Scope and Frequency of Review**
5. A-3012
   a. **§482.30(d) Standard: Determination Regarding Admissions or Continued Stays**
6. A-0313
   a. **§482.30(e) Standard: Extended Stay Review**
7. A-0314
   a. **§482.30(f) Standard: Review of Professional Services**
8. TENET Utilization Management Plan

CROSS REFERENCE P&P:
1.
2.
3.

Approval	Date
UR Committee	5/28/15
UR Physician	3/15
MEC	6/2/15
Board of Directors	6/17/15

Developed: 2/15
Reviewed:
Revised:
Supercedes:

Responsibility for review and maintenance:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Organ/Tissue/Eye Donation	
Scope: NIH	Manual: CPM
Source: Resuscitation Committee	Effective Date:

PURPOSE: To ensure that recovery and donation procedures are established, current and monitored.

POLICY:

1. Northern Inyo Hospital (NIH) will have an agreement with the California Transplant Donor Network (CTDN), the designated organ procurement agency for California.

2. NIH will contact CTDN in a timely manner (within at least one hour) about individuals who die or death is imminent.

3. CTDN will direct care to preserve tissue viability and serve as a resource.

4. A person may deed his/her body to be donated for research only if prearrangement has been made prior to death.

5. Eye recovery may be completed in any patient care area.

6. Imminent death must be reported to CTDN.

7. All deaths must be reported to CTDN.

8. NIH will collaborate with CTDN to educate staff on donation issues, reviewing death records to improve identification of potential donors and maintaining potential donors while necessary testing and placement of organs and tissues take place.

DEFINITIONS:

Brain Death: Total and irreversible cessation on all brain stem function including the brain stem and maintained on cardiopulmonary support system. Potential types of donation: heart, lung, liver, pancreas, kidneys, and intestines, along with eyes, skin, bone, veins, connective tissues, heat for valves.

Cardiac Death: Irreversible cessation of cardiac/respiratory function. Potential types of gifts recovered after Cardiac Death includes eyes, skin, bone, vessels, connective tissues, heart for valves.

Imminent Brain Death: A patient with a severe neurological injury and:

1. Who requires mechanical ventilation; and

2. Has clinical finding consistent with a Glasgow Coma Score (GCS) that is less than or equal to five (5); or,
   a. For whom physicians are evaluating a diagnosis of brain death;
   b. For whom a physician has ordered that life-sustaining therapies be withdrawn, pursuant to the family's decision; or
   c. Has lost two or more brain stem reflexes (no papillary response, no corneal reflex, not response to cold calorics, no doll's eyes, no cough/gag).

Title: Organ/Tissue/Eye Donation	
Scope: NIH	Manual: CPM
Source: Resuscitation Committee	Effective Date:

Legal Next of Kin: (In descending order):

- Agent
- Spouse
- Adult Child
- Parent
- Adult Sibling
- Adult Grandchild
- Grandparent
- Legal Guardian/Conservators
- Adult exhibiting special care/concern
- Other person with authority to dispose of the decedent's body

PROCEDURE:

A. At the time of cardiac death or imminent death (for patients on ventilators), the RN will check the chart for advance directives which expresses the patient's wishes with respect to organ and/or tissue donation. If the advance directive states that the patient does not wish to make an anatomical gift at the time of death, referral will be made to CTDN in order to inform CTDN of the patient's wishes.

B. Notification of Imminent & Cardiac deaths to the Donor Network at 1-800-553-DONO (800-553-6667). Ventilated patients will be triaged as organ referrals and non-vented as tissue referrals.

- For the patient on mechanical ventilation, the House Supervisor (HS) or designee will notify CTDN when criteria for imminent death have been met (GCS of 5 or less, or agreed upon clinical cues) or when there is discussions regarding the discontinuation of mechanical and/or pharmacological support.

- For the patient who is not on mechanical ventilation, the HS or designee will notify the Donor Network (1-800-55Donor) at the time of cardiac death.

- CTDN will determine medical suitability for organs tissue & eye donation.

- A CTDN Transplant Coordinator (via the Donor Network referral line) is available 24 hours a day to:
  1. Approach legal next of kin to offer the option of organ/tissue donation
  2. Assist in the clinical management of the potential donor
  3. Notify coroner and secure authorization for donation

C. Consent for Donation

- Consent from Legal Next of Kin:

Title: Organ/Tissue/Eye Donation	
Scope: NIH	Manual: CPM
Source: Resuscitation Committee	Effective Date:

1. The request for anatomical donation will be made by the Transplant or Family Resource Coordinator from CTDN or by a designated requestor trained by CTDN (House Supervisor).

2. The on-site CTDN Transplant Coordinator will evaluate all patients on ventilators referrals for appropriateness of organ donation.

3. Request for donation will occur only after declaration of brain death or, in the case of organ donation after cardiac death, after the decision has been made to withdraw life support.

4. For the patient who is considered an appropriate candidate for organ donation, the CTDN Coordinator will meet with the family to provide support, answer questions, and offer the option of organ and tissue donation.

5. For the patient who is not on mechanical support: the CTDNN Donor Coordinator will contact the legal next of kin by phone after expiration to request donation of tissue and/or eyes.

6. In order to honor the patient's wishes, the HS reviews the chart at the time of death to insure that the patient did not decline anatomical donation in an advance directive. In the absence of an anatomical gift made prior to the donor's death, approval for donation must be obtained from the attorney-in-fact under a valid Durable Power of Attorney for Health Care that expressly authorizes the attorney-in-fact to make an anatomical gift of all or part of the principal's body. If there is no Durable Power of Attorney for Health Care giving such authorization approval must be obtained from the legal next-of-kin which is defined in the following order: spouse, adult children, parents, adult siblings, grandparents, guardian or conservator.

7. In all instances, discretion and sensitivity to the family circumstances shall be encouraged in all discussions regarding donation of organs and tissues.

8. The deceased individual's religions and cultural beliefs or obvious non-suitability for organ and tissue donation must be considered.

9. The following consents are legal in the State of California:
   a. A donor card, a donor registry form, will, or other authorization form signed by the donor.
   b. Signed authorization of the attorney-in-fact or the legal next-of-kin for Contribution of Anatomical Donation.
   c. If recorded telephone consent from the legal next-of-kin is obtained by CTDN staff a transcription of the consent will be sent to the hospital for inclusion in the permanent record. In the case of tissue and/or eye donation, a recorded telephone consent will archived. A transcribed copy of the consent will be sent via facsimile to NIH Registration for inclusion in the permanent record.

10. The signed consent form is maintained with the Medical Record.

D. Coroner Authorization

- If the deceased falls under the jurisdiction of the coroner, the coroner must be advised that a request for anatomical donation has been made. The coroner's authorization must be obtained before proceeding with donation.

- The CTDN Transplant Coordinator will notify the coroner at the completion of the organ recovery if applicable.

E. Hospital authorization following diligent search for next of kin for Brain Dead Donors.

- The hospital may authorize anatomical donation only if there is no family available or known. Every effort must be made to locate the next-of-kin by examination of personal effects, questioning of acquaintances and communication with local police regarding missing person records. By statute, the search must be thorough and must be in progress for a minimum of 12 hours (California Health and Safety Code, Section 7151.5) Hospital authorization following diligent search will apply to brain dead donors only.

F. Organ Donation following brain death

- Donor Criteria and Donor Maintenance

1. Organ donation can take place after brain death has been established, and the potential donor is maintained on organ support systems.

2. A person shall be pronounced brain dead if it is determined by a physician that the person has suffered a total and irreversible cessation of brain function. There shall be independent confirmation of the brain death by another licensed physician. These physicians may not participate in or have any contingent interest in organ transplantation that may follow. Likewise, any member of the transplant team cannot be involved in the diagnosis of brain death.

3. A reasonably brief period of time will be afforded the family or next to kin to assemble at the patient's bedside between the time the physicians declare brain death and discontinuation of cardiopulmonary support. During this time only previously ordered cardiopulmonary support will be provided. No other medical intervention is required.

4. Donor Maintenance

   a. The donor will be maintained on organ support systems and cared for by hospital and CTDN staff until the transplant teams have arrived and the organ recovery surgery is completed. The Transplant Coordinator from CTDN may write orders for donor maintenance after brain death has been declared.

b. Appropriate consultations and clinical tests will be provided to ensure suitability of the organs, e.g. bronchoscopy, echocardiograms, and chest x-rays, biopsies, etc.

c. Mechanical support will be discontinued in the OR after organ recovery.

5. Organ Recovery

a. Perioperative Services will provide an OR suite, anesthesia support, one scrub tech/RN and one circulating tech/RN

b. The CTDN Coordinator will work closely with the OR staff to schedule the organ recovery procedure in the OR.

6. Medical Center Reimbursement: All charges that are incurred from the time the patient is declared brain dead and consents obtained, including the operating room fees, shall be billed to the California Transplant Donor Network.

G. Organ Donation after Cardiac Death (DCD) following the decision to withdraw life support.

- Donor Criteria and Donor Maintenance

1. Organ donation can take place following cessation of cardiopulmonary function when a patient or the legal next of kin has elected to withdraw life supporting therapy. Candidates for organ donation after cardiac death will meet the following criteria:

a. The patient has a non-recoverable illness or injury that has caused neurologic devastation though the patient does not fulfill the criteria for brain death, and/or patient has other system failure resulting in ventilator dependency and meets the criteria for imminent death.

b. The patient of legal next of kin has elected to withdraw life support following discussion with the physician. The referral to CTDN will occur as outlined above in section one.

c. The patient is expected to expire within one hour of the withdrawal of life support.

d. The patient has a known cause of injury or illness and no known medical conditions that would exclude organ donation. The patient has inadequate respiratory effort to maintain life when disconnected from the ventilator. Such determination will be made by the CTDN Coordinator. If the case falls under the jurisdiction of the coroner, the Transplant coordinator will contact the coroner to request authorization for organ donation.

2. Referral to CTDN and consent for organ donation after cardiac death.

   a. When there are discussions regarding the withdrawal of life support, signaling imminent death, a timely referral to CTDN will take place as outlined above in section one.

   b. The CTDN Coordinator will evaluate the patient for suitability for DCD. The evaluation for DCD will include Glasgow Coma Score, presence or absence of brain stem reflexes, laboratory findings, medical/social history, use and amount of vasopressor medication and assessment of respiratory drive.

   c. If the patient is determined to be a candidate for organ donation after cardiac death, and the legal next of kin has made a decision to withdraw life support, the CTDN Coordinator will present the option of organ donation to the family. The decision to withdraw support must be made independently of and prior to any decision to donate organs. The family will be informed of all aspects of the donation and recovery process and appropriate consents will be obtained.

   d. Support and counseling will be provided to the donor family. Case Management may be directly involved with CTDN and critical care staff in caring for families. The CTDN Family Care Advocate will provide continuing family care after completion of the organ recovery.

   e. If the legal next of kin consents to DCD, consent will also be obtained for any other procedures or medical interventions performed for the purpose of organ donation prior to the determination of death, e.g. administration of Heparin prior to death.

3. Donor Maintenance

   a. Diagnostic studies will be performed by hospital staff to determine suitable organ function and interventions to optimize organ function may also be done following the family's consent.

   b. The medical center physician and care team will continue to write and implement orders during the evaluation and prior to withdrawal of care. CTDN shall not write any orders.

4. Withdrawal of life support in the OR and pronouncement of the patient

   a. Perioperative Services will provide an OR suite, one scrub tech/RN and one circulating tech/RN. Anesthesia support is not necessary.

   b. The CTDN Coordinator will work closely with the OR staff to schedule the recovery procedure in the OR.

c. When the transplant team is assembled, the patient will be transported to the OR while still on mechanical ventilation. Up to four members of the family will be allowed to accompany the patient to the OR entrance then the family will be escorted by the Family Resource Coordinator from CTDN to a consultation room.

d. The organ recovery team (surgeons and other transplant center personnel) are prohibited from entering the operating room once the patient has been transferred into the room. The recovery team may not enter the OR until the patient has been declared cardiac dead by the hospital medical team. The patient will not be discharged from the system until death occurs. The patient's physician, RTP and an ICU nurse will accompany the patient to the OR and stay with the patient until pronounced dead. The RN caring for the patient will administer any medications needed by palliation. CTDN staff will assist with transport. The patient will be draped and prepared for recovery.

e. Once the patient has been prepared and organ recovery equipment and supplies are in place, the transplant recovery teams will leave the room and wait in a designated area until the patient has been pronounced. After pronouncement, the transplant teams may re-enter the OR for organ recovery.

f. Medication for patient comfort up to and during the withdrawal of support will be administered in accordance with established practice of the physician.

Extubation will be performed by the patient's physician.

g. Pronouncement of death will occur when the following conditions are met: 5 minutes of apnea AND 5 minutes of asystole or a rhythm consistent with irreversible cessation of circulatory function, e.g. pulseless electrical activity or ventricular fibrillation, demonstrated by cardiac monitoring.

h. The organ recovery will then proceed.

i. The patient's physician or attending physician will document the date and time of death in the medical record and will complete the death certificate if applicable.

j. If the patient's death does not occur within the designated timeframe, the recovery effort may, at the discretion of the transplant team, be terminated. The patient will then be transported back to their room where the attending physician will direct patient care. The House Supervisor or designee will notify the Donor Network (1-800-553-6667) within an hour of asystole to close out the referral.

5. Medical Center Reimbursement: All charges related to the evaluation and recovery or organs for transplantation, incurred after the DCD disclosure form has been signed by the family including the operating room fees and work up started, shall be billed to the California Transplant Donor Network, 1000 Broadway, Suite 600, Oakland, CA 94607.

6. The patient's attending physician shall not be paid or reimbursed by, nor associated with or employed by CTDN. The patient's attending physician shall not participate in the procedures for removing or transplanting an organ.

H. Tissue & Eye Donation

- Donor Criteria

1. Tissue donation will be considered on all deaths, including those patients who are declared brain dead. Tissues may include: bone, dura mater, costal cartilage, middle ear tissue, fascia lata, skin, veins, tendons, ligaments, heart valves, pericardium, and eyes (corneas and sclera).

2. Age Eligibility: Newborns (minimum 36 weeks and 5 pounds); upper age limitations are determined by CTDN

3. Possible Medical Exclusions:

   a. HIV infection utilizing the CDC criteria

   b. Hepatitis B or C

4. Eye donations: if suitable for transplant purposes, the body should be refrigerated and the corneas (or whole globes for research) must be removed within 12-14 hours after circulation ceases. The procedure is performed by a designee of CTDN. Other tissues can be removed within 24 hours after circulation ceases providing the body is refrigerated within 12 hours of asystole. The preferred location for tissue retrieval is the OR. Tissue retrieval may be performed by the staff of CTDN in a non-sterile environment using aseptic techniques (e.g. pathology department, morgue, or coroner's office).

EDUCATION/TRAINING:

A. Resource Manual for Organ and Tissue & Eye Donation is available in the House Supervisor's office including the appropriate phone numbers needed.

B. All appropriate personnel will be trained periodically.

DOCUMENTATION:

A. All referrals, referral numbers, and communication with CTDN for donation, whether accepted or declined by the next-of-kin are to be documented by the HS reporting and handling the process in the medical record.

Title: Organ/Tissue/Eye Donation	
Scope: NIH	Manual: CPM
Source: Resuscitation Committee	Effective Date:

B. The charts of all expired patient, aged 80 years or less, are audited on monthly basis by CTDN.

C. Reports and handouts from CTDN are maintained in Quality Management.

D. Checklist, "Process for Organ Donation After Cardiac Death" (not part of the medical record.

REFERENCES:

1. California Health and Safety Code, sections 7150-7156-.5
2. Strategies for Narrowing the organ Donation Gap and Protecting Patients (2004)
3. CAMCAH, 2011
4. The Joint Commission; Standard RI.01.05.01
5. California Transplant Donor Network Resource manual for Organ and Tissue Donation

CROSS REFERENCE P&P:

1. Organ Tissue Harvesting in Surgery
2. Obtaining Consents for Organ Tissue Donation
3. Death Disposition of Body

Approval	**Date**
Resuscitation	**4/2/14**
Emergency Services Committee	**6/1/15**
Surgery Committee	**10/22/14**
Resuscitation Committee	**4/2/14**
Medical/ICU Committee	**6/1/15**
MEC	**6/2/15**
Board of Directors	

Developed: 10/19/10
Reviewed:
Revised: 12/16/13
Supercedes:

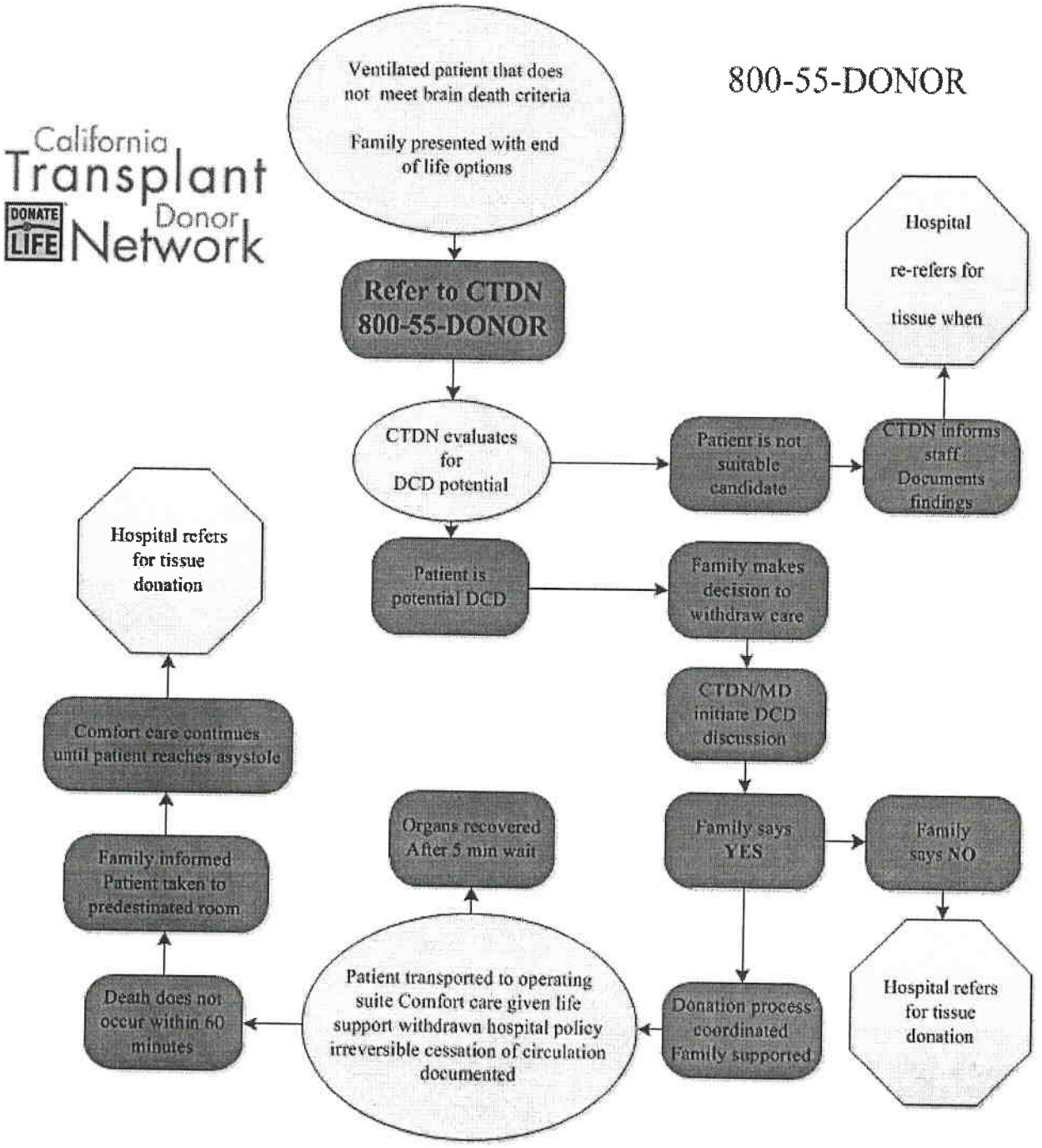
Responsibility for review and maintenance:
Index Listings:

Title: Organ/Tissue/Eye Donation	
Scope: NIH	Manual: CPM
Source: Resuscitation Committee	Effective Date:

ORGAN TISSUE DONATION FOR TRANSPLANTATION

ATTACHMENT A

Organ Donation after Cardiac Death



Title: Organ/Tissue/Eye Donation	
Scope: NIH	Manual: CPM
Source: Resuscitation Committee	Effective Date:

ATTACHMENT B

TASKS TO BE COMPLETED	PERSON(S) RESPONSIBLE	COMPLETED	
		DATE	TIME
1. ID ventilated patients in which MD and/or family considering DNR status, utilizing the following criteria: • GCS of 5 or less • Brain injury (i.e. bleed/anoxia/trauma) • Physician discussion of possible/imminent brain death • Discussion w/family about withdrawal of life support or possible DNR • Family has questions about donation	ICU RN/House Supervisor		
2. Review patient's advance directives	ICU RN/House Supervisor		
3. Notify CTDN and the House Supervisor of potential imminent death of vented patient that meets criteria.	ICU RN/House Supervisor		
4. Record the date/time CTDN notified and the Donor Referral Case Number in the nurses notes and give info to the HS.	ICU RN/House Supervisor		
5. CTDN will evaluate appropriateness of organ donation.	CTDN Coordinator		
6. A respiratory exam needs to be completed by the hospital staff.	RCP		
7. CTDN Coordinator will approach the legal next of kin to discuss the option of organ/tissue donation.	CTDN Coordinator		
8. The consent for organ donation must be obtained from the next of kin.	CTDN Coordinator		
9. Ensure the County Coroner is notified and release/authorization for donation is secured.	House Supervisor		
10. The medical management of the patient pending organ donation will be by the patient's attending MD, not CTDN. However, CTDN may provide information on physiological goals pending potential donation.	Attending MD/Hospitalist		
11. If invasive procedures of further diagnostic testing is necessary to determine appropriateness for donation, they are to be ordered and conducted by MD's and consents, when appropriate, should be obtained from the next of kin.	Attending MD/Hospitalist		

12. Once consent has been obtained and a plan for DCD has been put in place, prior to transferring the patient for organ recovery: An order for DNR status and comfort care measures needs to be written.	Attending MD/Hospitalist		
13. The attending MD must support the plan for DCD and be available to pronounce death following withdrawal of life support.	Attending MD/Hospitalist		
14. The OR will be notified of potential organ recovery and CTDN will work with OR staff to schedule and OR time. The OR time will also be coordinated with the Attending MD.	CTDN Coordinator		
15. The House Supervisor will ensure the original ICU bed is held until after patient expires. A med surg bed in a private room should also be designated in the event the patient requires ongoing comfort care measures.	House Supervisor		
16. The OR will provide a scrub nurse and circulating nurse to assist the CTDN recovery teams. An anesthesiologist will only be needed if requested by CTDN (for lung recovery only).	OR Staff		
17. OR scrub gown, cap and booties will be provided to: ICU RN, RT, Attending MD and family if appropriate.	OR Staff		
18. The Adm. Supervisor will arrange for 2 separate private waiting areas close to the OR: 1 for the family and 1 for the transplant team.	House Supervisor		
19. The CTDN Family Resource Coordinator (FRC) will provide all support and information to the family.	CTDN Coordinator		
20. Once the OR is ready and the CTDN recovery team is assembled, the patient will be transferred to the OR being mechanically ventilated and monitored by the ICU RN and RCP.	ICU RN/RCP		
21. Comfort care meds, the appropriate dosage of heparin and the chart will be taken to the OR with the pt.	ICU RN		
22. Heparin needs to be administered 5 minutes prior to Extubation as ordered by the pt's attending MD.	ICU RN		
23. Comfort care medications will be administered as needed by the ICU RN.	ICU RN		

24. The attending MD or MD designee will be called to the OR when the patient is ready for extubation. He/she will oversee the process of life support withdrawal, pronounce the patient and document in the medical record. He/she will also complete the death certificate. The RCP will extubate under direction of the attending MD.	Attending MD/Hospitalist RCP		
25. In the operating room, the OPO surgical team and the hospital surgical staff will prepare and drape the patient in a sterile fashion. Once the patient is prepared and all necessary recovery equipment and preservation solutions are in place, the hospital staff will proceed with removal of life support.	CTDN Team		
26. Prior to extubation, a blood draw is necessary for tissue typing purposes. This blood can be drawn by NIH staff or can be drawn by CTDN staff is desired.	ICU RN or CTDN Staff		
27. The organ recovery team (surgeons and other transplant center personnel) are prohibited from entering the operating room once the patient has been transferred into the room. The recovery team may not enter the OR until the patient has been declared cardiac dead by the hospital medical team.	CTDN Recovery Team		
28. The CTDN transplant coordinator will remain in the OR to document a running time of the withdrawal process and vital signs.	CTDN Coordinator		
29. The patient's family will be offered the opportunity to accompany the patient into the OR for the withdrawal of life support. Once the patient is pronounced, the family will be escorted to a designated waiting area.	CTDN Family Coordinator		
30. If the family chooses to be with the patient in the OR, the patient and environment should be appropriately prepared (chair for family, lights dimmed, patient face/arms exposed, Kleenex available, etc.).	OR Staff		
31. The attending MD will verbally indicate when circulation and respirations have ceased and the 5 minute observation period begins at this point.	Attending MD		

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TASKS TO BE COMPLETED	PERSON(S) RESPONSIBLE	COMPLETED	
		DATE	TIME
32. The Adm. Supervisor will be notified when patient expires so appropriate calls can be made to the coroner and tissue bank.	OR Staff		
33. The ICU RN and RCP may leave the OR and will document appropriately in the patient's medical record once CTDN arrives to initiate organ recovery.	ICU RN and RCP		
34. When the CTDN team has completed recovery, the body may be prepared for removal to the morgue.	OR Staff		
35. If desired, the family may see the deceased following organ recovery. The OR staff will identify a location for the viewing.	OR Staff		
36. Transport should be notified when the deceased is ready for transport to the morgue.	OR Staff		
37. The House Supervisor will be notified of when the deceased has been transported to the morgue.	OR Staff		
38. If the patient does not arrest within the designated time frame and the recovery effort is terminated, the HS will be notified.	OR Staff		
39. The House Supervisor will assign an appropriate bed for the patient to be transported to.	House Supervisor		
40. The attending MD will write further care orders prior to patient transfer.	Attending MD		
41. Report will be called to the receiving unit.	ICU RN		
42. The patient will be transported to the designated room	ICU RN		

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Northern Inyo County Local Hospital District

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Performance Excellence June 17, 2015

Quality Assurance and Performance Improvement (QAPI) Report

Joint Commission Survey Readiness

1. *Focused Standards Assessment. NIH continues to make improvements based on the FSA findings, in preparation for an on-site survey.*

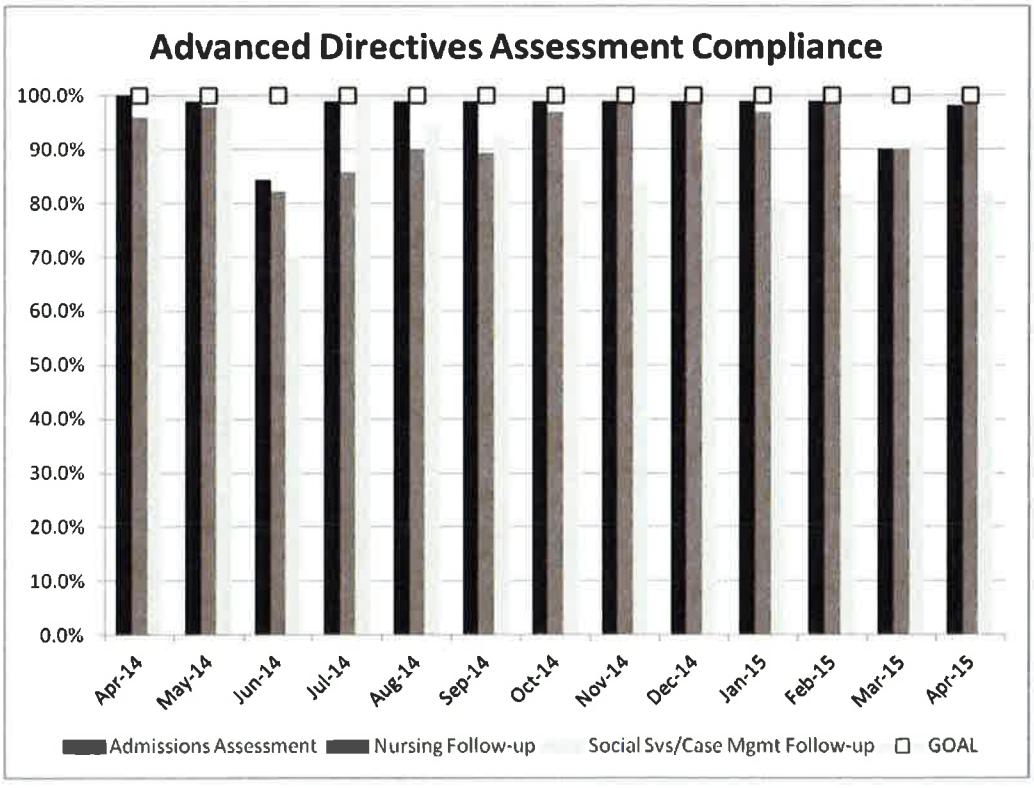
Lab Survey (CMS CLIA/CDPH)

1. *On 6/3/15-6/4/15, surveyors were on-site for a validation survey. NIH will be expecting correspondence and will take necessary action dictated by such correspondence.*

2013 CMS Validation Survey Monitoring

1. QAPI continues to receive and monitor data related to the previous CMS Validation Survey, including but not limited to, restraints, dietary process measures, case management, pain re-assessment, as follows:

   a. Advance Directives Monitoring.

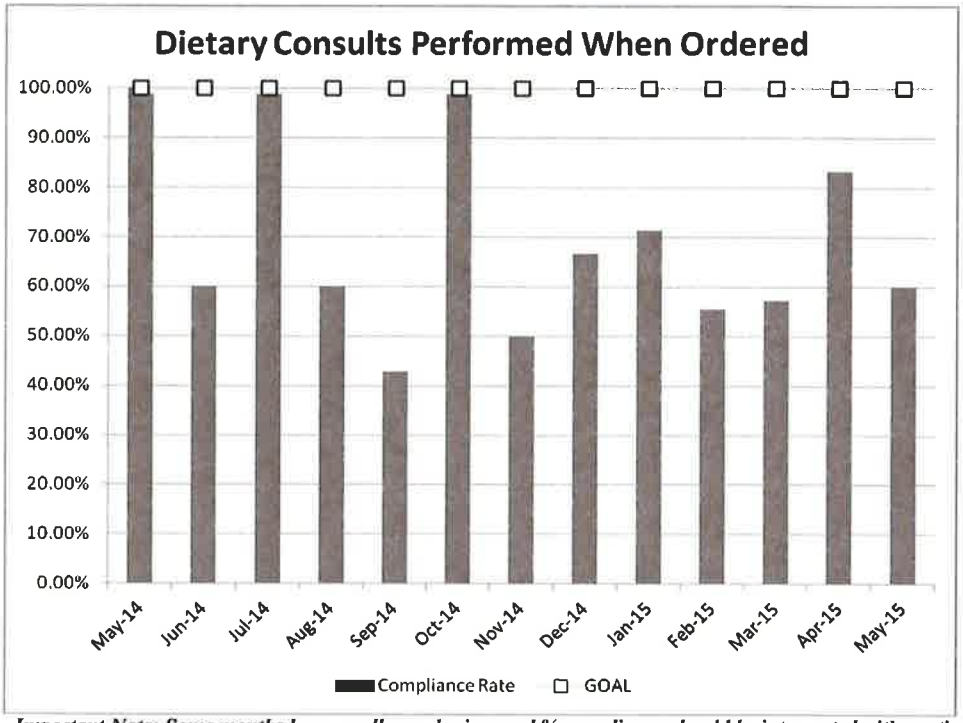


   b. Positive Lab Cultures are being routed to Infection Prevention and each positive is being investigated as to source. Monitoring has been ongoing and reported through Infection Control Committee. QAPI receives data.

   c. Safe Food cooling monitored for compliance with approved policy and procedure. 100% compliance since May 6, 2013.

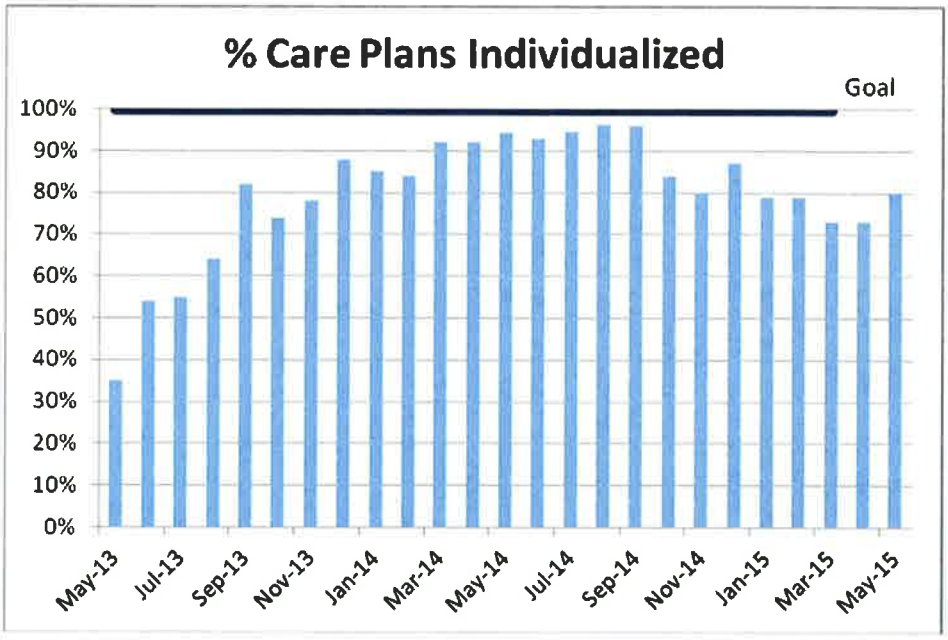
d. Dietary hand washing logs have been reported and are at 100% compliance since May 6, 2013. The Dietary department has developed and is testing new handwashing logs with the help of Nel Hecht, Infection Preventionist, to provide more meaningful data.

e. QAPI continues to monitor dietary referrals and the number of consults completed within 24 hours. No new data since last BOD meeting.



Important Note: Some months have small sample sizes and % compliance should be interpreted with caution.

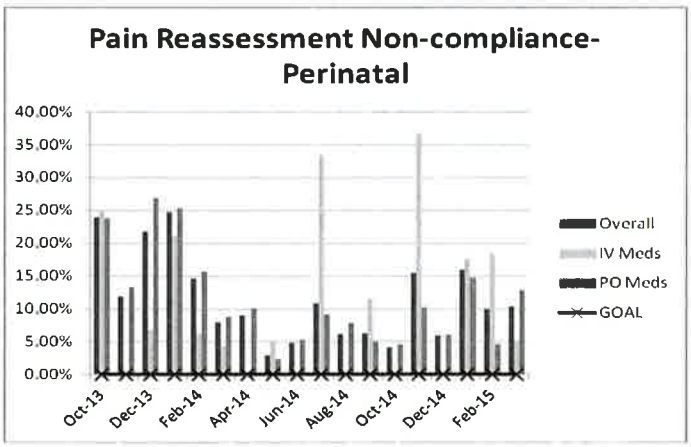
f. Care plans reviewed by Case Management and interventions made to produce care plans. Progress has been made in developing individualized care plans.

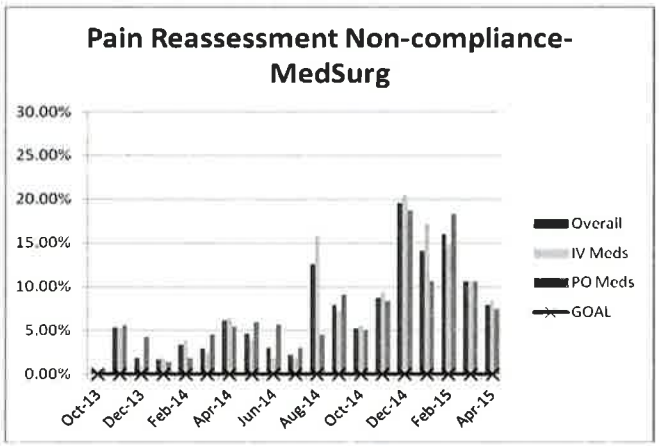


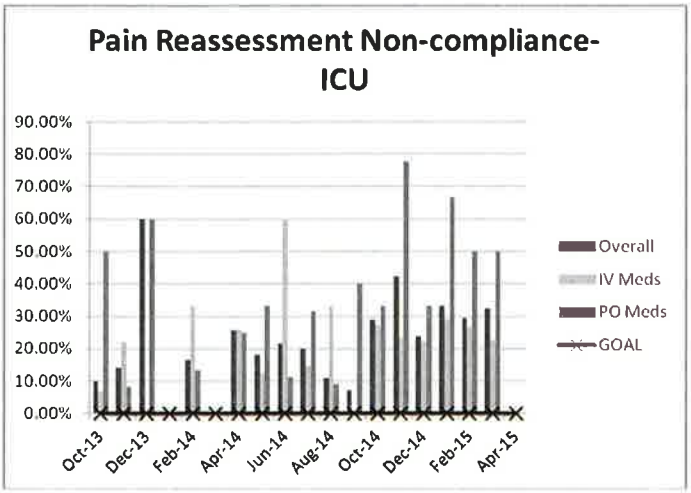
g. Fire drill date, times, attendance and outcomes, smoke detector tests, and fire extinguisher test grids have been

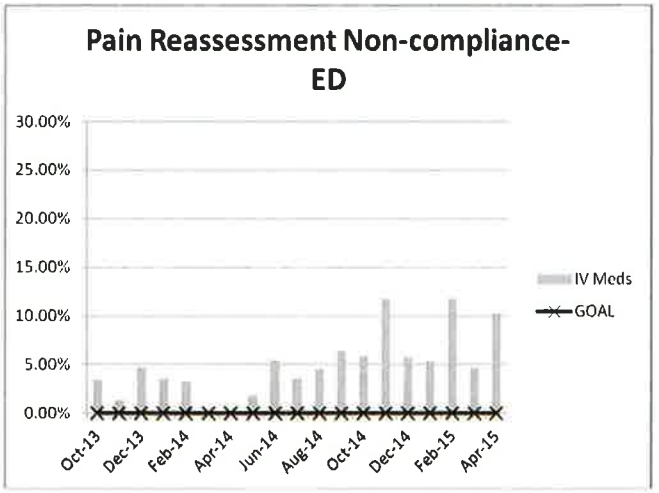
approved. All fire drills were complete and compliant from May 6, through present.

h. Pain Re-Assessment. NIH conducts pain re-assessment after administering pain medications and uses a 1-10 scale. No data since last BOD meeting.









Clinical Documentation Improvement

1. Emergency Department Charge Capture Improvement Project charter completed and project initiated.
   a. Defined desired outcomes & process characteristics, assessed current outcomes & process characteristics through staff interviews, document review, observation, research industry practices on this job function, identified process owners and made recommendations, in process of implementing recommendations for testing.
   b. HIMS Coordinator and Quality Improvement Analyst have made the following improvements to the ED charge entry process:
      - ***Next steps: Develop audit report template and additional performance metrics. Additional metrics may include productivity metrics such as % charts completed (weekly), # errors/chart for charts for any chart with charge issues.***

2. OB Biliscan Charge Capture Improvement Project charter drafted, approved
   - *Process/system issues have been identified & defined.*
   - *Baseline process and outcome data has been collected*
   - *In the process of discovering the root causes of the issues.*

3. ICD-10 Implementation project. No new updates since last BOD meeting.

4. Perinatal Chargemaster Improvement Project.

   a. *Project charter draft completed.*
   b. *Goal of project is to design a new user-friendly, streamlined, systematic process for applying selected Perinatal charges, while improving related clinical documentation.*

Leap Frog Survey

1. *Leapfrog kick-off party held on 5/4/15 and sections assigned. A new section on Bar Code Medication Administration was added. See 2015 Leap Frog Section Progress attached.*

Performance Excellence Training

1. Continue to develop train-the-trainer AIDET implementation strategy. First team meeting held on 9/26/14. Project Status: Organizing focus group for patients to provide feedback on customer service issues.
   - *Pilot tested the "Introduction to Customer Service" training with a small group of Phlebotomy employees. Opportunities identified to include in the next pilot test to be held in June with another small group of employees: increase training from 1.5 to 2.0 hours, send pre-questionnaire to determine specific issues for various functional areas and use this to develop role-play scenarios, more role-playing.*

2. Lean Six Sigma Green Belt training. (For more information about this methodology, please visit http://asq.org/cert/six-sigma-green-belt/bok. Lean Six Sigma is a scientific, data-driven methodology for improving processes and systems.

   First class was held on January 9, 2015 and the following topics were covered:

   - Value of Six Sigma
   - A Systems Approach & Baldrige
   - Organizational Drivers & Metrics
   - Organizational Goals & Six Sigma Projects
   - Lean Principles Introduction
   - Team Dynamics Introduction

   Second class was held on January 16, 2015 and the following topics were covered:

   - Change Management & Culture
   - Project Management
   - Business Results: Cost of Poor Quality & Saving Lives
   - Management & Planning Tools

   Third class was held on February 6, 2015 and the following topics were covered:

   - Process Management, Analysis & Documentation
     - Voice of the Customer, Customer-Centric Best Practices
     - Process Mapping, Work Instructions, Policies & Procedures

   Fourth class (short ½ class) was held on February 13, 2015 and the following topics were covered:

   - Working With Data
   - Probability & Statistics
   - Collecting & Summarizing Data

   Fifth class (short ½ class) was held on March 13, 2015 and the following topics were covered:

   - Measurement System Analysis
   - Process Capability & Performance
   - Deming's Red Bead Game
   - Review & revise team project charters

Sixth class was held on April 24, 2015 and the following topics were covered:

- Qualitative Analysis
  - Brainstorming & Affinity Diagrams
  - Fishbone/Cause & Effect/Ishikawa Diagrams & 5 Whys?
  - Failure Modes, Effects and Criticality Analysis & Pareto Charts
  - Review Lean & Process Analysis
- Quantitative Analysis
  - Statistical Probability Distributions & Hypothesis Testing
  - Exploratory Data Analysis (Multi-Vari, Regression, Correlation)

Seventh class was held on May 29, 2015 and the following topics were covered:

- *Innovation Methods, including, but not limited to the following:*
  - *Random Simulation, Six Thinking Hats*
  - *Benchmarking & Best Practices Research*
  - *Theory of Inventive Problem-Solving (TRIZ)*
  - *SCAMPER*
  - *Poka-Yoke*
- *Design of Experiments*
- *Selecting the best solutions*
- *Pilot test & implement solutions*
- *Control Plans, Statistical Process Control, Project Handover & Close-out*

NEXT STEPS:

- *Project & problem work sessions to be held in June, July, August, September*

Baldrige and the Journey to Excellence

1. See Handout – Category 3- Customer & Market Focus

Strategic Communications Report

Marketing/Internal Communication Projects

1. *Colleen McEvoy, Pediatric Clinic Nurse Practitioner. (Ad)*
2. *Press releases now posted on "News" link located on www.nih.org.*

Press Releases

1. *Diane Stevens named NIH's 2015 DAISY Award Winner*
2. *Ungersma named Healthcare District Trusteee of Year*

Events

1. *None since last BOD meeting.*

Medical Staff Office Report

Medical Staff Office Updates

1. No new updates since last BOD meeting.

Performance Improvement Projects Key: FOCUS-PDSA CYCLE: F (Find), O (Organize), C (Clarify), U (understand), S(Select), P(Plan), D(DO), S (Study), A (Act) (See FOCUS-PDSA Handout)

LEAP FROG 2015 SECTION PROGRESS

9C	Pneumonia LOS, 30D Readmission Rate	COMPLETED
9B	HF LOS, 30D Readmission Rate	COMPLETED
9 A	AMI LOS, 30D Readmission Rate	COMPLETED
8	Barcode Medication Admin	ASSIGNED
7 D	Pressure Ulcers & Injuries	COMPLETED
7C	CAUTI	ASSIGNED
7B	CLABSI	ASSIGNED
7 A	Managing Serious Errors	ASSIGNED
6- o	Culture of Safety Survey	ASSIGNED
6- 23	Prevent Ventilator Assoc Complic	ASSIGNED
6- 19	Hand Hygiene	ASSIGNED
6- 17	Medication Reconciliation	ASSIGNED
6- 9	Nursing Workforce	ASSIGNED
6- 4	Risks & Hazards	ASSIGNED
6- 3	Teamwork Training & Skills	ASSIGNED
6- 2	Culture Meas, Feedback,Intervent	ASSIGNED
6- 1	Safety Culture Ldrship Struct/Sys	ASSIGNED
5	ICU Physician Staffing	COMPLETED
4	Maternity Care	VALIDATED
3E	Evidence-Based Referral	ASSIGNED
3 D	Evidence-Based Referral Surgery	ASSIGNED
3C	Evidence-Based Referral Surgery	ASSIGNED
3B	Evidence-Based Referral Surgery	ASSIGNED
3A	Evidence-Based Referral Surgery	ASSIGNED
2	CPOE Standards	COMPLETED
1	Basic Hospital Info	COMPLETED
	Section Number & Name	*Section Progress*

ASSIGNED DISCUSSION IN PROGRESS COMPLETED VALIDATED SUBMITTED TO LEAP FROG

Rev. 6/5/15 mjs

SCAMPER
Improving Products and Services

Use SCAMPER to develop new products and services.

It can often be difficult to come up with new ideas when you're trying to develop or improve a product or service.

This is where creative brainstorming techniques like SCAMPER can help. This tool helps you generate ideas for new products and services by encouraging you to think about how you could improve existing ones.

We'll look at SCAMPER in this article.

About the Tool

SCAMPER is a mnemonic that stands for:

- Substitute.
- Combine.
- Adapt.
- Modify.
- Put to another use.
- Eliminate.
- Reverse.

You use the tool by asking questions about existing products, using each of the seven prompts above. These questions help you come up with creative ideas for developing new products, and for improving current ones.

Alex Osborn, credited by many as the originator of brainstorming, originally came up with many of the questions used in the technique. However, it was Bob Eberle, an education administrator and author, who organized these questions into the SCAMPER mnemonic.

Note:

Remember that the word "products" doesn't only refer to physical goods. Products can also include processes, services, and even people. You can therefore adapt this technique to a wide range of situations.

How to Use the Tool

SCAMPER is really easy to use.

First, take an existing product or service. This could be one that you want to improve, one that you're currently having problems with, or one that you think could be a good starting point for future development.

Then, ask questions about the product you identified, using the mnemonic to guide you. **Brainstorm** as many questions and answers as you can. (We've included some example questions, below.)

Finally, look at the answers that you came up with. Do any stand out as viable solutions? Could you use any of them to create a new product, or develop an existing one? If any of your ideas seem viable, then you can explore them further.

Example Questions

Let's look at some of the questions you could ask for each letter of the mnemonic:

Substitute

- What materials or resources can you substitute or swap to improve the product?
- What other product or process could you use?
- What rules could you substitute?
- Can you use this product somewhere else, or as a substitute for something else?
- What will happen if you change your feelings or attitude toward this product?

Combine

- What would happen if you combined this product with another, to create something new?
- What if you combined purposes or objectives?
- What could you combine to maximize the uses of this product?
- How could you combine talent and resources to create a new approach to this product?

Adapt

- How could you adapt or readjust this product to serve another purpose or use?
- What else is the product like?
- Who or what could you emulate to adapt this product?
- What else is like your product?
- What other context could you put your product into?
- What other products or ideas could you use for inspiration?

Modify

- How could you change the shape, look, or feel of your product?
- What could you add to modify this product?
- What could you emphasize or highlight to create more value?
- What element of this product could you strengthen to create something new?

Put to Another Use

- Can you use this product somewhere else, perhaps in another industry?
- Who else could use this product?
- How would this product behave differently in another setting?
- Could you recycle the waste from this product to make something new?

Eliminate

- How could you streamline or simplify this product?
- What features, parts, or rules could you eliminate?
- What could you understate or tone down?
- How could you make it smaller, faster, lighter, or more fun?
- What would happen if you took away part of this product? What would you have in its place?

Reverse

- What would happen if you reversed this process or sequenced things differently?
- What if you try to do the exact opposite of what you're trying to do now?
- What components could you substitute to change the order of this product?
- What roles could you reverse or swap?
- How could you reorganize this product?

Tip 1:

Some ideas that you generate using the tool may be impractical or may not suit your circumstances. Don't worry about this – the aim is to generate as many ideas as you can.

Tip 2:

To get the greatest benefit, use SCAMPER alongside other creative brainstorming and lateral thinking techniques such as **Random Input**, **Provocation**, **Reversal**, and **Metaphorical Thinking**.

Key Points

SCAMPER helps you develop new products and services. Many of the questions it uses were created by Alec Osborn, but Bob Eberle developed the mnemonic.

SCAMPER stands for:

- Substitute.
- Combine.
- Adapt.
- Modify.
- Put to another use.
- Eliminate.
- Reverse.

To use SCAMPER, you simply go down the list and ask questions regarding each element. Remember, not every idea you generate will be viable; however, you can take good ideas and explore them further.

Source: http://www.mindtools.com/pages/article/newCT_02.htm

Northern Inyo County Local Hospital District
150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811

Diane Stevens named NIH's 2015 DAISY Award Winner

Diane Stevens, an Emergency Department nurse at Northern Inyo Hospital (NIH), was named winner of the DAISY Award for Extraordinary Nurses. The recognition is part of a national program honoring nurses for clinical skills and compassionate care.

Lured into work to attend an early morning meeting, the 34-year veteran nurse walked into the main hospital lobby Wednesday and joined the assembled crowd. Overheard asking her colleagues what was going on, Stevens' face registered pure surprise when Chief Nursing Officer Kathy Decker named her the 2015 DAISY Award winner for NIH.

"This was supposed to be a safety meeting," Stevens laughed as she stepped forward. Stevens later said she was truly surprised to receive the award. "I don't see myself as doing anything other nurses don't do. I am touched to receive the honor. It was completely unexpected."

The presentation was the kickoff to the hospital's observation of National Nurses Week, May 6-12. "It's a time when we pay tribute to all the nurses and the rest of the team who help support care delivery," Decker said. "Nurses cannot do it alone. So, we recognize that it's an effort between everybody to make a difference in our delivery process."

Victoria Alexander-Lane, NIH's Chief Executive Officer and a former nurse herself, called Stevens the epitome of nursing. "I really wish we could model everyone after your wonderful, generous ability to make people feel comforted and cared for," Alexander-Lane said to Stevens. "And I want to say this: I think every nurse in this hospital is a DAISY Award winner."

Decker said the nursing staff often receives thank you cards and letters of recognition from patients and families. One such letter, read in part to those assembled, demonstrated Stevens' caring approach: "I cannot thank you enough for acting on my behalf in the hospital. With your caring nursing skills and (being) the loving person you are, it is a big part of why I am alive today. I am so grateful to God for giving us people like you. I could see the care in your face that day in the hospital ... You are truly an angel in the making. Thank you."

In addition, Decker said Stevens is respected by many of her co-workers. "She's known for being knowledgeable and caring, not only to patients and their families, but to the other staff who interact with her, "Decker said. "(Diane has) developed the respect of the physicians and all the health care team members."

Decker said Stevens' passion is a patient and family-centered approach which distinguishes her practice. "It's said Diane is the nurse many people would want to take care of them if they were really sick. Diane not only knows what she is doing, but she puts her patients at ease and gives them assurance."

Decker said DAISY recipients like Stevens are often surprised that they are receiving the honor. "To them, they don't do anything special. That's why at every DAISY Award presentation we ask each nurse to pause for just a minute and realize that they are also special, and how each nurse makes the world a better place just by doing their jobs," Decker said. "Today, a nurse's job may entail saving a patient's life, applying training and skills to a complex medical procedure, or maybe a nurse's act of kindness and sharing quick smile will make a family feel just a bit better."

Stevens received a certificate of recognition; a DAISY Award pin; a sculpture entitled "A Healer's Touch," which is hand-carved from serpentine stone by artists of the Shona Tribe in Zimbabwe; and, a DAISY Award tote bag.

Previous DAISY Award nurses at NIH include Christine Hanley (2013), Joey Zappia (2013), and Deborah Earls (2014). Northern Inyo Hospital has been recognized as a DAISY organization since 2013.

DAISY is an acronym for Diseases Attacking the Immune System. The DAISY Award is part of the DAISY Foundation's efforts to recognize the super-human efforts nurses make in direct care of patients and patient families every day. The not-for-profit DAISY Foundation, based in Glen Ellen, Calif., was established by family members in memory of J. Patrick Barnes.

Barnes died in 1999 at the age of 33 from an autoimmune disease. The care Barnes and his family received from nurses while he was ill inspired the award as a means of thanking nurses for making a profound difference in the lives of their patients and patient families.

Northern Inyo Hospital is a 25-bed, not-for-profit Critical Access Hospital located in Bishop. Accredited by The Joint Commission, NIH has been providing quality health care to the Eastern Sierra since 1946.

Diane Stevens, NIH's 2015 DAISY Award Winner

NORTHERN INYO HOSPITAL
People you know, caring for people you love.

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Ungersma named Healthcare District Trustee of Year

John Ungersma, MD, was named Healthcare District Trustee of the Year by the Association of California Healthcare Districts (ACHD) during the group's annual conference last week in Monterey, Calif.

Dr. Ungersma has served on the Northern Inyo Hospital (NIH) Board of Trustees for 12 years. During that time he has held the positions of President, Vice President and Director at Large. In his tenure on the board, Dr. Ungersma has led or participated in:

- Planning, financing and construction oversight of a new 25-bed Critical Access Hospital
- Recruiting a new Chief Executive Officer for the District
- Increasing physician recruitment to assure access to both primary and specialty care
- Establishing the Hospital's Community Action Committee

Understanding that finances are frequently a barrier to educational advancement, Dr. Ungersma has personally -- and quietly -- provided college scholarship support for graduating high school seniors annually for the past 30 years.

Dr. Ungersma served as a Naval Flight Surgeon and Senior Surgeon with the First Marine Division in Desert Shield as well as Desert Storm; his military career spans 48 years, 21 years of active duty and 27 in active reserve in the Marine Corps as well as the Navy. A pioneer in many ways, Dr. Ungersma was the first Orthopedic Surgeon to establish a practice in Bishop.

Dr. Ungersma received his Medical Degree from the University of Southern California and he completed his Orthopedic Residency at St. Mary's Hospital in San Francisco. Dr. Ungersma is an Adjunct Assistant Professor of Surgery at F. Edward Herbert School of Medicine in Bethesda Maryland; his orthopedic career includes participating in the training of 45 orthopedic residents, two of which have become Professors of Orthopedic Surgery.

In addition to his work locally, Dr. Ungersma has served on the ACHD Executive Board for the past few years. He has served as Treasurer and this past year as Vice President. While he has termed out for the ACHD board, he will remain active with the organization, working with its various committees.

Dr. Ungersma was nominated for this honor by NIH Board President MC Hubbard.

John Ungersma. *Photo courtesy Northern Inyo Hospital.*

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150 Pioneer Lane
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www.nih.org

June 4, 2015

To: Victoria Alexander-Lane, CEO

From: Carrie Petersen, Chief of Fiscal Services

RE: 2015-16 Budget

Attached you will find the income statement summary for the submitted department budgets for the upcoming 2015-16 budget year. The expenses in this budget would require a 3% price increase to break-even and that is without the contractual adjustment that would cause it to need to be more.

Our goal in the next month will be to work diligently with Management to get this budget to the right positive bottom line to meet our needs as an organization including the Bond Debt Service Coverage guidelines that require us to have the right income to cover our outstanding debt.

I will be prepared to discuss this with you and the Board at the June board meeting.

Northern Inyo Hospital
Fiscal Year 2015-16 Budget Income Statement

	Management Budget
Unrestricted Revenues, Gains & Other Support	
Inpatient Service Revenue	
Inpatient Routine Services	$9,587,952
Inpatient Ancillary Services	$32,579,292
Total Inpatient Service Revenue	**$42,167,244**
Outpatient Service Revenue	$84,132,780
Gross Patient Service Revenue	**$126,300,024**
Less Deductions from Revenue	
Patient Service Revenue Deductions	$2,929,776
Contractual Adjustments	$49,936,032
Prior Period Adjustments	($110,004)
Total Deductions from Patient Service Revenue	**$52,755,804**
Net Patient Service Revenue	**$73,544,220**
Other revenue	$492,984
Transfers from Restricted Funds for Operating Exp	$1,007,748
Total Other Revenue	**$1,500,732**
Expenses:	
Salaries and Wages	$24,416,772
Employee Benefits	$19,442,952
Professional Fees	$7,063,488
Supplies	$6,165,864
Purchased Services	$4,091,136
Depreciation	$5,110,188
Bad Debts	$2,402,316
Other Expense	$4,125,192
Total Expenses	**$72,817,908**
Operating Income (Loss)	**$2,227,044**
Other Income:	
District Tax Receipts	$532,992
Partnership Investment Incomce	$0
Grants and Other Contributions Unrestricted	$36,564
Interest Income	$165,960
Interest Expense	($3,427,872)
Other Non-Operating Income	$5,268
Net Medical Office Activity	($3,792,588)
340B Net Activity	$370,620
Non-Operating Income/Loss	**($6,109,056)**
Net Income/Loss	**($3,882,012)**

Northern Inyo Hospital - 2014-15 Capital Expenditure Requests

1-Patient Safety, Regulatory Compliance
2-Patient Satisfaction
3 - Strategic Purchase

Dept ID	Department	Description	Purpose	> $2000 Est Cost	Yrs of Life	Req prior	Est. Depr	Asset Type
6170	Med/Surg Acute/Subacute Services	MP5 Monitor with EKG, NIBP, SPO2, and Roll stand.	Monitor interfaces with Intellivue patient monitors assisting with real time documentation and immediate communication with care providers.	$ 9,111.00	7	1	$ 651.00	12411201
6170	Med/Surg Acute/Subacute Services	Hover Jack Air Patient Lift	Safe Patient Handling Lift for patients who have fallen and are unable to get up. A-1136 safe patient handling legislation signed into law October, 2011	$ 4,622.00	10	1	$ 231.00	12411201
6380	Perinatal	GE Healthcare Centricity Perinatal OB/GYN Comprehensive Continuum of Care program.	To replace the current OB TRACE monitoring program with an integrated documentation & fetal surveillance program	$ 173,940.99	7	1	$ 12,424.00	12411201
7010	Emergency Department	A GlideScope AVL Video Laryngoscope and accessories ($21,180.00) or a Storz C-Mac Video laryngoscope with accessories ($35,419.85)	Emergent intubation to be utilized for anticipated difficult intubations and or intubations that have failed with other assistive devices.	$ 35,419.85	5	1	$ 3,542.00	12411201
7070	RHC	Welch Allyn Diagnostic Sets - 4 @ $555.78	For examination of patients (opthalmascope and otoscope). Four remaining diagnostic sets originally purchased in 1986 are failing and are not worth repairing per BioMed.	$ 2,223.00	10	1	$ 111.00	12411201
7070	RHC	Suresigns VS2 + NBP/SPO2 monitors. 5 @ $1,934.25 + accessories and rollstands	For taking vital signs that include B/P, Heart Rate and Oxygen saturation at the RHC for every patient visit. Currently using many old monitors that have come from other departments.	$ 11,355.00	7	1	$ 811.00	12411201
7070	RHC	Intellivue MP5 Touch Screen Configured Patient Monitor	To measure complete Vital Signs, Oxygen Saturation and Monitor Cardiac Rhythm. Only a need if old monitor fails.	$ 9,111.00	7	1	$ 651.00	12411201
7420	Surgery	High Flow Insufflation Unit	Olympus insfflator for Surgery - need to have an insufflator in each surgery room in order to do laparoscopic surgeries in each of the 3 OR suites.	$ 9,970.16	5	1	$ 997.00	12411201
7420	Surgery	Money earmarked for new surgeon: Allison Robinson, for miscellaneous equipment needs when she starts in August, 2015	Dr. Robinson may find she needs additional or different equipment for surgery	$ 60,000.00	5	1	$ 6,000.00	12411201
7420	Surgery	Phacoemulsifier for cataract extraction / lens implant surgeries	Needed by Dr. Reid to remove old lens - and, we must have a back-up unit in case the phaco malfunctions in the middle of a cataract case	$ 75,000.00	7	2	$ 5,357.00	12411201
7420	Surgery	Bipolar resectoscope for the 3 Gynecologists	For use in endometrial ablations, fibroidectomies, myomectomies. Much safer than the monopolar resesctascope we currently have.	$ 27,303.92	5	2	$ 2,730.00	12411201
7420	Surgery	Zimmer pneumatic tourniquet	Replacement of one of the older tourniquets	$ 13,297.90	7	2	$ 950.00	12411201
7420	Surgery	Olympus Endoeye HD 5mm, 0 degree	Additional scope in lieu of the flexible scope.	$ 21,227.50	3	2	$ 3,538.00	12411201
7420	Surgery	Olympus Endoeye HD 10mm, 30 degree	Additional scope in lieu of the flexible scope.	$ 21,227.50	3	2	$ 3,538.00	12411201
7427	PACU	Philips ETCO2 modules (2 @ $4885)	Additional PACU and DI use of ETCO2 monitoring.	$ 9,770.00	7	1	$ 698.00	12411201
7503	Chemistry	RapidPoint 500 Arterial Blood Gas Analyzer and Co-oximeter	Primary Blood Gas Analyzer for use by RT and Lab in ED, ICU and OB	$ 11,300.00	5	1	$ 1,130.00	12411201
7503	Chemistry	Avox Co-oximiter	Back Up Blood Gas Analyzer for use by Lab. It is used only in the event of a break-down of the RP500. The Lab back up unit is very economical because QC is only done if it is to be used.	$ 6,000.00	5	1	$ 600.00	12411201

Dept ID	Department	Description	Purpose	Est Cost	Life	Req prior	Est. Depr	Asset Type
7540	Blood Bank	ID-MTS Gel Card Ortho Workstation	Pretransfusion testing - ABO/Rh, antibody screen and crossmatch. American Assoc. of Blood Banks recommends automated methods for labs.	$ 5,000.00	5	1	$ 500.00	12251201
7590	Cardiopulmonary/EKG	Holter / Event Monitor	To monitor and record heart rhythms on outpatients for up to 30 days. Includes four event recorders and software.	$ 8,000.00	7	1	$ 571.00	12411201
7630	Diagnostic Imaging	PhilipsExpression Patient Monitor (MR200) MRI compatible monitor	Replace current 15 year old monitor, allows for anxiolysis and conscious sedation of MR patients.	$ 60,000.00	7	1	$ 4,286.00	12411201
7630	Diagnostic Imaging	Liko Free span Straight Rail Lifting System	Increase safety for patient movement, Increase employee safety during patient transfer.	$ 9,365.00	10	1	$ 468.00	12411201
7630	Diagnostic Imaging	US table (Room2)	Replace current US table of unknown age (>15 years old)	$ 9,462.00	15	1	$ 315.00	12411201
7630	Diagnostic Imaging	Renova RP Paracentesis Pump / Supplies	Allow for quicker, easier, safer drainage of ascites fluid.	$ 8,130.00	10	2	$ 407.00	12411201
7630	Diagnostic Imaging	Optima XR200amx Portable Digital X-Ray unit	Second / Backup portable X-Ray unit	$ 74,000.00	7	3	$ 5,286.00	12411201
7630	Diagnostic Imaging	5 MP LED monitors FDA certified for use in Mammography - (2 monitors)	Allow mammography Images to continue to be interpreted in compliance with regulations.	$ 18,500.00	7	1 , 3	$ 1,321.00	12411201
7660	MRI Building	HVAC Back-up Unit	If primary chiller fails we would need secondary for back-up	$ 18,500.00	10	3	$ 925.00	12251201
7720	Cardiopulmonary / Respiratory	Vapotherm Precision Unit	Delivers High Flow Oxygen. Usage of current unit has increased. At times the current unit is in use when we needed it on another patient.	$ 3,554.00	8	1	$ 222.00	12411201
7720	Cardiopulmonary / Respiratory	V60 Noninvasive Ventilator/BiPAP	Requires Supplies, Masks, and Circuits	$ 14,000.00	10	1	$ 700.00	12411201
7720	Cardiopulmonary / Respiratory	Set up a one or two bed sleep lab	One bed sleep lab $17,200.00. This does not include room furnishings, or hiring a Polysomnographic Tech.	$ 35,000.00	7	1	$ 2,500.00	12411201
7770	Rehab Services - PT	Cold Laser Equipment (4 Lasers / 2 Probes)	To add this modality equipment to our offering...produces heat for pain and inflammation.	$ 6,800.00	5	2	$ 680.00	12411201
7770	Rehab Services - PT	Chattanooga Intelect Legend XT 4 Channel Combo with Cart.	For Ultrasound and E-Stimulation combination - Used to relax muscles and tendons for Manual therapy and exercise.	$ 3,800.00	7	2	$ 271.00	12411201
7770	Rehab Services - PT	Life Fitness Elliptical Machine	Exercise Equipment for Patients	$ 6,000.00	5	2	$ 600.00	12411201
7770	Rehab Services - PT	Electric Hi/Lo Traction Table with Tru Trac System	Mechanical Traction	$ 8,900.00	10	2	$ 445.00	12411201
7770	Rehab Services - PT	Safe Patient Handling Lift called a "Sara Stedy"	To assist in patient transfers up on Med-Surg unit - specifically for the at risk patient that requires at least a 50% to 85% assistance for transfer.	$ 2,600.00	10	2	$ 130.00	12411201
7770	Rehab Services - PT	New Electronic Charting System for In and Out-Patients of REHAB - includes PT, OT, and Speech	To automate Capture of Required G-Code application to PT, OT, and SP Documentation and billing. Current system is manual with human error and omissions.	$ 49,125.00	3	3	$ 8,188.00	12411201
7770	Rehab Services - PT	Set-Up Costs for new Occupational Therapy Department - with Simulation Equipment	We are starting a brand new OT Dept. this year and need equipment specific for Occupational Therapy.	$ 3,000.00	5	3	$ 300.00	12411201
8320	Dietary	Delfield UC4048 Under Counter Refrigerator	Stand-By Kitchen does not current have an under counter refrigerator to help replicate an efficient patient trayline in the event of a disaster or emergency	$ 2,500.00	10	1	$ 125.00	12411201
8320	Dietary	Follet REF5O-00-00 Refrigerator	Hospital Lab Grade for Nourishments in ICU	$ 2,000.00	10	1	$ 100.00	12411201
8320	Dietary	Follet REF5O-00-00 Refrigerator	Hospital Lab Grade for Nourishments in OB	$ 2,000.00	10	1	$ 100.00	12411201
8320	Dietary	Follet REF5O-00-00 Refrigerator	Hospital Lab Grade for Nourishments in PACU	$ 2,000.00	10	1	$ 100.00	12411201
8320	Dietary	Hobart FC3-150 Garbage Disposal	Food Disposal during dish washing	$ 2,200.00	5	1	$ 220.00	12411201
8320	Dietary	Turbo Air JRF19 Refrigerator	Hospital Lab Grade for Nourishments in ED	$ 3,000.00	10	1	$ 150.00	12411201

Dept ID	Department	Description	Purpose	Est Cost	Life	Req prior	Est. Depr	Asset Type
8320	Dietary	Hatco C12 Compact Booster Water Heater 12kW	Water Heater for Dish Machine to Ensure Regulated Temps on Water	$ 2,000.00	10	1	$ 100.00	12411201
8320	Dietary	Accutemp Food Steamer E62083E100	Current have only one steamer that is used for both patients and staff meals. Having a second one designated for patients only would streamline cooking for both staff and patients	$ 6,700.00	15	3	$ 223.00	12411201
8320	Dietary	AMS 39" Snack Vending Machine	To make snacks available to all staff members at all hours; current model does not hold refrigeration temp well.	$ 3,800.00	10	3	$ 190.00	12411201
8320	Dietary	Delfield EHE160L 4 Well Hot Steam Table	To update current from 3 to 4 wells and have a water drain	$ 2,300.00	15	3	$ 77.00	12411201
8320	Dietary	(3) Turbo Air JBT-72 Refrigerated Salad Bars	For Staff Meals in Caferia; currently set up requires additional items to be placed in ice and is not in compliance of food safety issues	$ 9,000.00	10	3	$ 450.00	12411201
8390	Pharmacy / IT	Omnicenter Virtual Server Upgrade - Windows 2012	Necessary for operation of all Omnicell units. Controls all units, processes all charges, maintains all records of transactions.	$ 9,151.00	5	1	$ 915.00	12411201
8390	Pharmacy	Sentinel Split billing program from Sentry	Regulatory for Split billing of 340B medication in Outpatient	$ 20,500.00	3	1	$ 3,417.00	12411201
8390	Pharmacy	15 PCA Pumps Sapphire from Hospira	Provide patient controlled analgesia	$ 34,193.00	10	1	$ 1,710.00	12411201
8390	Pharmacy	3 drawer module with capacity for 72 medications	To increase efficiency and safety for patients by providing sufficient capacity for necessary medications in the ICU.	$ 15,000.00	10	3	$ 750.00	12411201
8390	Pharmacy	3 drawer module with capacity for 72 medications	To increase efficiency and safety for patients by providing sufficient capacity for necessary medications in the OB Department.	$ 15,000.00	10	3	$ 750.00	12411201
8410	Grounds	Repair of Parking Lots @ 4 locations	Seal coat, crack fill, and restripe west parking lot, PMA parking lot, RHC & RHC annex parking lots	$ 40,000.00	8	1	$ 2,500.00	12101201
8410	Grounds	Various Concrete Repairs around campus	replace or repair any cracked or damaged concrete due to weather, tree roots, construction, etc.	$ 20,000.00	1	1	$ 10,000.00	12101201
8410	Grounds	Energy Efficient Lighting for Parking Lots	energy efficient lighting to Parking Lots for energy and cost savings	$ 18,000.00	15	3	$ 600.00	12101201
8440	Environmental Services	Focus 2 Compact Floor Scrubber	This will allow our EVS staff to scrub their own floors.	$ 6,200.00	5	1	$ 620.00	12411201
8440	Environmental Services	Focus 2 Auto Floor Stripper	This will allow our EVS staff to perform their own floor stripping.	$ 6,200.00	5	1	$ 620.00	12411201
8460	Maintenance	Medical Waste Autoclave (Replacement)	Recommended by Service Tech due to aging and daily use	$ 82,500.00	10	1	$ 4,125.00	12411201
8460	Maintenance	Re-Tube Ajax Boilers	current tubes >15 years old and used daily, service techs recommendation. This provides the sterilization steam for our Autoclave - for medical waste.	$ 13,058.00	15	1	$ 435.00	12251201
8460	Maintenance	Replace existing steam humidifier Ultrasorb H-1-2	Replace existing Ultrasorb H-1-2 in existing janitor closet Room H 2012	$ 18,500.00	15	1	$ 617.00	12411201
8460	Maintenance	Ramp for new Surgery Clinic	Old one is becoming unsafe due to the outdoor elements.	$ 9,026.64	15	1	$ 301.00	12211201
8460	Maintenance	Work that needs to be completed in the Central Plant in order to remove the old hospital building from OSHPD.	Remove Old Hospital from OSHPD inventory.	$ 45,000.00	18	2	$ 1,250.00	12211201
8460	MRI Building	Roof for MRI Building	replacement of weathered old roof on MRI building	$ 25,000.00	10	3	$ 1,250.00	12211201

Dept ID	Department	Description	Purpose	Est Cost	Life	Req prior	Est. Depr	Asset Type
8480	IT	Interface to transfer images directly from Skyvision camera to HPF	Transfer images from Skyvision camera directly to HPF would prevent scanning and any image degradation that happens during the scan process.	$ 20,000.00	3	1	$ 3,333.00	12411201
8480	IT	Electronic Prescribing of Controlled Substances - RHC and B Clinics.	Give the providers at the RHC and B clinics the ability to electronically prescribe schedule II meds.	$ 25,000.00	3	1	$ 4,167.00	12411201
8480	IT	Electronic Prescribing from Paragon including Controlled Substances.	Give providers the ability to electronically prescribe from Paragon including EPCS (scheduled meds)	$ 45,000.00	3	1	$ 7,500.00	12411201
8480	IT	Cloud Backup - Encryption License	Enable cloud backup of hospital data in a compliant manner.	$ 8,000.00	3	1	$ 1,333.00	12411201
8480	IT / HIM	Device to encrypt patient records and Diagnostic Images.	Enable NIH to encrypt patient data onto CD/DVD's. The current CD/DVD's that are used for Diagnostic Imaging is not encrypted	$ 35,000.00	3	1	$ 5,833.00	12411201
8480	IT	Electronic Media Degausser (Data eraser)	Ensure all data stored on electronic media is erased before being disposed of. HIPAA compliance.	$ 4,200.00	3	1	$ 700.00	12411201
8480	IT	Server Hardware	Server hardware in support of new systems, major upgrades and retirement of hardware that is end of life or not cost effective to upgrade. These servers are used to support applications such as Paragon, HPF, Kronos and Centricity.	$ 50,000.00	5	1	$ 5,000.00	12411201
8480	IT	Data storage system upgrade	Upgrade the hardware and software used to store all hospital data and systems while keeping cost of ownership for this critical system consistent with what we have today.	$ 195,000.00	5	1	$ 19,500.00	12411201
8480	IT	SQL Enterprise Core license for Paragon 13	Microsoft SQL Enterprise license to meet McKesson requirements for Paragon 13.	$ 40,000.00	3	1	$ 6,667.00	12411201
8480	IT	Paragon 13 and Clinician Hub Install	Paragon v13 upgrade to keep current and Clinician Hub replaces Web Station for Physicians.	$ 94,000.00	5	1	$ 9,400.00	12411201
8480	IT	Security scanning tool to ensure IT compliance related to systems and network infrastructure.	Scan network and systems looking for security vulnerabilities. Provide reports on systems and network security compliance as per HIPAA requirements.	$ 11,000.00	3	1	$ 1,833.00	12411201
8480	IT	DMS Replacement for HR, AP, Payroll	Storage solution that can hold any type of content (i.e.. image files, voice files, outlook messages etc.) for content storage for Accounting, HR, and Payroll. We can expand beyond the noted departments.	$ 52,000.00	3	1	$ 8,667.00	12411201
8480	Nursing / IT	Zynx order sets	To standardize care with the latest evidence based practice which results in improved patient safety / care.	$ 65,000.00	3	1	$ 10,833.00	12411201
8480	IT	New Provider licenses	Licenses - Centricity, Dragon, CHC, IdealImage licenses for new providers.	$ 58,630.00	3	1	$ 9,772.00	12411201
8480	IT	Upgrade HPF/MPF/OneContent from 16.2 to 16.3 and merge the database with MECM/OneContent creating a single OneContent DB.	This upgrade will merge two databases - the patient side HPF/HBF and the business side of OneContent HR, Payroll, etc. into one single database.	$ 40,000.00	3	3	$ 6,667.00	12411201
8480	IT	e-Signature within Paragon	Eliminate paper and printing costs	$ 70,000.00	3	3	$ 11,667.00	12411201
8480	IT	Network Monitoring Tool	Improved monitoring of telecommunications network infrastructure.	$ 4,600.00	3	3	$ 767.00	12411201

Dept ID	Department	Description	Purpose	Est Cost	Life	Req prior	Est. Depr	Asset Type
8480	IT	Computers for Informatics and IT Training Room	Provide for permanently setup computer training room.	$ 11,000.00	3	3	$ 1,833.00	12411201
8510	Payroll / HR	Kronos Workforce Central Scheduler and Kronos Workforce Analytics.	To upgrade our current Kronos system to provide scheduling and analytics performance to meet the needs of the nursing department and other clinical areas related to tracking for staffing ratios for regulatory reporting purposes.	$ 231,519.00	3	3	$ 38,587.00	12411201
8610	Administration	Set up Computer Lab in old Surgery Suite C	To provide a dedicated spot for training and meeting space requiring computer needs.	$ 14,050.00	20	3	$ 351.00	12211201
8650	Human Resources	Remaining Kronos Project - open project items	NGUI, Self-Service (home access), Applicant Tracking, Miscellaneous Completion.	$ 5,756.50	3	3	$ 959.00	12411201
8650	Human Resources	Scanners for HR associated with the purchase of OneContent (replacement of DMS)	Provide ability for HR to scan paper documents into electronic filing system - OneContent.	$ 8,000.00	5	3	$ 800.00	12411201
8650	Human Resources	Office furnishings for HR including 5 workstations, round tables, new chairs, guest seating and file cabinets.	To improve HR professional image, create better workflow, provide more ergonomical workspace for employees, and improve service for customers.	$ 23,889.75	15	3	$ 796.00	12411201
8660	Employee Health	Office furniture for Employee Health Office.	Transition to new location next to HR Department, and establish Employee Health office in new location. If a portion of this were approved, it is important to consider the bariatric chair for employee use, since current chairs do not accommodate all employees due to being narrow. Second priority would be a new office chair (same as those in Infusion Dept.) for prolonged sitting.	$ 9,731.08	15	3	$ 324.00	12411201
8660	Employee Health	Symplr Credentialing Company and Electronic Health Records (see Guide of available services)	To standardize clearance and credentialing of new employees, while reducing the amount of time by licensed staff for new hiring. The hiring of employees, credentialing and clearance (following basic guidelines) could be done by non-licensed staff, under the direction of the Employee Health Nurse/Manager with this product.	$ 9,480.00	3	3	$ 1,580.00	12411201
8754	Safety / Security	Install a Repeater - new Hospital Building	Allows outside agency radios to work better in the new building.	$ 6,500.00	5	1	$ 650.00	12251201
9516	Orthopedic Office	Add a reception window that is lower for wheelchair access.	To better serve our Patients.	$ 6,600.00	15	1	$ 220.00	12211201
9516	Orthopedic Clinic	Digital Radiology Room.	Allow sage, quality diagnostic radiography in the Orthopedic Clinic. X-Ray Equipment in Clinic currently was manufactured in 1984. Should be taken out of service per Med Physicist. Equipment has broken components making use challenging. Biomedical/Maintenance/ Physicist/Technologists have all recommended replacement of outdated borderline safe equipment.	$ 190,000.00	7	3	$ 13,571.00	12411201
9517	Surgery Clinic	Set up new General Surgeon's Clinic	Signed on new General Surgeon.	$ 20,000.00	10	1	$ 1,000.00	12211201
8460/9510	Maintenance	Electronic Door Replacement @ PMA Building	Doors are having issues and need to be replaced	$ 10,000.00	10	1	$ 500.00	12211201
			TOTALS FOR BUDGET	$ 2,623,400.79			$278,579.00	

NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT
401(a) RETIREMENT PLAN

AMENDMENT NO. 2

RECITALS

A. NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT ("Employer"), adopted the NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT 401(a) RETIREMENT PLAN (the "Plan") for the benefit of its Employees and their Beneficiaries, effective January 1, 2013.

B. The Employer desires to revise the timing requirements for funding employer contribution.

C. Article XII of the Plan provides that the Employer reserves the right to amend the Plan at any time.

AMENDMENT

NOW, THEREFORE, Employer hereby amends the NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT 401(a) RETIREMENT PLAN as follows:

1. Section 7.2 is hereby amended and restated in its entirety to read as follows:

> 7.2 Timing of Employer Contributions. Contributions made pursuant to Section 7.1 shall be made in accordance with the funding policy established by the Employer.

IN WITNESS WHEREOF, the Employer has caused this amendment to be executed on _____.

EMPLOYER:

NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT

By:_____

Title: _____

APPROVED AS TO FORM AND CONTENT
BEST BEST & KRIEGER LLP

By:_____
Attorneys for Employer

Patty Dickson

Subject: FW: Breast Imaging Services

To: Victoria Alexander-Lane, CEO

In order to continue to provide the highest quality of care to the citizens of the District, I am requesting approval to move ahead with a two-part project in Breast Imaging Services. The quotes we have are only good if we move forward with both components. If we choose a different strategy, I will need to get new quotes.

The upgrade of our mammography machine to 3D Breast tomosynthesis is a complete "forklift" replacement of the mammography unit.

Summary:

- **Upgrade to GE SenoClaire Digital Breast Tomosynthesis unit with SenoBright Contrast Enhanced Spectral Mammography package.**
  - We have a unique opportunity to perform this complete replacement of our current unit through a service contract refresh, which would not require a capital purchase.
  - There is a net increase to our service contract of $34,402.42 annually, for 5 years for the machine.
  - **Total price = $172,012.10** for this equipment (working through the service contract, there is no interest charged even though the upgrade is paid over 5 years)
  - There is an increase of $7,195, annually, to the service contract for service of the new unit. This would cover the tomography radiographic tube. We do not currently have our mammography tube under service contract, although all other parts of the system are covered.
- **Upgrade to GE Invenia Automated 3D Breast Ultrasound**
  - **Capital purchase of $85,360**
  - GE purchased U-systems shortly after our original purchase. GE has made major improvements to the unit and its sensitivity.
  - Platform upgrade would include 1 year warranty (service contract for current machine is $14,400 annually)
  - Net cost of equipment: $70,960
- Power injector for mammography - approximately $35,000 (quote to be brought to the Board at a future date). This is necessary for the contrast enhanced spectral mammography.

History:

Northern Inyo Hospital purchased our current machine, a GE SenoEssential Full field digital mammography unit in 2007.

Northern Inyo Hospital purchased a U-systems Automated 3D Breast Ultrasound machine in 2013. U-systems was purchased by GE shortly after our original purchase.
GE has made significant improvements in the sensitivity of the ultrasound components, improved the resolution, and made significant design improvements.

Why do we need this equipment:

Breast imaging has changed significantly since we purchased our previous unit eight years ago. Digital Breast Tomography (DBT or 3D mammography) is state-of-the art technology. Within the next 3-5 years,

2D mammography will be phasing out. Breast imaging is a high-awareness area for the general public and patients are requesting this level of service. There is a plethora of evidence-based studies demonstrating the increased sensitivity for detecting much smaller breast cancers. Earlier detection means better survival, and less expensive and less invasive treatments.

More Information:
3D Breast tomosynthesis first received FDA approval in February 2011. Dr. Souders felt it was in our patients' best interest to wait and ensure the technology actually delivered higher quality, earlier detection of breast cancer. After reviewing published literature and attending many conferences, he now believes 3D breast tomosynthesis will significantly increase our sensitivity and specificity for detecting early breast cancer.

The amount of information generated for each patient exam would be similar to the amount of data from a CT scan. There is a nominal increase in the radiation exposure to the patient. We would be able to perform 2D mammography (what our current machine does), 3D mammography, digital subtraction mammography, and contrast enhanced mammography.

We have conducted preliminary reviews of the IT systems involved (NovaRad PACS and Penrad Mammography Information System) and do not believe we will need additional bandwidth or a significant increase in server storage space. We have worked with Penrad to ensure our current software has the ability to display the new data studies. At this time, we do not believe we need to purchase GE's proprietary independent workstation to display these studies. We cannot engage GE's project management resources until we have a commitment to move forward with the project. Any data display issues will cause an immediate halt to the project. New quotes would be acquired and brought to the Board.

Centers for Medicare and Medicaid Services (CMS) has found value in 3D tomosynthesis and pay accordingly. Digital mammography with tomosynthesis is reimbursed at a higher national payment rate. The additional codes will be reviewed in three years. I suspect at that time they will be rolled into one mammography code with a lower payment rate. Purchasing the unit at this time allows us to capitalize on the increased revenue.

We could improve our service, lower our prices, and create more accessible women's health care. Additional reimbursement for 3D has the potential to **increase revenue $117,000** annually, even with no increase in volume.
We have had several patients inform us they sought care in Bakersfield because they have 3D mammography. If we expand to Digital Breast Tomography, we will most certainly grow our volume.

When GE purchased U-systems, they immediately began integrating different technology into the ultrasound probe, improving image quality and increasing the sensitivity and resolution. They have also improved the design of the "arm" that positions the probe over the patient, greatly reducing the risk of ergonomic injuries for the technologists and increasing patient comfort. GE made several changes to the geometric design of the probe housing, improving turn-around time between patients and reducing infection control issues. The technology used in the U-systems US probe has been replaced and is no longer produced. The improvements to the quality alone are enough to request this upgrade, however, my biggest concern is support for the current equipment in the out years.

NIH would be the only facility between Lancaster, California and Carson City, Nevada to offer 3D mammography and 3D whole-breast ultrasound.

We have an outstanding Breast Imaging Services program for the patients of our district and regional area. The purchase of this equipment will allow us to continue to provide the most efficient, effective, state-of-the-art diagnostic modalities in breast imaging and allow our patients to continue to receive the top-quality care they need within their local district.

Dr. Souders and I both have previously scheduled engagements out of state and regret that we cannot attend this Board meeting.
Please do not hesitate to call or email us if you have any questions or concerns.

Respectfully,

Patty Dickson, RT (R)(N)(M) *Director of Diagnostic Imaging*
Northern Inyo County Local Hospital District | 150 Pioneer Lane | Bishop, California 93514
(760) 873-2634 (Direct Line) | (760) 873-6393 (Imaging FAX)
Patty.Dickson@NIH.org

News

CMS Establishes Breast Tomosynthesis Values in 2015 MPFS Final Rule

November 05, 2014

Article Updated February 24, 2015

Digital breast tomosynthesis (DBT) has been assigned new billing codes and reimbursement rate values in the final rule for the calendar year (CY) 2015 Medicare Physician Fee Schedule (MPFS).

In response to a request from the American College of Radiology (ACR), the Current Procedural Terminology (CPT) Editorial Panel created three new codes (77061, 77062, and 77063) for CY 2015 to describe the physician work and practice expense associated with screening and diagnostic DBT. However, the Centers for Medicare & Medicaid Services (CMS) recommends in the 2015 MPFS that only 77063, (screening digital breast tomosynthesis, bilateral) be used at this time in conjunction with the digital screening mammography code G0202 . The recommendation is based on a Food & Drug Administration requirement that a 2-D mammogram accompany a DBT when used for screening purposes.

In lieu of using the new diagnostic DBT CPT codes (77061, 77062), CMS created a new add-on G code (G0279) to be used with the existing digital diagnostic mammography codes (G0204, G0206) to reflect the work of tomosynthesis when provided with diagnostic digital mammography. Therefore, the stand-alone diagnostic DBT codes have been replaced by add-on codes, leaving no means to report diagnostic DBT when it is reported separately from a full-field digital mammogram (FFDM).

Further, the payment rate for the new diagnostic DBT code G0279 (0.6 RVUs) is lower than the recommendation made by the AMA/Specialty Society RVS Update Committee (RUC) for the diagnostic DBT CPT codes (0.7 RVUs for unilateral and 0.9 RVUs for bilateral). The ACR disagrees with the payment rate for screening and diagnostic DBT being equal as diagnostic is more work intensive. Medicare will continue to pay separately for the existing FFDM G codes and film CPT mammography codes and has put its proposal to retire the G codes for digital mammography on hold pending a review of the entire mammography code family in 2015. CMS also will modify the descriptor for the FFDM G codes (G0202-G0204) so they are specific to 2-D digital mammography.

The 2014 relative value units (RVUs) from each of the following codes will be used to price mammography for 2015: G0202, G0204, G0206, 77055, 77056, and 77057. CMS noted in the Medicare Physician Fee Schedule Final Rule that they will continue to pay for mammography services at the 2014 rates until they revalue all mammography services. As noted in the following table, the diagnostic DBT codes 77061 and 77062 have not been assigned an RVU value, and the new add-on diagnostic DBT code G0279 has been assigned the same value as the screening DBT code 77063.

The ACR and RUC also made recommendations to CMS regarding the direct inputs used to determine practice expense (PE) RVUs (technical component (TC) payment). CMS lowered the price of the DBT unit from the RUC recommended invoice price of $498,412 to $381,360 based on separately acquired invoices.

View table

The ACR recommended in its comment on the 2015 proposed rule that CMS maintain the 2014 payment rate beyond CY 2015. CMS had asked the RUC to review the mammography CPT and G codes, but the ACR discouraged survey or formal recommendations until the RUC's recommendations for DBT were finalized by CMS; and the film-to-digital conversion, reflected in the use of picture archiving and communication system (PACS), was fully implemented beyond the proposal in the CY 2015 proposed rule.

In response to comments, CMS noted in the final rule that it is including the codes for digital mammography on the potentially misvalued codes list. However, CMS will wait to value the new diagnostic mammography tomosynthesis codes until CMS staff receives recommendations from the RUC for all mammography services. As noted above, codes 77061 and 77062 for diagnostic DBT will not be used in 2015. Diagnostic mammography using tomosynthesis will be reported with the diagnostic digital mammography codes G0204 and G0206, and add-on code G0279 (Diagnostic digital breast tomosynthesis, unilateral or bilateral (List separately in addition to G0204 or G0206)).

Using the 2015 conversion factor of $35.8013, the following global national payment rates will apply for mammography:

NIH Currently

Upgraded System

	Film	Digital	Digital With Tomo
Unilateral Diagnostic Mammogram	77055 = $90.10	G0206 = $129.43	G0206 + G0279 = $129.43 + $56.49
Bilateral Diagnostic Mammogram	77056 = $115.85	G0204 = $164.12	G0204 + G0279 = $164.12 + $56.49
Screening Mammogram	77057 = $82.59	G0202 = $134.80	G0202 + 77063 = $134.80 + $56.13

Updated 2/24/15

Note: Patients will not be responsible for any co-pays associated with the new screening DBT codes. The screening tomosynthesis add-on code, 77063, would be subject to the same co-insurance/deductible policies as other screening mammography services. Code G0279 relates to a diagnostic procedure; therefore, it would not follow the same policies as those established for the screening studies.

The ACR argued before the RUC that surveying mammography along with DBT would preclude an accurate valuation of DBT. DBT and mammography involve different technologies, different work, different practice expenses and often different patients. Because DBT is a new technology, the data regarding utilization, site of service and specialty remain to be seen. To include DBT as simply part of the mammography code family is premature and may eventually prove to be inaccurate. The ACR plan is to re-review the DBT family in three years per the conventional Relativity Assessment Workgroup schedule for the re-review of new technologies.

For more details on the 2015 Final Rule please reference the preliminary summary.

GE Healthcare

Service Contract Addendum

Northern Inyo Hospital

Physical Location Account #: 129271

Optional: Person(s) to be notified when this document is processed:
Name(s): _____
Email(s): _____

Support and prices quoted below are valid provided the customer signs and returns this quote to GE Healthcare by 6/12/2015

Equipment Description	Activity	Equipment	Effective Date	Service	Options	Features	Incremental Annual Amount	Comments
System ID: 760873MAM Contract: 339556 Global Order #: 2667565 Asset No: XMM555-GE13+2667565+1P1-000000001188046	MODIFY: Equipment Modify	GE XR SENOGRAPHE ESSENTIAL FFDM (NON-MOBILE) (XMM555)	6/26/2015	AssurePoint Advance	INCLUDED: • BREAST TOMOSYNTHESIS: AS PER TOMOSYNTHESIS WARRANTY • DETECTOR • GE-SOURCED MAMMO PADDLES • ILINQ RESPONSE TIME: 30 MIN. • TUBE COVERAGE: TUBE COV W/ SENOBRIGHT (CESM) EXCLUDED: • PERIPHERAL DEVICES • Printers • UNINTERRUPTED POWER SUPPLY • WORKSTATION	• FE Coverage Weekdays: MON-FRI, 8AM-9PM • FE Coverage Weekend: NO COVERAGE HRS • FE Onsite Response Time: 4-Hours • InSite/Tech Phone Support • PM Coverage HOURS/DAYS: MON-FRI, 8AM-9PM • Repair Parts: Included, Next Day 10:30 AM LSP-GDXR • Software Upgrades and Updates: Software and Quality Updates • TIP Answer Line • Uptime Commitment: 97% • TIP Succeed Lifecycle Program: LCYCLE-4D • TIP-Ed Online(TM) Subscription	Old Annual Amount: $32,495* Incremental Annual Amount: $1,945 New Annual Amount: $34,440*	
System ID: 760873MAM Contract: 339556 Global Order #: 2667565 Asset No: XMM555-GE13+2667565+1P1-000000001188046	MODIFY: Options Modify	GE XR SENOGRAPHE ESSENTIAL FFDM (NON-MOBILE) (XMM555)	12/25/2015	AssurePoint Advance	INCLUDED: • BREAST TOMOSYNTHESIS		Old Annual Amount: $34,440* Incremental Annual Amount: $5,250 New Annual Amount: $39,690*	End of 6 month TOMO Upgrade Warranty - 12/25/15

GE Healthcare

Service Contract Addendum

Equipment Identifiers	Transaction Type	Equipment	Effective Date	Duration	Options	Pricing	Incremental Annual Amount	Comments
System ID: 760873MAM Contract: 339556 Global Order #: 2667565 Asset No: XMM555-GE13+2667565+1P1-000000001188046	ADD GE Winback(WB)	GEXR SENOGRAPHE ESSENTIAL FFDM (NON-MOBILE) (XMM555)	6/26/2015 through 6/25/2020	AssurePoint Refresh**		• Catalog Description: S30361AK** • Payment Terms: $172,012 60MN** • Inflation Adjustment: Does not apply to this offering	$34,402	Equipment Quote #FR5-042452 Term is for 60 months, ending 6/25/2020

NET ADJUSTMENT TO CONTRACT:	$41,597

The existing Agreement is hereby amended for valuable consideration. Equipment listed above will be Added to, Deleted from, or Modified on the Agreement subject to terms of contract Deliverables document for indicated service offering. Coverage will end on the current Agreement end date unless the Agreement is subsequently renewed or extended. If there is a conflict between this Amendment and any other terms and conditions in the Agreement or Transaction Schedule, the terms and conditions of this Amendment will prevail. This Addendum shall commence on the LATER OF: (a) the above Effective Date if Customer signs and returns this Addendum within fifteen (15) calendar days of the Effective Date; or (b) the date of signature below if Customer does not sign and return this Addendum within fifteen (15) calendar days of the Effective Date.

Estimated Usage (for applicable systems and offering combinations only): Within 90 days after expiration of warranty, and at the end of each one-year anniversary date of the Agreement, GE will review your actual system usage during the prior 12-month period, and if applicable will adjust your estimated usage effective the first day of the next contract year. Corresponding adjustments will be made to your Normal Fixed Charges, effective on such date, to reflect your new estimated usage.

Customer:		GE Healthcare:	
Approved By: _____	Title: _____	Approved By: _____	Title: _____
Signature: _____	Date: _____	Signature: _____	Date: _____

GE Healthcare

Date: 05-18-2015
Quote #: PR5-C42452
Version #: 11

Northern Inyo Hospital
150 Pioneer Ln
Bishop CA 93514-2556

Attn: Patty Dickson
150 Pioneer Lane Bishop
CA 93514

Customer Number :
Quotation Expiration Date: 06-26-2015

This Agreement (as defined below) is by and between the Customer and the GE Healthcare business ("GE Healthcare"), each as identified herein. "Agreement" is defined as this Quotation and the terms and conditions set forth in either (i) the Governing Agreement identified below or (ii) if no Governing Agreement is identified, the following documents:

1) This Quotation that identifies the Product offerings purchased or licensed by Customer;

2) The following documents, as applicable, if attached to this Quotation: (i) GE Healthcare Warranty(ies); (ii) GE Healthcare Additional Terms and Conditions; (iii) GE Healthcare Product Terms and Conditions; and (iv) GE Healthcare General Terms and Conditions.

In the event of conflict among the foregoing items, the order of precedence is as listed above.

This Quotation is subject to withdrawal by GE Healthcare at any time before acceptance. Customer accepts by signing and returning this Quotation or by otherwise providing evidence of acceptance satisfactory to GE Healthcare. Upon acceptance, this Quotation and the related terms and conditions listed above (or the Governing Agreement, if any) shall constitute the complete and final agreement of the parties relating to the Products identified in this Quotation.

No agreement or understanding, oral or written, in any way purporting to modify this Agreement, whether contained in Customer's purchase order or shipping release forms, or elsewhere, shall be binding unless hereafter agreed to in writing by authorized representatives of both parties.

By signing below, each party certifies that it has not made any handwritten modifications.

Governing Agreement:	AmeriNet
Terms of Delivery:	FOB Destination
Billing Terms:	80% delivery / 20% Installation
Payment Terms:	NET 30
Total Quote Net Selling Price:	$172,012.10

INDICATE FORM OF PAYMENT:
(If there is potential to finance with a lease transaction, GE HFS or otherwise, select lease.)
____ Cash * ____ Lease ____ HFS Loan
If financing please provide name of finance company below*:
_____
*Selecting Cash or not identifying GE HFS as the finance company declines option for GE HFS financing.

By signing below, each party certifies that it has not made any handwritten modifications. Manual changes or mark-ups on this Agreement (except signatures in the signature blocks and an indication in the form of payment section below) will be void.

Each party has caused this agreement to be executed by its duly authorized representative as of the date set forth below.

CUSTOMER

_____ _____
Authorized Customer Signature Date

_____ _____
Print Name Print Title

_____
Purchase Order Number (if applicable)

GE HEALTHCARE
Christine Buehner 05-18-201
Signature Date

Vaso Healthcare - Authorized Manufacturer Rep
Email: christine.buehner@ge.com
Office: +1 949 607 7998

GE Healthcare

Date: 05-18-2015
Quote #: PR5-C42452
Version #: 11

Total Quote Selling Price	**$197,012.10**
Trade-In and Other Credits	$25,000.00
Total Quote Net Selling Price	**$172,012.10**

To Accept this Quotation

Please sign and return this Quotation together with your Purchase Order To:
Christine Buehner
Office: +1 949 607 7998
Email: christine.buehner@ge.com

Payment Instructions

Please **Remit** Payment for invoices associated with this quotation to:
GE Medical Systems
Ultrasound Primary Care Diagnostics, LLC
75 Remittance Drive, Suite #1080
Chicago, IL 60675-1080

To Accept This Quotation

- Please sign the quote and any included attachments (where requested).
- If requested, please indicate, your form of payment.
- If you include the purchase order, please make sure it references the following information
  - The correct Quote number and version number above
  - The correct Remit To information as indicated in **"Payment Instructions"** above
  - The correct SHIP TO site name and address
  - The correct BILL TO site name and address
  - The correct Total Quote Net Selling Price as indicated above

05-18-2015

For a copy of the GPO contract or summary, please go to your GPO Membership login page suppliers.amerinet-gpo.com. If a copy of the contract is not available on your membership page, please contact your GPO client manager.

Offer subject to the Terms and Conditions of the applicable Group Purchasing Agreements currently in effect between GE Healthcare and Amerinet include VQ10400 (Imaging, POS, and Multi Vendor Service).

GE Healthcare

Date: 05-18-2015
Quote #: PR5-C42452
Version #: 11

QTY	CATALOG	DESCRIPTION	Ext Sell Pri
1		**SenoClaire LLH1 - BI**	
1	S30361AK	SENOCLAIRE LLH1 INTL FOR	$114,190.

SenoClaire (3D imaging) is an exciting innovation in breast cancer screening and diagnosis. Breast Tomosynthesis is a three-dimensional imaging technology that uses a low dose short X-ray sweep around a compressed breast. The acquired projection images are processed electronically in order to reconstruct a 3D representation of the entire breast.This imaging technique is designed to separate the tissues and to reduce the overlapping of structures , which represents a limiting factor in standard 2D mammography.

SenoClaire is an option of the Senographe Essential platform that generates 3D and 2D images. The dose of SenoClaire view is designed to be equivalent to the dose of a 2D standard acquisition of the same view.

Specifications

Senographe Essential SenoClaire option kit

- Versatile add-on to Senographe Essential full-field digital mammography system
- Quick set-up for 2D and 3D capability
- Large field of view for easy patient positioning
- Carbon cover, ergonomic design and removable paddles make cleaning easy

Compatibility

SenoClaire is compatible with the Senographe Essential platform. Already upgradeable with Contrast Enhanced Spectral Mammography (SenoBright) and Stereotaxy, the Senographe Essential platform continues to demonstrate GE Healthcare's commitment in bringing breast care solutions without having to replace the original gantry and keeping the same interface.

SenoClaire ergonomic design for technologists

- SenoClaire is a simple plug and play option on Senographe Essential imaging system with an ergonomic handling design
- SenoClaire acquires the tomosynthesis images for each view with a simple action of the X-ray exposure control
- The projection images are displayed at the acquisition station for quality control

QTY	CATALOG	DESCRIPTION	Ext Sell Pr

- Removable paddles for easy cleaning
- SenoClaire AEM (Automatic Exposure Management) and manual mode available
- 3D visual indications given at the acquisition workstation and on the Tomosynthesis device
- Flexibility in the acquisition workflow definition
- Two compression modes: manual and motorized
- SenoClaire is taking advantage of the Senographe Essential ergonomic design.

SenoClaire Patient Comfort

- Ergonomic handles for arm rest during the exam
- Typical acquisition time is <10 sec (average breast of 4.5cm)
- Manual adjustment of the compression
- Possibility to automatically decompress after exposure to minimize patient time under compression

SenoClaire Data Management

- SenoClaire designed to allow exporting tomographic data sets with DICOM Breast Tomosynthesis Storage class.
- SenoClaire is designed to work with compatible IDI Workflow Solution.
- Image compression capability
- Tomo-planes spacing: 0.5mm.

SenoClaire Innovative Technology

- SenoClaire tomographic parameters: sweep angle is 25 with 9 projections
- The innovative "Step and Shoot" tube motion stops for each exposure to avoid image blur
- Mo and Rh tube tracks create very narrow x-ray spectra, exactly where the dose efficiency is for thin (Mo) and medium and thick breasts (Rh)
- Senographe Essential detector, 100 microns (no binning)
- SenoClaire uses ASiRDBT, an iterative reconstruction algorithm
- The dose of a SenoClaire view is designed to be equivalent to the dose of a 2D standard acquisition of the same view.

GE Healthcare

Date: 05-18-2015
Quote #: PR5-C42452
Version #: 11

QTY	CATALOG	DESCRIPTION	Ext Sell Pr
		Quality Control A dedicated quality control protocol is used for GE Breast Tomosynthesis	
1	S30361AD	DBT License The SenoClaire license is required only in France, Germany, Netherlands, Japan and USA.	$3,610
1	S30361AG	SENOCLAIRE LLH1 CART The cart is an option of the MTD, (Motorized Tomosynthesis Device), that helps the operator insert, remove, transport and store the device when not in use.	$1,900
1	W4020HC	DBT MED RADIOLOGIST TRNG 8-HOUR DIGITAL BREAST TOMOSYNTHESIS (DBT) TRAINING PROGRAM FOR Qty. (1) RADIOLOGIST Developed in cooperation with Daniel B. Kopans, M.D., FACR Professor of Radiology - Harvard Medical School Senior Radiologist Breast Imaging Division - Massachusetts General Hospital R. Edward Hendrick, Ph.D., FACR Clinical Professor of Radiology University of Colorado - Denver The following are the objectives and course outline for providing radiologists with 8 hours of training in Digital Breast Tomosynthesis to comply with FDA requirements. Objectives: The radiologist completing this course will: • Understand the basic principles of image formation and display in digital breast tomosynthesis (DBT) • Know the fundamental differences between DBT and 2D digital mammography • Know the design options for DBT and the specific choices made in design of the GE SenoClaire DBT system • Understand the clinical role of DBT in breast imaging, including the specific labeling of the GE SenoClaire system • Know the ACR accreditation and FDA certification requirements for DBT, including image archiving requirements Understand imaging trade-offs on in DBT - reconstructed plane thickness and other issues • Be familiar with basics of image acquisition using the MTD (motorized tomosynthesis device) on the GE Senographe Essential digital	$1,875.

QTY	CATALOG	DESCRIPTION	Ext Sell Pri

mammography system

- Be familiar with the basics of image transfer and storage of DBT images (file sizes and storage requirements of DBT compared to 2D digital mammography)
- Understand the important elements of image display and image interpretation in digital breast tomosynthesis
- Know the key diagnostic features for the display, detection, and diagnosis of lesions appearing as masses, calcification groups, asymmetries and architectural distortions, including both similarities and differences between interpretation of these findings on digital mammography and DBT.
- Understand and see examples of DBT image quality compared to 2D digital mammography.
- Understand DBT doses compared to those of 2D digital mammography

Content Outline: Introduction to DBT - 1 hour

- Basic principles of DBT
- Differences between DBT and 2D digital mammography
- DBT design elements
- Specific design choices in the SenoClaire DBT system -Step and shoot vs continuous motion -Choice of acquisition angles and number of views -Spatial resolution of DBT images -2D and DBT field-of-view and view options -Image reconstruction and artifact reduction -Patient breast doses on the SenoClaire DBT system
- QC on the SenoClaire DBT system and the roles of the QC technologist, medical physicist, and radiologist Using the DBT workstation - 1 hour
- Display features of the DBT workstation -Planes & slabs -Image display options -Viewing tools
- Options in reviewing cases with DBT -Image search strategies - planes, slabs, and viewing methods -Search for masses -Search for pleomorphic calcifications in clusters, linear branching, or segmental - use of slabs -Search for architectural distortions -Search for asymmetries -Comparison to prior mammograms
- Locating lesions by laterality, x-y coordinates & plane number

Appearance of Normal Anatomy and Assessment of Breast Density - hour

- Normal Anatomy on DBT
- Assessing Breast Density on DBT -Density 1: Mostly fatty

QTY	CATALOG	DESCRIPTION	Ext Sell Pri

-Density 2: Scattered Fibroglandular Structures -Density 3: Heterogenously dense -Density 4: Extremely dense -Assessing the Male Breast

Masses on DBT - 1 hour

- Shape -Round -Oval -Lobulated -Irregular -Architectural distortion.
- Margins (These modify the shape of the mass) -Circumscribed (well defined or sharply defined) margins. -Microlobulated margins -Obscured margins. -Indistinct (ill-defined) margins -Spiculated margins
- Special cases -Asymmetric Tubular Structure/Solitary dilated duct -Intramammary lymph nodes -"Global Asymmetry" "Asymmetric breast tissue" -Focal Asymmetric Density - a density that cannot be accurately described using the other shapes. It is visible as asymmetry of tissue density. It could represent an island of normal breast, but its lack of specific benign characteristics may warrant further evaluation. Additional imaging may reveal a true mass or significant architectural distortion.
- Density of lesions (attenuation) -High density -Equal density (isodense to fibroglandular tissue) -Low density (lower attenuation than an equal volume of fibroglandular tissue but not fat containing) -Fat containing (radiolucent)

Calcifications on DBT - 1 hour

- Typically benign -Skin calcifications -Vascular calcifications -Coarse or popcorn-like calcifications -Large rod-like calcifications -Round calcifications -Spherical or lucent-centered calcifications -Rim or eggshell calcifications -Milk of calcium calcifications -Suture calcifications -Dystrophic calcifications -Punctate calcifications
- Intermediate concern calcifications are indistinct or amorphous
- Higher probability of malignancy -Pleomorphic or heterogeneous calcifications (granular) -Fine linear or branching calcifications
- Distribution modifiers -Grouped or clustered. -Linear -Segmental -Regional -Scattered or diffuse -Multiple groups

Superposition Findings on DBT: Locations that appear to be of concern, but which appear normal on DBT. - hour

- Clustered Calcifications
- Mass
- Architectural distortion

Associated Findings on DBT: Used with masses or calcifications or may stand

QTY	CATALOG	DESCRIPTION	Ext Sell Pri
		alone as findings when no other abnormality is present - hour • Skin retraction. • Nipple retraction • Skin thickening • Trabecular thickening • Skin lesion • Axillary adenopathy Hands-on DBT interpretation - 2 hours • Training Cases • Difficult Cases • Test Cases Summary and Questions and Answers hour • Reporting DBT results • Important take-home points • Questions and answers	
1		**SENOGRAPHE ESSENTIAL IB OPTIONS - BI**	
1	S30331CM	CESM OPTION WITH LICENSE SenoBright Contrast Enhanced Spectral Mammography SenoBright is an exciting innovation to help doctors in the diagnosis of breast diseases. Two images are provided for each of the standard CC and MLO views. The first image of each view represents a standard mammography view, while the second is a recombined iodine contrast-enhanced image. A variety of technologies are combined to add this option to standard Senographe DS or Senographe Essential mammography systems. SenoBright performs data acquisition at multiple KV levels, spectrally filters the resulting x-rays to take advantage of typical attenuation curves of iodinated contrast agents, performs the data collection of these multiple energies of the x-ray profile and finally uses a patented recombination of the data to provide the resulting contrast-enhanced image. Intended Use Contrast Enhanced Spectral Mammography (CESM) is an extension of the existing indication for diagnostic mammography with the Senographe	$68,200.(

QTY	CATALOG	DESCRIPTION	Ext Sell Pri

Essential or Senographe DS. The CESM application shall enable contrast enhanced breast imaging using a dual energy technique. This imaging technique can be used as an adjunct following mammography and ultrasound exams to localize a known or suspected lesion.

Compatibility

SenoBright is compatible with the following new GE Digital Mammography systems:

- Senographe Essential
- Senographe DS. In addition, all of the existing Senographe Essential and Senographe DS can be field upgraded to run SenoBright. Contact your GE Sales Representative with questions about compatibility.

SenoBright is DICOM compatible. Refer to the appropriate Senographe Essential or Senographe DS DICOM Conformance Statement for details.

SenoBright is compatible with the following workstations:

- IDI version 4.6 or higher (recommended)

Ergonomic design for technologists

- Simple user switching between standard mammography and Spectral Mammography mode
- Contrast media information can be stored with the images
- SenoBright provides a timer function to both monitor and record time after injection which is displayed as an annotated field in the images
- SenoBright offers both automated and manual exposure modes for the dual-energy exam
- SenoBright will automatically acquire the Spectral Mammography images for each view with a single action of the x-ray exposure control
- Dose information is provided, both for skin entrance and average glandular dose for each image of the Spectral Mammography acquisition

Simple review Workflow

- Automatic display and storage of "Low Energy" conventional images
- Automatic calculation, display and storage of the recombined iodine image

Patient Comfort

- Compression time for each view is designed to be a maximum of 15 seconds

QTY	CATALOG	DESCRIPTION	Ext Sell Pri
		• Depending on the patient and technologist, the entire imaging procedure can be completed in as little as 4 minutes following the contrast media injection • As with our standard mammography systems, patients lying in a recumbent position can be examined with SenoBright Filter SenoBright chooses filtering materials depending on the operating mode and the exposure levels necessary. For the high-energy acquisition, a proprietary multi-layer filter is used to shape the resulting energies of the x-ray spectrum to those required to best highlight iodine. Energy Levels The energy levels will vary depending on the patient, specifically on the breast thickness within the range: • 26-30 KVp for lower energy acquisition • 45-49 KVp for higher energy acquisition Quality Control A dedicated quality control protocol is used for SenoBright, with the same phantoms used for Senographe DS and Senographe Essential	
1	S30351EJ	IDI CESM License The IDI CESM License allows the radiologist to easily review a GE Contrast Ehanced Spectral Mammography exam. IDI CESM License enables the IDI Mammo Workstation to provide an optimal way to display the GE CESM dataset using a dedicated hanging protocol	$2,200.(
1		**WORKSTATION IDI 4-7-0 - BI**	
1	S30351HD	IDI DICOM Shuttle DICOM Shuttle is a tool for fast transmission of medical image data. It connects DICOM enabled devices in different locations over a given - preferably secure - connection. DICOM Shuttle enables fast teleradiology transparent to connected DICOM devices leveraging JPEG2000 image compression.	$3,400.(
1	S30351AR	Power Cord Kit 1 Set One set of power cords for UK/USA/JAPAN/CHINA	$64.(

GE Healthcare

Date: 05-18-2015
Quote #: PR5-C42452
Version #: 11

QTY	CATALOG	DESCRIPTION	Ext Sell Pri
1	S30351GP	IDI Digit Breast Tomo License	$1,572
		IDI Digital Breast Tomosynthesis License	
		Quote Summary:	
		Customer Loyalty SenoClaire DBT Upgrade	
		Total Quote Net Selling Price	$172,012.
		(Quoted prices do not reflect state and local taxes if applicable.)	

GE Healthcare

Date: 05-13-2015
Quote #: PR9-C35071
Version #: 3

Northern Inyo Hospital
150 Pioneer Ln
Bishop CA 93514-2556

Attn: patty dickson
150 Pioneer Ln Bishop
CA 93514

Customer Number :
Quotation Expiration Date: 06-26-2015

This Agreement (as defined below) is by and between the Customer and the GE Healthcare business ("GE Healthcare"), each as identified herein. "Agreement" is defined as this Quotation and the terms and conditions se forth in either (i) the Governing Agreement identified below or (ii) if no Governing Agreement is identified, the following documents:

1) This Quotation that identifies the Product offerings purchased or licensed by Customer;

2) The following documents, as applicable, if attached to this Quotation: (i) GE Healthcare Warranty(ies); (ii) GE Healthcare Additional Terms and Conditions; (iii) GE Healthcare Product Terms and Conditions; and (iv) GE Healthcare General Terms and Conditions.

In the event of conflict among the foregoing items, the order of precedence is as listed above.

This Quotation is subject to withdrawal by GE Healthcare at any time before acceptance. Customer accepts by signing and returning this Quotation or by otherwise providing evidence of acceptance satisfactory to GE Healthcare. Upon acceptance, this Quotation and the related terms and conditions listed above (or the Governing Agreement, if any) shall constitute the complete and final agreement of the parties relating to the Products identified in this Quotation.

No agreement or understanding, oral or written, in any way purporting to modify this Agreement, whether contained in Customer's purchase order or shipping release forms, or elsewhere, shall be binding unless hereafter agreed to in writing by authorized representatives of both parties.

By signing below, each party certifies that it has not made any handwritten modifications.

Governing Agreement:	AmeriNet
Terms of Delivery:	FOB Destination
Billing Terms:	80% delivery / 20% Installation
Payment Terms:	NET 30
Total Quote Net Selling Price:	$85,360.00

INDICATE FORM OF PAYMENT:
(If there is potential to finance with a lease transaction, GE HFS or otherwise, select lease.)
____ Cash * ____ Lease ____ HFS Loan
If financing please provide name of finance company below*:
_____
*Selecting Cash or not identifying GE HFS as the finance company declines option for GE HFS financing.

By signing below, each party certifies that it has not made any handwritten modifications. Manual changes or mark-ups on this Agreement (except signatures in the signature blocks and an indication in the form of payment section below) will be void.

Each party has caused this agreement to be executed by its duly authorized representative as of the date set forth below.

CUSTOMER

_____ _____
Authorized Customer Signature Date

_____ _____
Print Name Print Title

_____
Purchase Order Number (if applicable)

GE HEALTHCARE
Elizabeth Birkmeyer 05-18-201
Signature Date

Product Sales Specialist
Email: Elizabeth.Birkmeyer@ge.com
Office: +1 541 223 2143
Mobile: (541) 223-2143

GE Healthcare

Date: 05-13-2015
Quote #: PR9-C35071
Version #: 3

Total Quote Selling Price	$85,360.00
Trade-In and Other Credits	$0.00
Total Quote Net Selling Price	$85,360.00

To Accept this Quotation

Please sign and return this Quotation together with your Purchase Order To:
Elizabeth Birkmeyer
Office: +1 541 223 2143
Mobile: (541) 223-2143
Email: Elizabeth.Birkmeyer@ge.com

Payment Instructions

Please **Remit** Payment for invoices associated with this quotation to:
GE Medical Systems
Ultrasound Primary Care Diagnostics, LLC
75 Remittance Drive, Suite #1080
Chicago, IL 60675-1080

To Accept This Quotation

- Please sign the quote and any included attachments (where requested).
- If requested, please indicate, your form of payment.
- If you include the purchase order, please make sure it references the following information
  - The correct Quote number and version number above
  - The correct Remit To information as indicated in **"Payment Instructions"** above
  - The correct SHIP TO site name and address
  - The correct BILL TO site name and address
  - The correct Total Quote Net Selling Price as indicated above

05-13-2015

For a copy of the GPO contract or summary, please go to your GPO Membership login page suppliers.amerinet-gpo.com. If a copy of the contract is not available on your membership page, please contact your GPO client manager.

Offer subject to the Terms and Conditions of the applicable Group Purchasing Agreements currently in effect between GE Healthcare and Amerinet include VQ10400 (Imaging, POS, and Multi Vendor Service).

GE Healthcare

Date: 05-13-2015
Quote #: PR9-C35071
Version #: 3

QTY	CATALOG	DESCRIPTION	Ext Sell Pr
1		**Invenia ABUS USA**	
1	H5014UP	Invenia* ABUS Upgrade Current customer package for existing somo v ABUS customers. The Invenia* ABUS (Automated Breast Ultrasound System) is designed for automated, full-field, 3D breast screening and diagnostic workflows. The Invenia ABUS platform is comprised of the Invenia ABUS Scan Station and the Invenia ABUS Workstation. The Invenia ABUS Scan Station offers: • An intuitive, icon-driven 17 inch LCD touchscreen that is easy to use and supports streamlined workflow. • Compression Assist functionality, enabled by an advanced system of locking mechanisms in the articulating arm, allowing for an exam that is comfortable for patients and operators alike. • An integrated C15-6XW ultra-broadband, Reverse Curve* transducer designed for uniform contact, and patient comfort. • Intelligent Imaging Algorithms with feature detection and enhancement techniques that automatically optimize the image for extraordinary image quality. The Invenia ABUS Workstation operates on innovative, 64 bit technology. The Invenia ABUS application runs on a Microsoft** operating system and is displayed on a 24 in. I high resolution monitor. The workstation incorporates patented hanging protocols and advanced analysis tools for efficient review and reporting. GE Healthcare hereby grants Customer a one-time option to have any GE Healthcare-provided Invenia ABUS Workstation software transferred to a different, compatible Workstation owned by the Customer, subject to the same software license terms. If Customer exercises this option, the software de-installation/re-installation shall be performed only by GE Healthcare-authorized personnel at GE Healthcare's then-applicable labor rates, less any applicable discounts. Customer may exercise this option by written notice to GE Healthcare at any time during the three-year period following delivery of the Workstation. If this option is not exercised within such three-year period, it will automatically expire. Supports DICOM 3.0, providing Verify, Print, Store, Multi-frame, Modality Worklist, MPPS (Modality Performed Procedure Step), Storage Commitment, and Media Exchange. Additionally, supports Additionally, supports Query/Retrieve and Structured Reporting. The included Invenia ABUS Marketing Kit provides targeted marketing tools to help educate patients and generate awareness among clinicians. The kit	$82,256

QTY	CATALOG	DESCRIPTION	Ext Sell Pr
		features professionally designed content for you to market Invenia ABUS screening to referring physicians, their patients, and women in your community. This complete kit of tools will help with the implementation of ABUS imaging in your practice. Requires one of the following FDA-required applications trainings: H5013AP, H5014IA, OR H5013AT AND one of the following FDA-required physician trainings: H5013RA or H5014PW. Offer includes initial installation and connection to customer network, one-year warranty, a starter kit of 50 membranes, and 12 bottles of Parker polysonic lotion. Application training must be completed within six (6) months after Product delivery, otherwise GE Healthcare's obligation to provide the training will expire without refund. *Trademark of General Electric Company **Third party trademarks are the property of their respective owners	
1	H5014PW	Invenia* ABUS Mastery Program for Physicians Waiver This waiver may be used for physicians that have already completed the eight hour FDA-required ABUS physician training. Certificate of completion must be provided for this option. *Trademark of General Electric Company **Third party trademarks are the property of their respective owners	In
1	H5013AT	Invenia* ABUS Applications Refresher Course Invenia* ABUS applications one day training refresher/follow-up on a future date after the initial ABUS purchase/installation. Conducted by a Clinical Applications Specialist for up to 3 personnel. For new users, a minimum of 3 days are required per FDA and CEUs (Please refer to H5013AP). *Trademark of General Electric Company	$3,104.(
		Configuration List Price:	$110,000.(
		Quote Summary: **Platinum ABUS** **Total Quote Net Selling Price** (Quoted prices do not reflect state and local taxes if applicable.)	**$85,360.(**

GE Healthcare

Date: 05-13-2015
Quote #: PR9-C35071
Version #: 3

QTY	CATALOG	DESCRIPTION	Ext Sell Pr

NORTHERN INYO HOSPITAL
People you know, caring for people you love.

Northern Inyo County Local Hospital District

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811
www.nih.org

May 20, 2015

To: Northern Inyo County Local Hospital
District Board of Directors

From: Scott Hooker Property / Project Manager

Richard Miears EVS Manager

Topic: Floor Waxing Contract

Dear Board of Directors,

Northern Inyo Hospital advertised a request for proposal for floor waxing, this RFP was advertized during the month of May.

We received two proposals:

Just Do Right Janitorial $96,577.47 3/ year contract

Bishop Building Maintenance $134,709.00 3/ year contract

Richard and I are asking for your approval on the contract provided by Just Do Right Janitorial, in the amount of $96,577.47 this covers a three year period, and provides us with routine floor waxing on all of Northern Inyo's Properties.

Thank You very much for your time and consideration,

Scott Hooker

Contract and Terms

Services Agreement

THIS AGREEMENT is made this 1st day of June, 2015 by and between Just Do Right Janitorial ("Company") and Northern Inyo Hospital ("Customer").

Term

The Company shall provide services to the Customer for a period of *thirty-seven months/three years and one month (37 months/3 years and 1 month)* with a commencement date of *June 1, 2015* and ending *June 30, 2018* for the amount of *Ninety-Six Thousand, Five Hundred Seventy-Seven Dollars and Forty-Seven Cents ($96,577.47)* for said term, as described in Exhibit A.

Recitals

A. Company has experience and expertise in VCT/Sheet Vinyl Strip, Scrub, Wax and Maintenance.

B. Customer desires to have Company provide services for them.

C. Company desires to provide services to Customer on the terms and conditions set forth herein (the "Services").

Agreements

In consideration of the mutual covenants set forth in this Agreement, Customer and Company hereby agree as follows:

1. Services Rendered.

Company agrees to render and be compensated for the Services according to the terms listed on Exhibit A attached hereto.

2. Scope of Work.

Company agrees to provide Services pursuant to the Scope of Work set forth in Exhibit B attached hereto (the "Scope of Work").

3. Delivery of Services.

Company agrees to provide to the Customer, all labor, supervision, materials and equipment necessary to assure the performance the Company's Floor Waxing Services for the Customer.

The Services that the Company shall provide to the Customer are as set out in Exhibit B attached hereto (the "Scope of Work").

4. Ownership Rights.

Customer shall retain all of its intellectual property rights in any text, images or other components it owns and transmits to Company for use in the Services. Customer shall hold the copyright for the agreed-upon version of the Services as delivered, and Customer's copyright notice may be displayed in the final version.

Company retains exclusive rights to pre-existing material it uses in Customer's project(s). Customer does not have right to reuse, resell or otherwise transfer material owned by Company or third parties. Company's materials shall be defined as set forth in Exhibit C, attached.

5. Compensation.

For all of Company's services under this Agreement, Customer shall compensate Company, in cash, pursuant to the terms of Exhibit A attached hereto. In the event Customer fails to make any of the payments referenced in Exhibit A by the deadline set forth in Exhibit A, Company have the right, but is not obligated, to pursue any or all of the following remedies: (1) terminate the Agreement, (2) remove or withhold services or deliverables, or (3) bring legal action.

6. Confidentiality.

Customer and Company acknowledge and agree that the Scope of Work and all other documents and information related to the development of the Services (the "Confidential Information") will constitute valuable trade secrets of Company. Customer shall keep the Confidential Information in confidence and shall not, at any time during or after the term of this Agreement, without Company's prior written consent, disclose or otherwise make available to anyone, either directly or indirectly, all or any part of the Confidential Information. Excluded from the "Confidential Information" definition is anything that can be seen by the public.

7. Limited Warranty and Limitation on Damages.

Company warrants the Services will conform to the Scope of Work. If the Services or Deliverables do not conform to the Scope of Work, Company shall be responsible to correct the Services or Deliverables without unreasonable delay, at Company's sole

expense and without charge to Customer, to bring the Services or Deliverables into conformance with the Scope of Work. This warranty shall be the exclusive warranty available to Customer. Customer waives any other warranty, express or implied. Customer acknowledges that Company is not responsible for the results obtained by Customer on the Services. See Exhibit D for Workman's Comp. and Liability Coverages Information

8. Independent Contractor.

Company shall be retained as an independent contractor. Company will be fully responsible for payment of its own income taxes on all compensation earned under this Agreement. Customer will not withhold or pay any income tax, social security tax, or any other payroll taxes on Company's behalf. Company understands that it will not be entitled to any fringe benefits that Customer provides for its employees generally or to any statutory employment benefits, including without limitation, worker's compensation or unemployment insurance.

9. Equipment.

Customer agrees to make available to Company, for Company's use in performing the Annual HIPPA training required as stated in Section B of the Contractor Requirements/Expectations Item C in the RFP, such items of hardware and software as Customer and Company may agree are reasonably necessary for such purpose.

10. General Provisions.

10.1 Entire Agreement.

This Agreement contains the entire agreement between the parties relating to the subject matter hereof and supersedes any and all prior agreements or understandings, written or oral, between the parties related to the subject matter hereof. No modification of this Agreement shall be valid unless made in writing and signed by both of the parties hereto.

10.2 Governing Law.

This Agreement shall be governed by and construed in accordance with the laws of the State of CA. Exclusive jurisdiction and venue shall be in the Inyo County, CA Superior Court.

10.3 Binding Effect.

This Agreement shall be binding upon and inure to the benefit of Customer and Company and their respective successors and assigns, provided that Company may not assign any of its obligations under this Agreement without Customer's prior written consent.

10.4 Waiver.

The waiver by either party of any breach or failure to enforce any of the terms and conditions of this Agreement at any time shall not in any way affect, limit, or waive such party's right thereafter to enforce and compel strict compliance with every term and condition of this Agreement.

10.5 Good Faith.

Each party represents and warrants to the other that such party has acted in good faith, and agrees to continue to so act, in the negotiation, execution, delivery, performance, and any termination of this Agreement.

10.6 Right to Remove Services.

In the event Customer fails to make any of the payments set forth on Exhibit A within the time prescribed in Exhibit A, Company has the right to remove or withhold the Services or Deliverables until payment in full is made, plus accrued late charges of 1 ½%.

10.7 Indemnification.

Customer warrants that everything it gives Company to use in the delivery of the Services or any deliverable is legally owned or licensed to Customer. Customer agrees to indemnify and hold Company harmless from any and all claims brought by any third party relating to any aspect of the Services, including, but without limitation, any and all demands, liabilities, losses, costs and claims including attorney's fees arising out of injury caused by Customer's products/services, material supplied by Customer, copyright infringement, and defective products sold via the Services or Deliverables.

10.8 Use of Services for Promotional Purposes.

Customer grants Company the right to reference the Services or Deliverables or the Customer's name for promotional purposes and/or to cross-link it with other Services offered by Company.

10.9 No Responsibility for Theft.

Company has no responsibility for any third party taking, stealing, destroying or otherwise ruining all or any part of the Services or Deliverables rendered under this Agreement.

10.10 Attorney's Fees.

In the event any party to this Agreement employs an attorney to enforce any of the terms of the Agreement, the prevailing party shall be entitled to recover its actual attorney's fees and costs, including expert witness fees.

10.11 Identification of Company.

Customer agrees that Company's identification may be associated with the Services or Deliverables as the creators. Customer also agrees to put Company's copyright notices on the Services or Deliverables and the relevant content therein.

10.12 No Responsibility for Loss.

Company is not responsible for any non-accessible project areas due high census during scheduled tasks. EVS Manager will reschedule with the Company those project tasks during a low census time and/or department closures to allow Company to fulfill contract requirements.

The parties represent and warrant that, on the date first written above, they are authorized to enter into this Agreement in its entirety and duly bind their respective principals by their signatures below:

EXECUTED as of the date first written above.

Northern Inyo Hospital

By: _____

Title: _____

Date signed: _____

Just Do Right Janitorial

By: _____

Title: _____

Date signed: _____

RESOLUTION NO. ____
OF THE
NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT
BOARD OF DIRECTORS

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

WHEREAS, using data provided by the State of California Department of Finance, on May, 2014, the Board of Directors of Northern Inyo Hospital established an appropriations limit of $532,992.51 for the July 1, 2014 to June 30, 2015 fiscal year; and

WHEREAS, using the attached data provided by the State of California Department of Finance, an appropriations limit of $553,086.33 has been calculated for the July 1, 2015 to June 30, 2016 fiscal year.

NOW, THEREFORE, BE IT RESOLVED by this Board of Directors of Northern Inyo County Local Hospital District, meeting in regular session this 17th day of June, 2015 that an appropriations limit of $553,992.51 be established for the Northern Inyo County Local Hospital District for the 2015-2016 fiscal year; and

BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting.

_____
M.C. Hubbard., President

Attest: _____
D. Scott Clark, MD, Secretary

APPROPRIATIONS LIMIT CALCULATIONS
FISCAL YEAR 2015

Per capita change multiplied by the population change yields a calculation factor.

For the district this is:

1.0382 X .9995 = 1.0377

1.0377 times $532,992.51 equals 553,086.33

New Limit is $553,086.33

DEPARTMENT OF FINANCE
OFFICE OF THE DIRECTOR

EDMUND G. BROWN JR. • GOVERNOR
STATE CAPITOL ■ ROOM 1145 ■ SACRAMENTO CA ■ 95814-4998 ■ WWW.DOF.CA.GOV

May 2015

Dear Fiscal Officer:

Subject: Price and Population Information

Appropriations Limit
The California Revenue and Taxation Code, section 2227, mandates the Department of Finance (Finance) to transmit an estimate of the percentage change in population to local governments. Each local jurisdiction must use their percentage change in population factor for January 1, 2015, in conjunction with a change in the cost of living, or price factor, to calculate their appropriations limit for fiscal year 2015-16. Attachment A provides the change in California's per capita personal income and an example for utilizing the price factor and population percentage change factor to calculate the 2015-16 appropriations limit. Attachment B provides city and unincorporated county population percentage change. Attachment C provides population percentage change for counties and their summed incorporated areas. The population percentage change data excludes federal and state institutionalized populations and military populations.

Population Percent Change for Special Districts
Some special districts must establish an annual appropriations limit. Consult the Revenue and Taxation Code section 2228 for further information regarding the appropriations limit. Article XIII B, section 9(C), of the State Constitution exempts certain special districts from the appropriations limit calculation mandate. The Code and the California Constitution can be accessed at the following website: http://leginfo.legislature.ca.gov/faces/codes.xhtml.

Special districts required by law to calculate their appropriations limit must present the calculation as part of their annual audit. Any questions special districts have on this issue should be referred to their respective county for clarification, or to their legal representation, or to the law itself. No state agency reviews the local appropriations limits.

Population Certification
The population certification program applies only to cities and counties. Revenue and Taxation Code section 11005.6 mandates Finance to automatically certify any population estimate that exceeds the current certified population with the State Controller's Office. **Finance will certify the higher estimate to the State Controller by June 1, 2015**.

Please Note: Prior year's city population estimates may be revised.

If you have any questions regarding this data, please contact the Demographic Research Unit at (916) 323-4086.

MICHAEL COHEN
Director
By:

KEELY M. BOSLER
Chief Deputy Director

Attachment

May 2015

Attachment A

A. **Price Factor**: Article XIII B specifies that local jurisdictions select their cost of living factor to compute their appropriation limit by a vote of their governing body. The cost of living factor provided here is per capita personal income. If the percentage change in per capita personal income is selected, the percentage change to be used in setting the fiscal year 2015-16 appropriation limit is:

Per Capita Personal Income

Fiscal Year (FY)	Percentage change over prior year
2015-16	3.82

B. Following is an example using sample population change and the change in California per capita personal income as growth factors in computing a 2015-16 appropriation limit.

2015-16:

Per Capita Cost of Living Change = 3.82 percent
Population Change = 0.93 percent

Per Capita Cost of Living converted to a ratio: $\frac{3.82 + 100}{100} = 1.0382$

Population converted to a ratio: $\frac{0.93 + 100}{100} = 1.0093$

Calculation of factor for FY 2015-16:

$1.0382 \times 1.0093 = 1.0479$

Fiscal Year 2015-16

Attachment B
Annual Percent Change in Population Minus Exclusions*
January 1, 2014 to January 1, 2015 and Total Population, January 1, 2015

County City	Percent Change 2014-2015	--- Population Minus Exclusions --- 1-1-14	 1-1-15	Total Population 1-1-2015
Inyo				
Bishop	0.05	3,879	3,881	3,881
Unincorporated	-0.08	14,612	14,600	14,693
County Total	-0.05	18,491	18,481	18,574

*Exclusions include residents on federal military installations and group quarters residents in state mental institutions, state and federal correctional institutions and veteran homes.

NORTHERN INYO HOSPITAL
People you know, caring for people you love.

Northern Inyo County Local Hospital District

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811
www.nih.org

TO: Board of Directors

FROM: Leon Freis, R.Ph., COO/CIO

RE: Request for Approval of Microsoft Licensing Agreement Renewal

DATE: June 4, 2015

Background:

- Northern Inyo Hospital uses Microsoft Software licensed under an "Enterprise Agreement" contract with Microsoft.
- Our contract is under a master agreement held by the City of Riverside, affording us buying power we could not negotiate on our own.
- NIH is ineligible for Microsoft Non-Profit Foundation Pricing due to our status as a governmental agency and as a health care organization with own-use software.
- Our current Microsoft Licensing Agreement ends in July.
- For the past contract period July 1, 2012 through June 30, 2015, our licensing costs were $108,000. This amount was never adjusted for the addition of 150 user devices, 100 servers and database size increases.
- The true number of Microsoft Licenses has been reported to Microsoft and the maintenance fee adjusted to approximately $163,000 per year. This new operating cost has been included in the 2015-16 operating budget which will come before the board for approval.
- As the renewal is mandatory for continued use of Microsoft products, but the amount of the renewal is approximately 50% greater than the past agreement, I am asking the board's approval of the Microsoft Licensing Renewal Agreement.

NORTHERN INYO HOSPITAL
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Northern Inyo County Local Hospital District

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811
www.nih.org

June 4, 2015

To: Victoria Alexander-Lane, CEO

From: Carrie Petersen, Chief of Fiscal Services & Mary Ellen Tillemans Director of Revenue Cycle

RE: Proposed update of current employee discount policy

In September of 2013, the NIH Board approved a 50% discount policy for employees of Northern Inyo to be effective January 1, 2014. In January of 2014, the Administrator sent clarification to the Patient Accounting staff that physicians on the active medical staff were to be included in the discount policy. It is my understand that he planned to update the policy and present to the Board of Directors by June 30, 2014, the outlined date in the information for expiration of the extension of the policy to the physicians.

After receiving a legal opinion on this practice, we have been advised that we should not offer an "employee discount" to physicians. Some physicians may end up being eligible for the "employee discount" as part of their status of employed instead of independent contractor.

We are also using this opportunity to correct the policy to reflect our current District Discount of 25% and Prompt Pay policy of 20% for all patients.

Thank you for your consideration.

NORTHERN INYO HOSPITAL
EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: Benefits - EMPLOYEE MEDICAL EXPENSE DISCOUNT	
Scope: Hospital Wide	Department: **Human resources – Employee Handbook**
Source: Human Resources	Effective Date: 01/01/2014

POLICY:

Effective with dates of service January 1, 2014, all current Northern Inyo Hospital employees, covered under Northern Inyo Hospital's medical benefit plan, or other group medical benefit plan in its place, and only dependents covered under Northern Inyo Hospital medical benefit plan, will be entitled to a 50 percent discount off their "covered" out of pocket medical expense for services received at Northern Inyo Hospital.

The 50 percent discount will be applied upon receipt of payment in full for the employee's or dependent's "covered" out of pocket expense. The payment in full is due within 30 days of receipt of the first bill following reimbursement of the benefit plan. The 50 percent discount will be applied following either the applicable District Resident Discount of 25 percent, or the applicable Prompt Pay Discount of 20 percent, both also due within 30 days of receipt of the first bill following reimbursement of the benefit plan.

Approval	**Date**
Human Resources	
Administration	
Board of Directors	09/18/2013

Northern Inyo Hospital District

Addendum to Hospitalist Agreement

Joy Engblade, MD, has served under her current contract dated 1/1/15. The following is being put before the Board of Directors on June 17th, 2015 Directors Meeting.

1. Tuition reimbursement of $10,000 (ten thousand dollars) will be paid at the end of each year of service.

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TO: Board of Directors

FROM: Leon Freis, R.Ph., COO/CIO

RE: Microsoft Licensing Adjustment

DATE: June 5, 2015

Background:

- Northern Inyo Hospital uses Microsoft Software licensed under an "Enterprise Agreement" contract with Microsoft
- Our contract is under a master agreement held by the City of Riverside, affording us buying power we could not negotiate on our own.
- During the past 3-year contract, we added many Microsoft-using devices which were not reported to Microsoft. This oversight has been discovered and rectified by IT and the 150 user devices, 100 servers and database increases have been reported to Microsoft. This has resulted in a "True-up" liability of not to exceed $155,000.
- The Microsoft maintenance increase of approximately $60,000 per year has been budgeted in the IT operating budget for next fiscal year and will come to the board as part of the operating budget.

Request:

Approve Microsoft True-up payment: Not to exceed $155,000.00