Northern Inyo Hospital

January 15 2020 Regular Meeting

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AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

January 15, 2020 at 5:30 p.m.

2957 Birch Street, Bishop, CA

1. Call to Order (at 5:30 pm).
2. At this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers are limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the agenda.
3. Strategic Plan update, Patient Experience Committee report (*information item*).
4. NIHD Auxiliary report (*information item*).
5. Wipfli Audit Report for fiscal year ending 6/30/19 (*action item*).
6. Wipfli report on converting Northern Inyo Associates to a provider-based entity (*information item*).
7. Ad Hoc Committee report and appointment of new Board member for District Zone 5 (*action item*).
8. New Business:
   A. Care Grant award, Population Health (*information item*).
   B. LAIF Account updates (*action items*).
   C. Revised Workplace Violence Prevention Plan (*action item*).
   D. Policy and Procedure approval, *Obtaining Blood Bank Samples from Patients in Surgery* (*action item*).
   E. Holiday event with physicians and planning for the future (*discussion item*).
   F. Appointment of Ad Hoc Committee to review Legal Services RFP responses (*action item*).
6. Old Business:
   A. Governance consultant update (*discussion item*).
7. Reports (*information items*):
   A. Eastern Sierra Emergency Physicians Quarterly Report (*information item).*
   B. Med Staff Services Quarterly Pillars of Excellence report (*information item*).

C. Behavioral Health update (*information item*).

8. Chief of Staff Report, William Timbers, MD:
   A. Policy and Procedure approvals (*action items*):
      1. *Emergency Medication and Code Blue Crash Cart Policy*
      2. *Fiberoptic Endoscopic Evaluation of Swallowing Policy*
      3. *Steris Gravity – Prevacuum Sterilizer Surgery (Autoclave)*
   B. Modification to Medical Staff and Advanced Practice Provider Application Packets (*action item*)
      1. Addition of criminal background checks
   C. Advanced Practice Provider Appointment (*action item*):
      1. Sarah Malloy, FNP (*family practice*)
   D. Medical Staff reappointments for calendar years 2020-2021 (*action items*):
      1. Daniel K. Davis, MD (*orthopedic surgery*) – Provisional Consulting Staff
      2. Kevin Deitel, MD (*orthopedic surgery*) – Provisional Consulting Staff
      3. Elizabeth Maslow, MD (*infectious disease*) – Telemedicine Staff
   E. Extension of Temporary Privileges for 120 days (*action item*):
      1. Shiva Shabnam, MD (*internal medicine*) – temporary/locum tenens privileges
   F. Additional Privileges (*action item*):
      1. Tammy O'Neill, PA-C (*physician assistant*) – addition of OR physician assistant protocol
   G. Medical Staff advancement (*action item*):
      1. Monika Mehrens, DO (*family medicine/hospitalist*) – recommendation for advancement from Provisional Active Staff to Active Staff
   H. Pediatrics Core Privilege form update (*action item*).
   I. Annual Reviews (*action items*):
      1. Critical Indicators
         i. Neonatal
         ii. Perinatal
         iii. Pediatrics
         iv. ICU
         v. RHC
         vi. Medical Services
   J. Physician recruitment update (*information item*).

Consent Agenda (action items)

9. Approval of minutes of the December 18 2019 regular meeting
10. Financial and statistical reports as of November 2019
11. Chief Executive Officer Report
12. Chief Operating Officer Report
13. Chief Financial Officer Report
14. Chief Nursing Officer Report
15. Policy and Procedure annual approvals

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16. Reports from Board members (*information items*).
17. Adjournment to Closed Session to/for:
    A. Discussion of a real estate negotiation regarding price, 152 Pioneer Lane, Bishop, California, Agency negotiators Kevin S. Flanigan MD, MBA and Pioneer Medical Associates partners (*pursuant to Government Code Section 54956.8*).
18. Return to Open Session and report of any action taken in Closed Session.
19. Adjournment.

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

Northern Inyo Healthcare District

Bishop, California

Financial Statements and Supplementary Information

Years Ended June 30, 2019 and 2018

WIPFLi LLP
CPAs and Consultants

Northern Inyo Healthcare District

Financial Statements and Supplementary Information

Years Ended June 30, 2019 and 2018

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WIPFLI LLP

Independent Auditor's Report

Board of Directors
Northern Inyo Healthcare District
Bishop, California

Report on the Financial Statements

We have audited the accompanying financial statements of Northern Inyo Healthcare District and its discretely presented component unit as of and for the years ended June 30, 2019 and 2018, and the related notes to the financial statements, which collectively comprise the Northern Inyo Healthcare District basic financial statements as listed in the table of contents.

Management's Responsibility for the Financial Statements

Management is responsible for the preparation and fair presentation of these financial statements in accordance with accounting principles generally accepted in the United States; this includes the design, implementation, and maintenance of internal control relevant to the preparation and fair presentation of financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the entity's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the District as of June 30, 2019 and 2018, and the changes in financial position and cash flows thereof, for the years then ended in accordance with accounting principles generally accepted in the United States.

Required Supplementary Information

Accounting principles generally accepted in the United States require the schedule of changes in the net pension liability and related ratios and contributions on pages 50 through 53 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express an opinion or provide any assurance.

Management has omitted the management's discussion and analysis that accounting principles generally accepted in the United States require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Supplementary Information

Our audit was conducted for the purpose of forming an opinion on the financial statements that collectively comprise the Northern Inyo Healthcare District's financial statements as a whole. The combining financial statements and statistical section are presented for purposes of additional analysis and are not a required part of the financial statements. The combining financial statements are the responsibility of management and were derived from and relate directly to the underlying accounting and other records used to prepare the financial statements.

Such information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States. In our opinion, the combining financial statements are fairly stated in all material respects in relation to the financial statements as a whole.

The statistical information has not been subjected to the auditing procedures applied in the audit of the basic financial statements and, accordingly, we do not express an opinion or provided any assurance on it.

INSERT WIPFLI SIGNATURE
Wipfli LLP

REPORT DATE
Spokane, Washington

Northern Inyo Healthcare District

Statements of Net Position

June 30, 2019 and 2018

	2019		2018	
Assets and Deferred Outflows of Resources	Hospital	Pioneer Medical Associates	Hospital	Pioneer Medical Associates
Current assets:				
Cash and equivalents	$ 26,464,807	$ 136,306	$ 21,034,292	$ 119,812
Receivables:				
Patient accounts - Net	19,069,551	-	14,684,069	-
Other - Government agency	935,509	-	3,535,824	-
Inventories	2,431,341	-	3,256,568	-
Prepaid expenses and other	1,789,821	-	1,982,299	-
Total current assets	50,691,029	136,306	44,493,052	119,812
Other assets:				
Noncurrent cash and investments	6,647,888	-	7,377,420	-
Investment in PMA	501,030	-	379,758	-
Goodwill in PMA	581,219	-	581,219	-
Total other assets	7,730,137	-	8,338,397	-
Capital assets:				
Nondepreciable capital assets	1,683,741	352,694	1,464,183	341,260
Depreciable capital assets - Net	76,157,826	208,256	75,357,824	195,070
Capital assets - Net	77,841,567	560,950	76,822,007	536,330
Deferred outflows of resources - Pensions	13,637,748	-	13,550,703	-
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 149,900,481	$ 697,256	$ 143,204,159	$ 656,142

Northern Inyo Healthcare District

Statements of Net Position (Continued)

June 30, 2019 and 2018

Liabilities, Deferred Inflows of Resources, and Net Position	2019 Hospital	2019 Pioneer Medical Associates	2018 Hospital	2018 Pioneer Medical Associates
Current liabilities:				
Bonds payable - Current portion	$ 2,293,000	$ -	$ 2,092,000	$ -
Capital lease obligation - Current portion	472,517	-	18,089	-
Accounts payable	5,372,255	-	3,656,555	-
Accrued interest	102,216	-	140,774	-
Accrued payroll and related liabilities	8,289,170	-	6,153,360	-
Due to third-party reimbursement program	1,550,939	-	1,300,000	-
Unearned revenue	22,268	-	68,644	-
Total current liabilities	18,102,365	-	13,429,422	-
Noncurrent liabilities:				
Bonds payable - Net of current portion	40,028,742	-	42,374,441	-
Accreted interest	13,520,264	-	12,193,679	-
Capital lease obligation - Net of current portion	1,762,938	-	-	-
Net pension liability	32,705,323	-	31,778,171	-
Total noncurrent liabilities	88,017,267	-	86,346,291	-
Total liabilities	106,119,632	-	99,775,713	-
Deferred inflows of resources - Pensions	3,459,270	-	4,037,270	-
Net position:				
Net investment in capital assets	32,741,974	-	32,198,861	-
Restricted for debt service	2,817,042	-	4,200,769	-
Restricted for programs	150,576	481,483	130,526	494,205
Unrestricted	4,611,987	215,773	2,861,020	161,937
Total net position	40,321,579	697,256	39,391,176	656,142
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION	$ 149,900,481	$ 697,256	$ 143,204,159	$ 656,142

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statements of Revenues, Expenses, and Changes in Net Position

Years Ended June 30, 2019 and 2018

	2019		2018	
	Hospital	Pioneer Medical Associates	Hospital	Pioneer Medical Associates
Revenue:				
Net patient service revenue	$ 93,433,917	$ -	$ 86,628,531	$ -
Other operating revenue	798,862	200,669	1,176,188	197,879
Total revenue	94,232,779	200,669	87,804,719	197,879
Operating expenses:				
Salaries and wages	31,964,133	-	25,726,930	-
Employee benefits	21,534,871	-	20,374,657	-
Professional fees	11,309,459	1,860	13,195,960	3,251
Supplies	10,753,782	-	9,881,868	-
Purchased services	3,938,164	-	4,055,876	-
Depreciation	4,259,708	14,716	4,456,699	14,831
Other operating expenses	6,094,829	42,979	4,947,216	38,692
Total operating expenses	89,854,946	59,555	82,639,206	56,774
Income from operations	4,377,833	141,114	5,165,513	141,105
Nonoperating revenue (expenses):				
Tax revenue for operations	582,378	-	682,286	-
Tax revenue for debt services	1,671,511	-	1,543,646	-
Interest income	774,619	-	306,915	29
Interest expense	(2,917,371)	-	(2,892,775)	-
Noncapital grants and contributions	2,215,420	-	1,650,788	-
Medical office building, net	(6,210,601)	-	(4,760,636)	-
Total nonoperating revenue (expenses)	(3,884,044)	-	(3,469,776)	29
Excess of revenue over expenses	493,789	141,114	1,695,737	141,134
Capital grants and contributions	(500)	-	15,063	-
Distributions to PMA investors	-	(100,000)	-	(100,000)
Increase in net position	493,289	41,114	1,710,800	41,134
Net Contribution from Pioneer Home Health	437,114	-	-	-
Net position at beginning	39,391,176	656,142	37,680,376	615,008
Net position at end	$ 40,321,579	$ 697,256	$ 39,391,176	$ 656,142

See accompanying notes to financial statements. 5

Northern Inyo Healthcare District

Statements of Cash Flows

Years Ended June 30, 2019 and 2018

	2019		2018	
	Hospital	Pioneer Medical Associates	Hospital	Pioneer Medical Associates
Increase (decrease) in cash and cash equivalents:				
Cash flows from operating activities:				
Receipts from and on behalf of patients and third-party payors	$ 66,882,869	$ -	$ 85,369,849	$ -
Receipts from other operating revenue	25,769,306	200,669	(1,752,269)	197,879
Payments to employees	(51,101,087)	-	(43,575,196)	-
Payments to suppliers, contractors, and others	(29,362,829)	(44,839)	(30,063,186)	(41,906)
Net cash provided by operating activities	12,188,259	155,830	9,979,198	155,973
Cash flows from noncapital financing activities:				
District tax revenue for operations	582,378	-	682,286	-
Noncapital grants	2,215,420	-	1,650,788	-
Medical office building, net	(6,210,601)	-	(4,760,636)	-
Net cash used in noncapital financing activities	(3,412,803)	-	(2,427,562)	-
Cash flows from capital and related financing activities:				
District tax revenue for debt services	1,671,511	-	1,543,646	-
Capital grants and contributions	(500)	-	15,063	-
Principal paid on long-term debt	(1,610,205)	-	(1,902,000)	-
Principal paid on capital lease obligations	2,217,366	-	(128,221)	-
Interest paid	(2,163,838)	-	(1,663,279)	-
Payments for purchase of property and equipment	(5,279,268)	(39,336)	(1,545,596)	-
Transfer in of opening equity in PHH	437,114	-	-	-
Net cash used in capital and related financing activities	(4,727,820)	(39,336)	(3,680,387)	-

Northern Inyo Healthcare District

Statements of Cash Flows (Continued)

Years Ended June 30, 2019 and 2018

	2019		2018	
	Hospital	Pioneer Medical Associates	Hospital	Pioneer Medical Associates
Cash flows from investing activities:				
Interest received	$ 774,619	$ -	$ 306,915	$ 29
Purchases of investments	(1,114,016)	-	(3,416)	-
Partnership distributions/contributions	(121,272)	(100,000)	133,052	(100,000)
Net cash provided by (used in) investing activities	(460,669)	(100,000)	436,551	(99,971)
Net increase in cash and cash equivalents	3,586,967	16,494	4,307,800	56,002
Cash and cash equivalents at beginning	26,464,257	119,812	22,156,457	63,810
Cash and cash equivalents at end	$ 30,051,224	$ 136,306	$ 26,464,257	$ 119,812
Reconciliation of cash and equivalents to the statements of net position:				
Current assets: Cash and equivalents	$ 26,464,807	$ 136,306	$ 21,034,292	$ 119,812
Other assets:				
Bond payment funds - Under indenture agreement	2,242,042	-	2,745,825	-
Nursing scholarship fund	150,576	-	130,526	-
Restricted for bonds and interest	-	-	1,454,944	-
Internally designated for capital acquisitions	1,193,799	-	1,098,670	-
Cash and equivalents	$ 30,051,224	$ 136,306	$ 26,464,257	$ 119,812

Northern Inyo Healthcare District

Statements of Cash Flows (Continued)

Years Ended June 30, 2019 and 2018

	2019		2018	
	Hospital	Pioneer Medical Associates	Hospital	Pioneer Medical Associates
Reconciliation of income from operations to net provided by operating activities:				
Income from operations	$ 4,377,833	$ 141,114	$ 5,165,513	$ 141,105
Adjustments to reconcile income from operations to net cash provided by operating activities:				
Depreciation and amortization	4,259,708	14,716	4,456,699	14,868
Provision for bad debts	4,932,520	-	2,684,312	-
Capital expenditures charged to current year	-	-	54,272	-
Changes in assets and liabilities:				
Receivables:				
Patient - Net	(9,318,002)	-	(3,675,449)	-
Other - Government agency	2,600,315	-	(3,499,900)	-
Inventory	825,227	-	739,990	-
Prepaid expenses and deposits	192,478	-	(627,014)	-
Accounts payable	1,715,700	-	1,850,486	-
Accrued payroll and related liabilities	2,135,810	-	1,887,683	-
Estimated third-party payor settlements	250,939	-	312,681	-
Unearned revenue	(46,376)	-	(8,783)	-
Net pension liability	927,152	-	1,290,639	-
Change in deferred outflows	(87,045)	-	(185,318)	-
Change in deferred inflows	(578,000)	-	(466,613)	-
Total adjustments	7,810,426	14,716	4,813,685	14,868
Net cash provided by operating activities	$ 12,188,259	$ 155,830	$ 9,979,198	$ 155,973

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Net Position of Pension Trust Fund - Plan

December 31, 2018

Assets	
Assets:	
Fixed dollar account	$ 11,029,164
Indexed bond fund	11,054,845
TOTAL ASSETS	$ 22,084,009
Net Position	
Net position held in trust for pension benefits	$ 22,084,009
TOTAL NET POSITION	$ 22,084,009

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Changes in Net Position of Pension Trust Fund - Plan

Year Ended December 31, 2018

Additions:	
Employer contributions	$ 6,300,000
Return on plan assets	(180,625)
Total additions	6,119,375
Deductions:	
Benefits paid	8,082,821
Change in net position	(1,963,446)
Net position at beginning	24,047,455
Net position at end	$ 22,084,009

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Net Position of Pension Trust Fund - PEPRA Plan

December 31, 2018

Assets		
Assets:		
Cash	$	82,769
TOTAL ASSETS	$	82,769
Net Position		
Net position held in trust for pension benefits	$	82,769
TOTAL NET POSITION	$	82,769

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Statement of Changes in Net Position of Pension Trust Fund - PEPRA Plan

Year Ended December 31, 2018

Additions:		
Employee contributions	$	13,869
Employer contributions		13,868
Total additions		27,737
Change in net position		27,737
Net position at beginning		55,032
Net position at end	$	82,769

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Notes to Financial Statements

Note 1: Summary of Significant Accounting Policies

Reporting Entity

Northern Inyo Healthcare District (the “District”) was organized in 1946 under the terms of the Local Health Care District Law and is operated and governed by an elected Board of Directors. The District includes a 25-bed acute care facility that provides inpatient, outpatient, emergency care services, and a rural health clinic in Bishop, California, and it's surrounding area.

Northern Inyo Hospital Foundation, Inc. (the "Foundation") is a legally separate 501(c)(3) tax-exempt nonprofit public benefit corporation. The Foundation acts primarily as a fundraising organization to supplement the resources that are available to the District. Although the District does not control the timing or amount of receipts from the Foundation, the majority of the resources, or income thereon that the Foundation holds and invests are restricted to the activities of the District by the Foundation's bylaws. The Foundation's Board of Directors may also restrict the use of such funds for capital asset replacement, expansion, or other specific purposes. The District shall appoint the Board of Directors for the Foundation per the Foundation's bylaws, and for this reason it is a blended component unit of the District.

Northern Inyo Hospital Auxiliary, Inc. (the "Auxiliary") is also a legally separate 501(c)(3) tax-exempt public benefit corporation. The Auxiliary's actions are subject to the approval of the District and for this reason it is a blended component unit of the District.

Pioneer Home Health Care, Inc. (PHH) is also a legally separate 501(c)(3) tax-exempt public benefit corporation. The District is the sole corporate owner of PHH and for this reason it is a blended component unit of the District.

Discretely Presented Component Unit

Pioneer Medical Associates (PMA) is a partnership established by a group of physicians and practitioners in 1986 within the District campus at 152 Pioneer Lane. In an effort to support the continued recruitment for physicians and services, it has been the practice of the District to work with the PMA partners when appropriate and directed by the Board of Directors to purchase practices of individuals or groups who are leaving the area or retiring. The District currently owns a 66.67% interest in the partnership through acquisitions. PMA is reported in a separate column in the accompanying financial statements to emphasize that it is legally separate from the District. Separate financial statements for the component unit are not available.

Basis of Presentation

The financial statements have been prepared in accordance with the accounting principles generally accepted in the United States (GAAP) as prescribed by the Governmental Accounting Standards Board (GASB).

Note 1: Summary of Significant Accounting Policies (Continued)

Use of Estimates in Preparation of Financial Statements

The preparation of the accompanying financial statements in conformity with GAAP requires management to make certain estimates and assumptions that directly affect the reported amounts of assets and liabilities and disclosure contingent assets and liabilities at the date of the financial statements. Estimates also affect the reported amounts of revenue and expenses during the reporting period. Actual results may differ from these estimates.

The District considers significant accounting estimates to be those that require more significant judgments and include the valuation of accounts receivable, including contractual allowances and provision for uncollectible accounts, estimated third-party payor settlements, and an estimate for claims incurred, but not reported under a self-funded health insurance plan.

Cash and Cash Equivalents

The District considers all highly liquid debt instruments with an original maturity of three months or less to be cash equivalents, excluding noncurrent cash and investments.

The District is authorized under California Government Code to make direct investments in local agency bonds, notes, or warrants within the state; U.S. Treasury instruments; registered state warrants or treasury notes; securities of the U.S. government or its agencies; bankers' acceptances; commercial paper; certificates of deposit placed with commercial banks and/or savings and loan companies; repurchase or reverse repurchase agreements; medium-term corporate notes; shares of beneficial interest issued by diversified management companies, certificates of participation, and obligations with first-priority security; and collateralized mortgage obligations.

All investments are stated at fair value. Investment gain (loss) includes changes in fair value of investments, interest, and realized gains and losses.

Patient Receivables and Credit Policy

Patient receivables are uncollateralized patient obligations that are stated at the amount management expects to collect from outstanding balances. These obligations are primarily from local residents, most of whom are insured under third-party payor agreements. The District bills third-party payors on the patients' behalf, or if a patient is uninsured, the patient is billed directly. Once claims are settled with the primary payor, any secondary insurance is billed, and patients are billed for copay and deductible amounts that are the patient's responsibility. Payments on patient receivables are applied to the specific claim identified on the remittance advice or statement. The District does not have a policy to charge interest on past due accounts.

Note 1: Summary of Significant Accounting Policies (Continued)

Patient Receivables and Credit Policy (Continued)

The carrying amounts of patient receivables are reduced by allowances that reflect management's estimate of the amounts that will not be collected. Management provides for contractual adjustments under terms of third-party reimbursement agreements through a reduction of gross revenue and a credit to patient receivables. In addition, management provides for probable uncollectible amounts, primarily for uninsured patients and amounts patients are personally responsible for, through a reduction of gross revenue and a credit to the allowance for uncollectible accounts based on its assessment of historical collection experience and the current status of individual accounts. Balances that are still outstanding after management has used reasonable collection efforts are written off through a charge to the allowance for uncollectible accounts and a credit to patient receivables.

Patient receivables are recorded in the accompanying statements of net position net of contractual adjustments and an allowance for uncollectible accounts.

The District has a discount policy established for residents of the district. The amount of charges foregone for services and supplies furnished under the District's discount policy aggregated approximately $326,000 and $439,000 for the years ended June 30, 2019 and 2018, respectively.

Investment in PMA

Investment in a partnership is carried at the District's equity in the partnership's net assets. The partnership was organized to provide real estate for PMA. Ownership of the partnership consists of the District and local physicians.

Goodwill in PMA

Goodwill represents the excess of purchase price of an acquired business over the identifiable intangible assets acquired and liabilities assumed in connection with the acquisition of practices in PMA. The District reviews for impairment of goodwill on an annual basis, and this is amortized when a change in the expected duration of the intangible asset has occurred. No goodwill impairment was recognized in 2019 and 2018.

Inventories

Inventories are stated at the lower of cost, determined on the average cost method, or net realizable value.

Noncurrent Cash and Investments

Noncurrent cash and investments include assets held under indenture agreements, assets held to service debt under the bond issue, and designated assets set aside by the Board of Directors for future capital improvements, over which the Board retains control and may, at its discretion, use for other purposes.

Note 1: Summary of Significant Accounting Policies (Continued)

Fair Value Measurement

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. A three-tier hierarchy prioritizes the inputs used in measuring fair value. These tiers include Level 1, defined as quoted market prices in active markets for identical assets or liabilities; Level 2, defined as inputs other than quoted market prices in active markets that are either directly or indirectly observable; and Level 3, defined as significant unobservable inputs therefore, requiring an entity to develop its own assumptions. The asset's or liability's fair value measurement within the hierarchy is based on techniques that maximize the use of relevant observable inputs and minimizes the use of unobservable inputs.

Assets or liabilities measured and reported at fair value are classified and disclosed in one of the three following categories:

Level 1 - Inputs to the valuation methodology are unadjusted quoted priced for identical assets or liabilities in active markets that the District has the ability to access.

Level 2 - Inputs to the valuation methodology include:

- Quoted prices for similar assets or liabilities in active markets.
- Quoted prices for identical or similar assets or liabilities in inactive markets.
- Inputs, other than quoted prices, those are observable for the asset or liability.
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

If the asset or liability has a specified contractual term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 - Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset's or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs.

Capital Assets and Depreciation

Capital assets are recorded at cost if purchased or fair value at date received if contributed. The District capitalizes assets using the criteria established by the Office of Statewide Health Planning and Development (OSHPD):

Land, land improvements, buildings, and fixed equipment	$3,000
Major movable equipment	3,000

Note 1: Summary of Significant Accounting Policies (Continued)

Capital Assets and Depreciation (Continued)

Depreciation is provided over the estimated useful life of each class of depreciable asset and is computed using the straight-line method.

Estimated useful lives range from 2 to 25 years for land improvements, buildings and improvements, leasehold improvements, and fixed equipment and from 3 to 20 years for equipment.

Accreted Interest

Interest expense on capital appreciation bonds is being accreted on the straight line basis to maturity of the individual bonds.

Asset Impairment

Capital assets are reviewed for impairment when events or changes in circumstances suggest that the service utility of the capital asset may have significantly and unexpectedly declined. Capital assets are considered impaired if both the decline in service utility of the capital asset is large in magnitude and the event or change in circumstance is outside the normal life cycle of the capital asset. Such events or changes in circumstances that may be indicative of impairment include evidence of physical damage, enactment, or approval of laws or regulations or other changes in environmental factors; technological changes or evidence of obsolescence; changes in the manner or duration of use of a capital asset; and construction stoppage. The determination of the impairment loss is dependent on the event or circumstance in which the impairment occurred. Impairment losses, if any, are recorded in the statements of revenues, expenses, and changes in net position. There were no impairment losses recorded in the years ended June 30, 2019 and 2018.

Compensated Absences

The District accrues all leave time for employees as paid time-off (PTO) in the financial statements. In addition, employees hired prior to January 1, 2003, might have accumulated additional sick leave for major medical health problems. Usage of the additional sick leave must be approved by management.

The total potential liability of the District's accumulated sick leave for major medical is approximately $140,000 and $154,000 for the years ended June 30, 2019 and 2018, respectively. Such benefits do not vest; therefore, no liability has been accrued.

Note 1: Summary of Significant Accounting Policies (Continued)

Retirement Plan

For purposes of measuring the net pension liability and deferred outflows/inflows of resources related to pensions, and pension expense, information about the pension net position of the District Retirement Plan ("the Plan") and Northern Inyo Healthcare District PEPRA Retirement Plan (the "PEPRA Plan") and additions to/deductions from the plans' pension net position have been determined on the same basis as they are reported by the Plan and PEPRA Plan. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Unearned Revenue

Unearned revenue consists of tax collections the District received from the local tax agency. Amounts expected to be recognized in revenue within one year have been reclassified to current liabilities in the accompanying statements of net position.

Net Position

Net position of the District is classified in four components. Net investment in capital assets consists of capital assets net of accumulated depreciation and reduced by the current balances of any outstanding borrowings used to finance the purchase or construction of those assets. Restricted for debt service is cash that must be used for payments toward debt service. Restricted for programs is cash that must be used for nursing scholarships, as specified by external contributors. Unrestricted is remaining net position that does not meet the definitions above.

Net Patient Service Revenue

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and are adjusted in future periods as final settlements are determined.

Charity Care

The District provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. The District maintains records to identify the amount of charges forgone for services and supplies furnished under the charity care policy. Because the District does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenue.

Note 1: Summary of Significant Accounting Policies (Continued)

Operating Revenue and Expenses

The District's statements of revenues, expenses, and changes in net position distinguish between operating and nonoperating revenue and expenses. Operating revenue results from exchange transactions associated with providing health care services. Nonexchange revenue, including taxes, investment gain, grants, contributions received for purposes other than capital asset acquisition, and certain other revenue, is reported as nonoperating revenue. Operating expenses are all expenses incurred to provide health care services, other than financing costs.

District Property Tax Revenue

The District has the authority to impose taxes on property within the boundaries of the health care district. Taxes are received from Inyo County (the "County"), which bills and collects the taxes for the District. Secured property taxes attach as an enforceable lien on property as of January 1 and are payable in two installments on November 1 and February 1.

Grants and Contributions

The District receives grants as well as contributions from individuals and private organizations. Revenue from grants and contributions (including contributions of capital assets) is recognized when all eligibility requirements, including time requirements, are met. Grants and contributions may be restricted for either specific operating purposes or capital purposes. Amounts that are unrestricted or are restricted to a specific operating purpose are reported as nonoperating revenue. Amounts restricted to capital acquisitions are reported after nonoperating revenue (expenses).

Advertising Costs

Advertising costs are expensed as incurred.

Tax Status

The District is is a local agency of the State of California within the meaning of Section 56054 of the California Government Code. Accordingly, the District is exempt from federal income and state income, property, and franchise taxes. The District is not exempt for California Sales Tax and pays sales tax as required based on the type of product and or service purchased.

Unemployment Compensation

The District is a part of a pooled unemployment insurance group through California Association of Hospital and Healthcare Systems (CAHHS) for unemployment insurance and does not pay state unemployment tax. Cost incurred were $58,929 and $66,652, in 2019 and 2018, respectively.

Note 1: Summary of Significant Accounting Policies (Continued)

Deferred Outflows/Inflows of Resources

In addition to assets, the statements of net position will sometimes report a separate section of deferred outflows of resources. This separate financial statement element, *deferred outflows of resources,* represents a consumption of net position that applies to future periods and so will not be recognized as an outflow of resources (expense) until then. The District has one item that qualifies for reporting in this category. The District reports deferred outflows of resources related to pensions for its proportionate share of collective deferred outflows of resources related to pensions and District contributions to pension plans subsequent to the measurement date of the collective net pension liability.

In addition to liabilities, the statements of net position will sometimes report a separate section of deferred inflows of resources. This separate financial statement element, *deferred inflows of resources,* represents a acquisition of net position that applies to future periods and so will not be recognized as an inflow of resources (revenue) until then. The District has one item that qualifies for reporting in this category. The District reports deferred inflows of resources related to pensions for its proportionate share of collective deferred inflows of resources related to pensions.

Deferred Financing Costs

Costs related to obtaining long-term financing from HUD are deferred and amortized using accelerated methods over the term of the related mortgage.

New Accounting Pronouncements

Management elected early-adopt GASB Statement No. 87, Leases. This statement requires lease assets and liabilities to be recorded on the statement of net position for the year ended June 30, 2019. The statement is not expected to have a significant effect on these financial statements and related disclosures.

Reclassifications

Certain reclassifications have been made to the 2018 financial statements to conform to the 2019 presentation. Such reclassifications have no effect on the previously-reported amounts of net position.

Subsequent Events

Subsequent events have been evaluated through REPORT DATE, which is the date the financial statements were available to be issued.

Note 2: Reimbursement Arrangements With Third-Party Payors

The District has agreements with third-party payors that provide for reimbursement to the District at amounts that vary from its established rates. A summary of the basis of reimbursement with major third-party payors follows:

Hospital

Medicare – The Medicare program has designated the District as a critical access hospital (CAH) for Medicare reimbursement purposes. Under this designation, District inpatient, outpatient, and swing bed services rendered to Medicare program beneficiaries are paid based on a cost-reimbursement methodology, with the exception of certain lab and mammography services, which are reimbursed based on fee schedules. The cost-based payments are reduced by a two percent mandatory reduction called sequestration. Sequestration reductions for Medicare hospital services were approximately $490,000 and $485,000 for 2019 and 2018, respectively.

Medi-Cal – Under CAH designation, the District inpatient and swing bed services rendered to Medi-Cal program beneficiaries were paid on a cost-based reimbursement methodology through June 30, 2015. As of July 1, 2015, the State of California established rates are based on the most recently audited cost report for the District. There are no settlements for cost based methods after June 30, 2015. The reimbursement for outpatient services is based on a fee schedule. Starting in 2014, the State of California expanded the provision of coverage to managed care organization in rural California. The District applied for and received supplemental reimbursements for its inpatient and outpatient services during 2019 and 2018. The supplemental reimbursements are based on a cost based reimbursement method. This method does not guarantee that all cost are recovered after the Federal match and administrative fees are paid.

Physician and Professional Services in Rural Health Clinics

Certain physician and professional services rendered to Medicare and Medi-Cal beneficiaries qualify for reimbursement as Medicare-approved rural health clinic services. Qualifying services are reimbursed based on a cost-reimbursement methodology. The cost based reimbursement payments from Medicare are reduced by a two percent mandatory reduction called sequestration. The sequestration reductions for the Rural Health Clinic services was approximately $50,000 and $39,000 for 2019 and 2018, respectively.

Hospital Based and Free Standing Physicians and Professional Services

The District has entered into payment agreements with certain commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for payment to the District under these agreements includes discounts from established charges and prospectively determined daily rates.

Note 2: Reimbursement Arrangements With Third-Party Payors (Continued)

Accounting for Contractual Arrangements

The District is reimbursed for certain cost-reimbursable items at an interim rate, with final settlements determined after an audit or review of the District's related annual cost reports by the Medicare Administration Contractor. Estimated provisions to approximate the final expected settlements are included in the accompanying statements of net position as due to third-party reimbursement provisions. The cost reports for the District have been final settled through June 30, 2017.

Compliance

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, particularly those relating to the Medicare and Medi-Cal programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Violation of these laws and regulations could result in the imposition of fines and penalties, as well as repayments of previously billed and collected revenue from patient services.

CMS uses recovery audit contractors (RAC) to search for potentially inaccurate Medicare payments that might have been made to health care providers and that were not detected through existing CMS program integrity efforts. Once the RAC identifies a claim it believes is inaccurate, the RAC makes a deduction from or addition to the provider's Medicare reimbursement in an amount estimated to equal the overpayment or underpayment. As of June 30, 2019, the District has not been notified by the RAC of any potential significant reimbursement adjustments.

Note 3: Cash and Cash Equivalents and Investments

Deposits

Custodial Credit Risk - Custodial credit risk is the risk that, in the event of a bank failure, the District's deposits may not be returned. The District does not have a deposit policy for custodial credit risk.

The California Government Code requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law (unless so waived by the governmental unit). The market value of the pledged securities in the collateral pool must equal at least 110% of the total amount deposited by the public agencies.

California law also allows financial institutions to secure public deposits by pledging first trust deed mortgage notes having a value of 150% of the secured public deposits and letters of credit issued by the Federal Home Loan Bank of San Francisco having a value of 105% of the secured deposits.

Note 3: Cash and Cash Equivalents and Investments (Continued)

At June 30, 2019, the net carrying amount of deposits was $3,542,390, and the bank balance was $5,743,602. Of the bank balance, $250,000 was covered by federal deposit insurance, and $4,535,121 was collateralized (i.e., collateralized with securities held by the pledging financial institutions of at least 110% of the District's cash deposits, in accordance with the California Government Code).

Investments

Interest Rate Risk – As a means of limiting its exposure to fair value losses arising from rising interest rates, the District's investment policy includes its investment portfolio to the Local Agency Investment Guidelines promulgated by the California Debt & Investment Advisory Commission.

The District is a participant in the Local Agency Investment Fund (LAIF), which is regulated by California Government Code Section 16429 under the oversight of the Treasurer of the State of California. The fair value of the District's investment in this pool is reported in the accompanying financial statements at amounts based on the District's pro rata share of the fair value provided by LAIF for the entire LAIF portfolio (in relation to the amortized cost of that portfolio). The balance available for withdrawal is based on the accounting records maintained by LAIF, which are recorded on an amortized cost basis.

The LAIF investment portfolio consists primarily of treasury bills, notes, and certificates of deposit.

Investments included in cash and cash equivalents and noncurrent cash and investments consisted of the following at June 30, 2019:

		Remaining Maturity (in Years)			
	Fair Value	0-1	1-5	5-10	More Than 10
Assets - Included in cash and cash equivalents:					
LAIF	$ 22,928,543	$ 22,928,543	$ -	$ -	$ -
Subtotal	22,928,543	22,928,543	-	-	-
Assets - Included in noncurrent cash and investments:					
Certificates of deposit	2,486,471	150,305	2,336,166	-	-
Fixed income securities	575,000	-	-	575,000	-
Subtotal	3,061,471	150,305	2,336,166	575,000	-
Totals	$ 25,990,014	$ 23,078,848	$ 2,336,166	$ 575,000	$ -

Note 3: Cash and Cash Equivalents and Investments (Continued)

Following is a description of the valuation methodologies used for assets measured at fair value.

Certificates of deposit and fixed-income securities are valued at cost, which approximates fair value and are not rated by the national rating agencies.

The methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future values. Furthermore, while the District believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following tables set forth by level, within the fair value hierarchy, the District's assets at fair value at June 30:

	Fair Value Measurements Using			
2019	Level 1	Level 2	Level 3	Total Assets at Fair Value
Assets:				
Fixed income securities	$ -	$ 575,000	$ -	$ 575,000
Certificates of deposit	-	2,486,471	-	2,486,471
Totals	$ -	$ 3,061,471	$ -	$ 3,061,471

	Fair Value Measurements Using			
2018	Level 1	Level 2	Level 3	Total Assets at Fair Value
Assets:				
Fixed income securities	$ -	$ 951,395	$ -	$ 951,395
Certificates of deposit	-	996,060	-	996,060
Totals	$ -	$ 1,947,455	$ -	$ 1,947,455

Employees' Retirement System - The District's governing body has the responsibility and authority to oversee the investment portfolio. Various professional investment managers are contracted to assist in managing the District's investments; all investment decisions are subject to California law and the investment policy established by the governing body. The District's investments are held by a trust company.

Note 3: Cash and Cash Equivalents and Investments (Continued)

The District's retirement system investments are stated at net asset value (NAV) and fair value. The fixed dollar fund is stated at NAV, which is determined based on the total value of all investments in its portfolio minus the value of liabilities. The index bond fund is stated at fair value, using a level one measurement (Level 1), which is determined as follows: (a) short-term investments are reported at cost, which approximates fair value; (b) securities traded on a national or international exchange are valued at the last reported sales price at current exchange rates; (c) investments for which market quotations are not readily available are valued at their fair values as determined by the custodian under the direction of the District's governing body, with the assistance of a valuation service; and (d) cash deposits are reported at carrying amounts, which reasonably approximate fair value.

Following is a summary of the District's investments as of June 30:

	2019	2018
Fixed dollar fund	$ 11,029,164	$ 12,929,366
Indexed bond fund	11,054,845	11,118,089
Totals	$ 22,084,009	$ 24,047,455

Credit Risk - Credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by assignment of a rating by a nationally recognized statistical rating organization. The District has an investment policy that limits its investment choices by credit rating. LAIF is not rated.

Concentration of Credit Risk - The California Government Code limits the purchase of certain investments to defined percentages of the investment portfolio.

Custodial Credit Risk - For an investment, custodial credit risk is the risk that, in the event of the failure of the counter party (e.g., broker-dealer) to the transaction, the District will not be able to recover the value of its investment or collateral securities that are in the possession of another party. The District's investment policy does not limit the exposure to custodial credit risk for investments. All investments are held by the District's agent in the District's name and, therefore, are not exposed to custodial risk.

Noncurrent cash and investments that are required for obligations classified as current liabilities are reported in current assets.

Note 3: Cash and Cash Equivalents and Investments (Continued)

Noncurrent cash and investments consisted of the following at June 30:

	2019	2018
Noncurrent cash and other investments		
External restrictions:		
Bond payment funds - Under indenture agreement	$ 2,242,042	$ 2,745,825
Nursing scholarship fund	150,576	130,526
Bonds and interest	-	1,454,944
Board designations:		
Internally designated for capital acquisitions	1,193,799	1,098,670
Fixed income, corporate bonds - Future operations	575,000	951,395
Certificates of deposit - Future operations	2,486,471	996,060
Total noncurrent cash and investments	$ 6,647,888	$ 7,377,420

Note 4: Patient Receivables - Net

Patient receivables - net consisted of the following at June 30:

	2019	2018
Patient receivables	$ 47,085,757	$ 29,807,652
Less:		
Contractual adjustments	24,557,937	13,368,583
Allowance for uncollectible accounts	3,458,269	1,755,000
Patient receivable - Net	$ 19,069,551	$ 14,684,069

The District gross days in accounts receivable was 110.49 and 72.72 for 2019 and 2018, respectively.

Note 5: Net Patient Service Revenue

Net patient service revenue consisted of the following for the years ended June 30:

	2019	2018
Gross patient service revenue:		
Inpatient services	$ 35,743,626	$ 44,036,028
Outpatient services	119,739,909	105,583,048
Totals	155,483,535	149,619,076
Less:		
Contractual adjustments	57,117,098	60,306,233
Provision for uncollectible accounts	4,932,520	2,684,312
Net patient service revenue	$ 93,433,917	$ 86,628,531

The following table reflects the percentage of gross patient service revenue by payor source for the years ended June 30:

	2019	2018
Medicare	36 %	45 %
Medi-Cal	23 %	21 %
Other third-party payors	31 %	30 %
Patients	10 %	4 %
Patient service revenue (net of contractual allowances and discounts)	100 %	100 %

Note 6: Charity Care

The District provides health care services and other financial support through various programs that are designed, in part, to enhance the health of the community including the health of low-income patients. Consistent with the mission of the District, care is provided to patients regardless of their ability to pay, including providing services to those persons who cannot afford health insurance because of inadequate resources.

Patients who meet certain criteria for charity care, generally based on federal poverty guidelines, are provided care based on criteria defined in the District's charity care policy. The District maintains records to identify and monitor the level of charity care it provides. The amount of charges foregone for services and supplies furnished under the District's charity care policy aggregated approximately $1,101,505 and $1,696,883 for the years ended June 30, 2019 and 2018, respectively.

Note 6: Charity Care (Continued)

The estimated cost of providing care to patients under the District's charity care policy aggregated approximately $617,000 and $950,000 in 2019 and 2018, respectively. The cost was calculated by multiplying the ratio of cost to gross charges for the District times the gross uncompensated charges associated with providing charity care.

Note 7: Capital Assets

The District's capital assets activity consisted of the following:

	2019				
	Balance July 1, 2018	Additions	Transfers	Deletions	Balance June 30, 2019
Nondepreciable capital assets:					
Land	$ 735,330	$ 130,000	$ -	$ -	$ 865,330
Construction in progress	728,853	405,819	(316,261)	-	818,411
Total nondepreciable capital assets	1,464,183	535,819	(316,261)	-	1,683,741
Depreciable capital assets:					
Land improvements	867,086	-	-	-	867,086
Buildings	87,840,944	1,306,126	-	-	89,147,070
Equipment	32,383,124	3,518,360	316,261	(11,081)	36,206,664
Total depreciable capital assets	121,091,154	4,824,486	316,261	(11,081)	126,220,820
Less - Accumulated depreciation	45,733,330	4,259,708	81,037	(11,081)	50,062,994
Net depreciable capital assets	75,357,824	564,778	235,224	-	76,157,826
Totals	$ 76,822,007	$ 1,100,597	$ (81,037)	$ -	$ 77,841,567

At June 30, 2019, construction in progress consisted of pharmacy clean room, major equipment, lab software, and a building retrofit. The projects are expected to be completed during fiscal year 2019 and the cost to complete is estimated to be less than $1,651,000.

Northern Inyo Healthcare District

Notes to Financial Statements

Note 7: Capital Assets (Continued)

	2018				
	Balance July 1, 2017	Additions	Transfers	Deletions	Balance June 30, 2018
Nondepreciable capital assets:					
Land	$ 735,330	$ -	$ -	$ -	$ 735,330
Construction in progress	225,814	636,319	(79,008)	(54,272)	728,853
Total nondepreciable capital assets	961,144	636,319	(79,008)	(54,272)	1,464,183
Depreciable capital assets:					
Land improvements	867,086	-	-	-	867,086
Buildings	87,809,217	10,872	20,855	-	87,840,944
Equipment	31,426,566	898,405	58,153	-	32,383,124
Total depreciable capital assets	120,102,869	909,277	79,008	-	121,091,154
Less - Accumulated depreciation	41,276,631	4,456,699	-	-	45,733,330
Net depreciable capital assets	78,826,238	(3,547,422)	79,008	-	75,357,824
Totals	$ 79,787,382	$ (2,911,103)	$ -	$ (54,272)	$ 76,822,007

Northern Inyo Healthcare District

Notes to Financial Statements

Note 7: Capital Assets (Continued)

PMA's capital assets activity consisted of the following:

	2019			
	Balance July 1, 2018	Additions	Deletions	Balance June 30, 2019
Nondepreciable capital assets:				
Land	$ 341,260	$ 11,434	$ -	$ 352,694
Total nondepreciable capital assets	341,260	11,434	-	352,694
Depreciable capital assets - Buildings	1,043,214	32,979	-	1,076,193
Less - Accumulated depreciation	848,144	19,793	-	867,937
Net depreciable capital assets	195,070	13,186	-	208,256
Totals	$ 536,330	$ 24,620	$ -	$ 560,950

	2018			
	Balance July 1, 2017	Additions	Deletions	Balance June 30, 2018
Nondepreciable capital assets:				
Land	$ 341,260	$ -	$ -	$ 341,260
Total nondepreciable capital assets	341,260	-	-	341,260
Depreciable capital assets - Buildings	1,043,214	-	-	1,043,214
Less - Accumulated depreciation	833,276	14,868	-	848,144
Net depreciable capital assets	209,938	(14,868)	-	195,070
Totals	$ 551,198	$ (14,868)	$ -	$ 536,330

Northern Inyo Healthcare District

Notes to Financial Statements

Note 8: Long-Term Debt and Capital Lease Obligations

Long-term debt and capital lease obligations activity consisted of the following:

	Balance July 1, 2018	Additions	Reductions	Balance June 30, 2019	Amounts due within 1 year
Bonds payable:					
2016 General Obligation Refunding Bond	$ 16,997,000	$ -	$ (287,000)	$ 16,710,000	$ 293,000
General Obligation Bonds, 2009 Series:					
Current Interest Bonds	1,590,000	-	(725,000)	865,000	-
Capital Appreciation Bonds	8,144,947	-	-	8,144,947	865,000
Revenue Bonds, 2010 Series	7,420,000	-	(740,000)	6,680,000	785,000
Revenue Bonds, 2013 Series	9,780,000	-	(340,000)	9,440,000	350,000
Subtotal bonds payable	43,931,947	-	(2,092,000)	41,839,947	2,293,000
Bond premiums:					
General Obligation Bonds:					
2009 Series	391,487	-	(37,645)	353,842	-
Revenue Bonds, 2013 Series	143,007	-	(15,054)	127,953	-
Total bonds payable	44,466,441	-	(2,144,699)	42,321,742	2,293,000
Accreted Interest - General Obligation Bonds, 2009 Series, Capital Appreciation Bonds	12,193,679	1,326,585	-	13,520,264	-
Capital lease obligations:					
GE Financing 2	18,089	-	(18,089)	-	-
Orchard Software	-	232,308	(69,086)	163,222	67,898
Intuitive Surgical	-	1,775,000	(57,640)	1,717,360	347,475
7 Medical	-	392,184	(37,311)	354,873	57,144
Total capital leases payable	18,089	2,399,492	(182,126)	2,235,455	472,517
Totals	$ 56,678,209	$ 3,726,077	$ (2,326,825)	$ 58,077,461	$ 2,765,517

Northern Inyo Healthcare District

Notes to Financial Statements

Note 8: Long-Term Debt and Capital Lease Obligations (Continued)

	Balance July 1, 2017	Additions	Reductions	Balance June 30,2018	Amounts due within 1 year
Bonds payable:					
2016 General Obligation Refunding Bond	$ 17,279,000	$ -	$ (282,000)	$ 16,997,000	$ 287,000
General Obligation Bonds, 2009 Series:					
Current Interest Bonds	2,185,000	-	(595,000)	1,590,000	725,000
Capital Appreciation Bonds	8,144,947	-	-	8,144,947	-
Revenue Bonds, 2010 Series	8,120,000	-	(700,000)	7,420,000	740,000
Revenue Bonds, 2013 Series	10,105,000	-	(325,000)	9,780,000	340,000
Subtotal bonds payable	45,833,947	-	(1,902,000)	43,931,947	2,092,000
Bond premiums:					
General Obligation Bonds:					
2009 Series	463,394	-	(71,907)	391,487	-
Revenue Bonds, 2013 Series	158,060	-	(15,053)	143,007	-
Total bonds payable	46,455,401	-	(1,988,960)	44,466,441	2,092,000
Accreted Interest - General Obligation Bonds, 2009 Series, Capital Appreciation Bonds	10,867,094	1,326,585	-	12,193,679	-
Capital lease obligations:					
Bank of the West-Trinity Hospital Equipment	43,251	-	(43,251)	-	-
GE Financing 2	50,645	-	(32,556)	18,089	18,089
GE Financing 3	52,414	-	(52,414)	-	-
Total capital leases payable	146,310	-	(128,221)	18,089	18,089
Total	$ 57,468,805	$ 1,326,585	$ (2,117,181)	$ 56,678,209	$ 2,110,089

Note 8: Long-Term Debt and Capital Lease Obligations (Continued)

The terms and due dates of the District's long-term debt and capital lease obligations at June 30, 2019, consist of the following:

Long-Term Debt

General Obligation Bonds, 2009 Series

On April 21, 2009, the District issued $14,464,947 in General Obligation Bonds, 2005 Election, 2009 Series to finance the construction and equipping of an expansion and renovation of the Hospital. The 2009 Bonds consist of two types of bonds, Current Interest Bonds and Capital Appreciation Bonds, issued in the amounts of $6,320,000 and $8,144,947, respectively.

Interest on the Current Interest Bonds is payable semiannually on May 1 and November 1 at 5.75%. Current Interest Bonds mature annually commencing on November 1, 2012, through November 1, 2019, in amounts ranging from $60,000 to $865,000, as well as a bond maturing on November 1, 2038, for $3,150,000. Interest on the Capital Appreciation Bonds is accreted annually and paid at maturity. The Capital Appreciation Bonds mature annually commencing on November 1, 2020, through November 1, 2038, in amounts ranging from $1,020,000 to $3,420,000, inclusive of interest accreted through such maturity dates.

The Current Interest Bonds maturing on November 1, 2038, may be called by the District beginning November 1, 2017. The Capital Appreciation Bonds are not subject to redemption prior to their fixed maturity dates. The Current Interest Bond debt was partially extinguished in 2016 using proceeds from the issuance of the 2016 General Obligation Refunding Bond.

Revenue Bonds, 2010 Series

On April 14, 2010, the District issued $11,600,000 in Revenue Bonds, 2010 Series to finance the replacement hospital, finance the bond reserve account, and pay certain costs of issuance related to the 2010 Bonds.

Interest on the 2010 Bonds is payable semiannually on June 1 and December 1 at rates ranging from 5.000% to 6.375%. Mandatory sinking fund deposits to retire the bonds on their term maturity dates, ranging from $510,000 to $1,145,000, are due annually through December 2025.

The 2010 Bonds maturing on December 1, 2021, may be called by the District beginning December 1, 2016.

The District is required to maintain certain covenants and provide various reporting under the agreement.

Note 8: Long-Term Debt and Capital Lease Obligations (Continued)

Revenue Bonds, 2013 Series

On January 17, 2013, the District issued $11,335,000 in Revenue Bonds, 2013 Series to finance the replacement hospital, finance the bond reserve account, and pay certain costs of issuance related to the 2013 Bonds.

Interest on the 2013 Bonds is payable annually on December 1 at rates ranging from 3.875% to 5.000%. Mandatory sinking fund deposits to retire the bonds on their term maturity dates, ranging from $295,000 to $1,805,000, are due annually through December 2029.

The 2013 Bonds maturing on December 1, 2027, may be called, without premium, by the District on December 1, 2013, through December 1, 2015.

2016 General Obligation Refunding Bond

On May 12, 2016, the District issued $17,557,000 in a 2016 General Obligation Refunding Bond, to refinance the General Obligation Bonds, 2005 Series in whole and to pay a portion of General Obligation Bonds, 2009.

Interest on the 2016 bond is payable semiannually on November 1 and May 1 at a rate of 3.450%. Mandatory sinking fund deposits to retire the bonds on their term maturity dates, ranging from $278,000 to $1,874,000, are due annually through December 2035.

Capital Lease Obligations

Lease obligations to 7 Medical, Inc. are due in total monthly installments of $5,989 in October 2018 through 2021, including interest at 3.000%.

Lease obligations to Intuitive Surgical are due in total monthly installments of $24,344 in March 2019 through 2024, including interest at 3.500%.

Lease obligations to Orchard Software are due in total monthly installments of $5,447 in October 2018 through 2025, including interest at 2.500%.

Note 8: Long-Term Debt and Capital Lease Obligations (Continued)

Advanced Refunding

The District issued $17,557,000 in General Obligation Refunding Bonds (“2016 GOR Bond") with interest rates of 3.45% in November 2016. The proceeds were used to advance refund and considered defeased $3,150,000 of outstanding General Obligation Bonds Election of 2005, Series 2009 (“2009 GO Bond”), which had interest rates of 5.75% and General Obligation Bonds Election of 2005, Series 2005 (“2005 GO Bond”), which had varying interest rates of 6.00% to 4.25%. Net proceeds of $17,281,182 were derived from the issuance of the 2016 GOR bonds at par, including a $9,103 premium, and after payment of $275,818 in underwriting fees. Of the net proceeds, $17,281,182 was deposited in an irrevocable trust with an escrow agent to provide funds for the future debt service payment on the 2005 GO Bond and 2009 GO Bond, and $276,071 was used for issuance and other costs. As a result, the 2005 GO Bond and 2009 GO Bonds are considered defeased, and the liability for those bonds has been removed from the statements of net position. The District advance refunded bonds to reduce its total debt service payments and obtain an economic gain (difference between the present values of the old and new debt service payments) of $30,996. On June 30, 2018, $3,150,000 of bonds outstanding are considered defeased.

Scheduled principal and interest payments on long-term obligations are as follows:

	Long-Term Debt	
Years Ending June 30,	Principal	Interest
2020	$ 2,293,000	$ 1,397,010
2021	1,997,219	1,909,063
2022	2,112,448	1,913,015
2023	2,262,173	1,887,856
2024	2,544,996	1,732,485
2025-2029	14,571,948	8,852,139
2030-2034	10,625,498	9,525,081
2035-2039	5,914,460	12,688,636
Totals	$ 42,321,742	$ 39,905,285

Note 8: Long-Term Debt and Capital Lease Obligations (Continued)

Years Ending June 30,	Capital Leases Principal and Interest Payments
2020	$ 533,711
2021	495,006
2022	448,665
2023	423,140
2024	307,215
2025-2029	192,436
Less: Amounts attributable to interest	(164,718)
Total	$ 2,235,455

Note 9: Leases

The District leases office space in a medical office building under a noncancelable operating lease as an agreement with PMA that expires in 2018. In June 29, 2017, the District entered into an operating lease agreement with Athena Health for electronic health records and financial accounting system, which the lease term begins October 2018, and automatically extends yearly unless terminated.

The future minimum required payments by year and in the aggregate under the noncancelable operating lease, as of June 30, 2019, are as follows:

	2019
2020	$ 1,276,393
2021	1,276,393
2022	1,276,393
2023	1,276,393
2024 and beyond	1,276,393
Total	$ 6,381,965

Total building rent expense for the years ended June 30, 2019 and 2018, was $1,168,032 and $1,048,657, respectively.

Note 10: Pledged Revenue

The District has pledged future revenue to repay $11,600,000 million in District revenue bonds issued in March 2010. Proceeds from the bonds are to provide a portion of the funding for its replacement hospital project. The bonds are payable solely from revenues through 2025. The total principal and interest remaining to be paid on the bonds is $8,262,744. Principal and interest paid for the current year and revenues were $1,178,638 and $94,232,779, respectively.

The District has pledged future revenue to repay $11,335,000 in District revenue bonds issued in January 2013. Proceeds from the bonds are to provide a portion of the funding for its remodeling, expansion, improvement, and equipping of the facility. The bonds are payable solely from revenues through 2029. The total principal and interest remaining to be paid on the bonds is $13,451,231. Principal and interest paid for the current year and revenues were $768,750 and $71,823,552, respectively.

Note 11: Retirement Plans

Defined Benefit Plan - The Plan

The District sponsors a single-employer defined benefit pension plan for employees over age 21 with at least one year of service. The plan is governed by the Board of Directors, which may amend benefits and other plan provisions and which is responsible for the management of plan assets. The primary factors affecting the benefits earned by participants in the pension plan are employees' years of service and compensation levels.

The District provides service retirement and pre-retirement death benefits to plan members, who must be District employees and beneficiaries. Benefits are based on years of credited service, equal to one year of full-time employment. Members with five years of total service are eligible to retire at age 55 with statutorily reduced benefits. All members are eligible for pre-retirement death benefits after five years of service. The benefit vesting schedule is 50% vesting after five years, increasing 10% per year to 100% vested after 10 years of service.

Active participants automatically become 100% vested upon attainment of normal retirement age or if they become totally and permanently disabled.

The Plan’s provisions and benefits in effect at June 30, 2019, are summarized as follows:

Hire date	Prior to January 1, 2013
Benefit Payments	Life Annuity
Retirement Age	65-70
Monthly benefits, as a % of eligible compensation	2.50%, not less than $600
Required employer contribution rates	22.1% of applicable payroll

Note 11: Retirement Plans (Continued)

Employees covered at January 1, 2019, by the benefit terms for the Plan are as follows:

Inactive employees or beneficiaries currently receiving benefits	77
Active employees	155
Total	232

The employer contribution rates are determined on an annual basis by the actuary and shall be effective on July 1 following notice of a change in the rate. Funding contributions for the Plan are determined annually on an actuarial basis as of January 1 by the Plan. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability.

The District's net pension liability for the Plan is measured as the total pension liability, less the pension plan's fiduciary net position. The net pension liability of the Plan is measured as of June 30, 2019, using an annual actuarial valuation as of January 1, 2019, rolled forward to June 30, 2019, using standard update procedures. A summary of principal assumptions and methods used to determine the net pension liability is shown on the next page.

The total pension liabilities in the January 1, 2019, actuarial valuations were determined using the following actuarial assumptions:

Valuation date (actuarial valuation date)	January 1, 2019
Measurement date (net pension liability measured)	June 30, 2019
Actuarial cost method	Entry-Age Normal Cost Method
Actuarial assumptions	
Discount rate	5.00%
Projected salary increase	4.00%
Investment rate of return	5.00%
Mortality: Pre-retirement	RP-2014 Healthy Mortality w/generational projection from 2006, base year using scale MP-2017.
Mortality: Post-retirement (annuity elected)	RP-2014 Healthy Mortality w/generational projection from 2006, base year using scale MP-2017.
Mortality: Post-retirement (lump sum elected)	Based on date of participation DOP before 7/1/2009: 1984 UP, Mortality table set back four years. DOP on/after 7/1/2009: RP-2000. Table for males set back four years.

Northern Inyo Healthcare District

Notes to Financial Statements

Note 11: Retirement Plans (Continued)

The table below reflects the long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. These rates of return are net of administrative expenses.

Asset Class	Target Asset Allocation	Long-Term Expected Real Rate of Return
Cash	1.00 %	2.75 %
U.S. fixed income	50.05 %	4.24 %
U.S. governmental bonds	7.49 %	3.68 %
U.S. credit bonds	12.24 %	4.96 %
U.S. mortgages	8.49 %	4.44 %
U.S. bank/leveraged loans	14.73 %	5.50 %
U.S. high yield bonds	3.00 %	6.23 %
Private equity	3.00 %	11.96 %
Total	100.00 %	

The changes in the net pension liability of the Plan are as follows for the year ended June 30, 2019:

	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
	$ 57,266,032	$ 25,492,382	$ 31,773,650
Changes for the year:			
Service cost incurred	2,174,400	-	2,174,400
Interest on total pension liability	2,748,540	-	2,748,540
Differences between actual and expected experience	2,751,955	-	2,751,955
Changes in assumptions	(87,727)	-	(87,727)
Benefit payments	(9,049,661)	(9,049,661)	-
Contributions - Employer	-	6,060,000	(6,060,000)
Net investment income	-	680,602	(680,602)
Administrative expense	-	(67,342)	67,342
Totals	$ 55,803,539	$ 23,115,981	$ 32,687,558

Note 11: Retirement Plans (Continued)

The following presents the net pension liability of the District's Plan, calculated using the discount rate, as well as what the District's net pension liability would be if it were calculated using a discount rate that is one-percentage point lower or one-percentage point higher than the current rate:

1% decrease	4.00%
Net pension liability	$39,470,843
Current discount rate	5.00%
Net pension liability	$32,687,558
1% increase	6.00%
Net pension liability	$26,959,818

The District recognized pension expense of $6,335,128 and $5,222,823 in 2019 and 2018, respectively. At June 30, 2019, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Inflows of Resources	Deferred Outflows of Resources
Differences between actual and expected experience	$ 2,159,238	$ 4,265,084
Changes in assumptions	1,298,982	7,203,808
Net differences between projected and actual earning on plan investments	-	2,163,518
Totals	$ 3,458,220	$ 13,632,410

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Year Ended June 30,	Increase in Pension Expense
2020	$ 2,348,095
2021	2,151,157
2022	1,852,059
2023	1,553,677
2024	1,625,224
Thereafter	643,978
Total	$ 10,174,190

Note 11: Retirement Plans (Continued)

Defined Benefit Plan - The PEPRA Plan

The District sponsors a defined benefit pension plan (the "PEPRA Plan"), a single-employer defined benefit plan for the Chief Executive Officer (CEO). The PEPRA Plan is governed by the Board of Directors, which may amend benefits and other plan provisions and which is responsible for the management of plan assets. The primary factors affecting the benefits earned by participants in the pension plan are employees' years of service and compensation levels.

The District provides service retirement and pre-retirement death benefits to plan members, who must be District employee holding the position of Chief Executive Officer and beneficiaries. Benefits are based on years of credited service, equal to one year of full-time employment. Members with five years of total service are eligible to retire at age 62 with statutorily reduced benefits. All members are eligible for early retirement benefits at age 52 with at least 5 years of credited services with reduced benefits. The benefit vesting schedule is 100% vesting after five years of credited service, or upon total and permanent disability.

The PEPRA Plan's provisions and benefits in effect at June 30, 2019, are summarized as follows:

Hire date	Beginning January 1, 2016
Benefit Payments	Life Annuity
Retirement Age	62 or 5th anniversary of participant
Monthly benefits, as a % of eligible compensation	2% of Average Annual Compensation multiplied by years of Credited Service
Required employee contribution rates	12% of applicable payroll
Required employer contribution rates	11.50% of applicable payroll

Employees covered at January 1, 2019, by the benefit terms for the PEPRA Plan are as follows:

Inactive employees or beneficiaries currently receiving benefits	-
Active employees	1
Total	1

The employer contribution rates are determined on an annual basis by the actuary and shall be effective on July 1 following notice of a change in the rate. Funding contributions for the PEPRA Plan are determined annually on an actuarial basis as of January 1 by the PEPRA Plan. The actuarially determined rate is the estimated amount necessary to finance the costs of benefits earned by employees during the year, with an additional amount to finance any unfunded accrued liability.

Note 11: Retirement Plans (Continued)

The District's net pension liability for the PEPRA Plan is measured as the total pension liability, less the pension plan's fiduciary net position. The net pension liability of the PEPRA Plan is measured as of June 30, 2019, using an annual actuarial valuation as of January 1, 2019, rolled forward to June 30, 2019, using standard update procedures. A summary of principal assumptions and methods used to determine the net pension liability is shown on the next page.

The total pension liabilities in the January 1, 2019, actuarial valuations were determined using the following actuarial assumptions:

Valuation date (actuarial valuation date)	January 1, 2019
Measurement date (net pension liability measured)	June 30, 2019
Actuarial cost method	Entry-Age Normal Cost Method
Actuarial assumptions	
Discount rate	5.00%
Inflation	2.50%
Payroll growth	4%
Investment rate of return	5.00%
Mortality: Pre-retirement	RP-2014 Healthy Mortality w/ generational projection from 2006, base year using scale MP-2017.
Mortality: Post-retirement (annuity elected)	RP-2014 Healthy Mortality w/generational projection from 2006, base year using scale MP-2017.

The table below reflects the long-term expected real rate of return by asset class. The rate of return was calculated using the capital market assumptions applied to determine the discount rate and asset allocation. These rates of return are net of administrative expenses.

Asset Class	Target Asset Allocation	Long-Term Expected Real Rate of Return
U.S. fixed income	60.00 %	4.23 %
Global equity	40.00 %	7.90 %
Total	100.00 %	

Note 11: Retirement Plans (Continued)

The changes in the net pension liability of the PEPRA Plan are as follows for the year ended June 30, 2019:

	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability (Asset)
	$ 72,633	$ 68,112	$ 4,521
Changes for the year:			
Service cost incurred	27,705	-	27,705
Interest on total pension liability	5,017	-	5,017
Differences between actual and expected experience	71	-	71
Changes in assumptions	(382)	-	(382)
Contributions - Employee	-	9,583	(9,583)
Contributions - Employer	-	9,584	(9,584)
Current-year net changes	32,411	19,167	13,244
Totals	$ 105,044	$ 87,279	$ 17,765

The following presents the net pension liability of the District's PEPRA Plan, calculated using the discount rate, as well as what the District's net pension liability would be if it were calculated using a discount rate that is one-percentage point lower or one-percentage point higher than the current rate:

1% decrease	4.00%
Net pension liability	$32,244
Current discount rate	5.00%
Net pension liability	$17,765
1% increase	6.00%
Net pension liability	$3,241

Note 11: Retirement Plans (Continued)

The District recognized pension expense of $20,745 in 2019 and $18,014 in 2018. At June 30, 2019, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	Deferred Inflows of Resources	Deferred Outflows of Resources
Differences between actual and expected experience	$ 313	$ 65
Changes in assumptions	737	-
Net differences between projected and actual earning on plan investments	-	5,273
Total	$ 1,050	$ 5,338

Other amounts reported as deferred outflows of resources and deferred inflows of resources related to pensions will be recognized as pension expense as follows:

Year Ended June 30,	Increase (Decrease) in Pension Expense
2020	$ 1,486
2021	1,488
2022	1,260
2023	687
2024	(88)
Thereafter	(545)
Total	$ 4,288

Defined Contribution Plan

The District sponsors and contributes to the Northern Inyo County Local Hospital District 401(a) Retirement Plan (NICLHD), a defined contribution pension plan, for its employees. The plan covers its employees who have attained the age of 21 years and were not a participant in the District's defined benefit plan prior to January 1, 2013, and completed of one year of service. NICLHD is administered by the District.

Benefit terms, including contribution requirements, for NICLHD are established and may be amended by the District's Board of Directors. For each employee in the pension plan, the District is required to contribute 7% as a percent of annual salary, exclusive of overtime pay, to an individual employee account. Employees are not permitted to make contributions to the pension plan. For the year ended June 30, 2019 and 2018, the District recognized pension expense of $789,151 and $949,437, respectively.

Note 11: Retirement Plans (Continued)

Each participant shall have a nonforfeitable and vested right to his or her account for each year of service completed while an employee of the employer, in accordance with the following schedule:

Years	Nonforfeitable Percentage
5	50.0 %
6	60.0 %
7	70.0 %
8	80.0 %
9	90.0 %
10 or more	100.0 %

Nonvested District contributions are forfeited upon termination of employment. Such forfeitures are used to cover a portion of the pension plan's administrative expenses. There have been no forfeitures to date.

Note 12: Medical Office Building, Net

The District has a number of Board-approved management practice arrangements with physicians to provide services for primary care and specialty services in the district. These managed contracts are nonoperating activities of the District and are listed in the nonoperating revenue (expenses) on the statements of revenues, expenses, and changes in net position. The Hospital provides an income guarantee against net revenue while also providing all services for operating of the physician practices. The District has practice management agreements for the following physician practices: Pediatrics, Internal Medicine, Orthopedic Surgery, Specialty Clinic, and General Surgery. The net cost of this activity is included in medical office building, net in the accompanying statements of revenues, expenses, and changes in net position for the years ended June 30, 2019 and 2018.

Note 13: Risk Management

The District is exposed to various risks of loss related to medical malpractice; torts; theft of, damage to, and destruction of assets; errors and omissions; injuries of employees; and natural disasters.

The District's comprehensive general liability insurance covers losses of up to $20,000,000 per claim with $30,000,000 annual aggregate for occurrence basis during a policy year regardless of when the claim was filed (occurrence-based coverage). The District's professional liability insurance covers losses up to $5,000,000 per claim with $5,000,000 annual aggregate for claims reported during a policy year (claims-made coverage). Under a claims-made policy, the risk for claims and incidents not asserted within the policy period remains with the District.

Although there exists the possibility of claims arising from services provided to patients through June 30, 2019, which have not yet been asserted, the District is unable to determine the ultimate cost, if any, of such possible claims, and accordingly no provision has been made for them. Settled claims have not exceeded commercial coverage in any of the three preceding years.

The District is a participant in the Association of California Healthcare Districts' ALPHA Fund, which administers a self-insured workers' compensation plan for participating member hospitals and their employees. The District pays a premium to the ALPHA Fund; the premium is adjusted annually. If participation in the ALPHA Fund were terminated by the District, the District would be liable for its share of any additional premiums necessary for final disposition of all claims and losses covered by the ALPHA Fund.

Note 14: Self-Funded Insurance

The District has a self-funded health care plan that provides medical and dental benefits to employees and their dependents. Employees share in the cost of health benefits. Health care expense is based on actual claims paid, reinsurance premiums, administration fees, and unpaid claims at year-end. The District buys reinsurance to cover catastrophic individual claims over $150,000. The District records a liability for claims incurred, but not reported that is recorded in accrued payroll and related liabilities in the accompanying statements of net position.

Northern Inyo Healthcare District

Notes to Financial Statements

Note 15: Functional Expenses

The District provides general health care services to residents within its geographic area. Expenses, including interest expense, related to providing these services consisted of the following for the following for the years ended June 30:

	2019	2018
Health care service	$ 79,958,597	$ 72,822,566
Management and administration	12,415,514	12,709,415
Total expenses	$ 92,374,111	$ 85,531,981

Note 16: Concentration of Credit Risk

Financial instruments that potentially subject the District to credit risk consist principally of patient receivables.

Patient receivables consist of amounts due from patients, their insurers, or governmental agencies (primarily Medicare and Medi-Cal) for health care provided to the patients. The majority of the District's patients are from Bishop, California, and the surrounding area.

The mix of receivables from patients and third-party payors was as follows at June 30 :

	2019	2018
Medicare	44 %	37 %
Medi-cal, including CMSP	22 %	23 %
Other third-party payors	32 %	32 %
Patients	2 %	8 %
Totals	100 %	100 %

Note 17: Commitments and Contingencies

Litigation

The District may from time to time be involved in litigation and regulatory investigations that arise in the normal course of doing business. After consultation with legal counsel, management estimates that matters, if applicable, existing as of June 30, 2019, will be resolved without material adverse effect on the District's future financial position, results from operations, or cash flows.

Pollution Remediation Obligations

Pollution remediation obligations are triggered by an obligating event. An obligating event is when a government is compelled to take action to protect the public from pollution; has violated a pollution permit, license, or law; has or will be named in a lawsuit; or voluntarily engages in a cleanup. Management has considered this guidance specifically as it relates to its legal obligations related to asbestos removal on its existing properties. Management of the District believes there has not been an obligating event, and if there had been, the amount of the potential liability could not be reasonably estimated. Therefore, no obligations have been recorded for pollution remediation as of June 30, 2019 and 2018.

Required Supplementary Information

Northern Inyo Healthcare District

Schedule of Changes in the Net Pension Liability and Related Ratios and Contributions - Plan

Last Ten Fiscal Years (If Available)

Total Pension Liability	2019	2018	2017	2016
Service cost incurred	$ 2,174,400	$ 2,281,116	$ 2,812,178	$ 2,219,985
Interest in total pension liability	2,748,540	2,805,649	3,053,437	3,047,939
Difference between actual and expected	2,751,955	1,343,607	(3,295,677)	1,385,608
Change in assumption	(87,727)	(185,137)	(417,283)	12,966,856
Benefit payments	(9,049,661)	(5,554,374)	(7,575,753)	(8,213,871)
Net change in total pension liability	(1,462,493)	690,861	(5,423,098)	11,406,517
Total pension liability - Beginning	57,266,032	56,575,171	61,998,269	50,591,752
Total pension liability - Ending (a)	55,803,539	57,266,032	56,575,171	61,998,269
Plan fiduciary net position:				
Contribution - Employer	6,060,000	5,340,000	5,340,000	3,900,000
Net investment income (loss)	680,602	(292,381)	(126,769)	880,376
Administrative expense	(67,342)	(88,502)	(55,640)	(51,336)
Benefit payments	(9,049,661)	(5,554,374)	(7,575,753)	(8,213,871)
Net change in plan fiduciary net position	(2,376,401)	(595,257)	(2,418,162)	(3,484,831)
Plan fiduciary net position - Beginning	25,492,382	26,087,639	28,505,801	31,990,632
Plan fiduciary net position - Ending (b)	23,115,981	25,492,382	26,087,639	28,505,801
Net pension liability - Ending (a)-(b)	$ 32,687,558	$ 31,773,650	30,487,532	33,492,468
Plan fiduciary net position as a percentage of the total pension liability	41.42 %	44.52 %	46.11 %	45.98 %
Covered-employee payroll	$ 12,968,106	$ 13,529,712	$ 15,892,425	$ 17,664,833
Net pension liability as percentage of covered employee payroll	206.00 %	245.01 %	225.34 %	210.74 %

Notes to Schedule:

Changes in assumptions: In 2019, amounts reported as changes in assumptions resulted primarily from adjustments to expected form of, discount rate, payment election, and mortality assumptions.

Northern Inyo Healthcare District

Schedule of Changes in the Net Pension Liability and Related Ratios and Contributions - Plan (Continued)

Last Ten Fiscal Years (If Available)

SCHEDULE OF CONTRIBUTIONS	2019	2018	2017	2016
Actuarially determined contribution	$ 5,484,000	$ 4,716,000	$ 5,340,000	$ 3,900,000
Contributions in relation to the actuarially determined contributions	6,060,000	5,340,000	5,340,000	3,900,000
Contribution excess	$ (576,000)	$ (624,000)	$ -	$ -
Covered-employee payroll	$ 12,968,106	$ 13,529,712	$ 15,892,425	$ 17,664,833
Contributions as a percentage of covered employee payroll	46.73 %	39.47 %	33.60 %	22.08 %

Notes to Schedule:

Valuation date:	January 1, 2019
Methods and assumptions used to determine contribution rates:	
Single-employer plan	Entry Age Normal Cost Method
Amortization method	Level percentage of payroll, closed
Remaining amortization period	17 years
Asset valuation method	Market value
Inflation	2.3%
Salary increases	4%, including inflation
Investment rate of return	5.00%
Retirement age	65, or 70 *
Mortality: Pre-retirement	**
Mortality: Postretirement (annuity elected)	***
Mortality: Postretirement (lump sum elected)	****

** RP-2014 Healthy Mortality w/generational projection from 2006, Base Year using Scale MP-2017.
*** RP-2014 Healthy Mortality w/generational projection from 2006, Base Year using Scale MP-2017.
**** DOP before 7/1/2009: 1984 UP, Mortality Table set back four years. DOP On/After 7/1/2009: RP-2000 Table for Males set back four years.

SCHEDULE OF INVESTMENT RETURNS	2019	2018	2017	2016
Annual money-weighted rate of return, net of investment expense	2.96 %	(1.16)%	(0.48)%	3.11 %

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Schedule of Changes in the Net Pension Liability and Related Ratios and Contributions - PEPRA Plan

Last Ten Fiscal Years (If Available)

Total Pension Liability	2019	2018
Service cost incurred	$ 27,705	$ 27,571
Interest in total pension liability	5,017	3,498
Difference between actual and expected	71	(369)
Change in assumption	(382)	(456)
Net change in total pension liability	32,411	30,244
Total pension liability - Beginning	72,633	42,389
Total pension liability - Ending (a)	105,044	72,633
Plan fiduciary net position:		
Contribution - Employer	9,583	10,938
Contribution - Employee	9,584	10,938
Net change in plan fiduciary net position	19,167	21,876
Plan fiduciary net position - Beginning	68,112	46,236
Plan fiduciary net position - Ending (b)	87,279	68,112
Net pension liability - Ending (a)-(b)	$ 17,765	$ 4,521
Plan fiduciary net position as a percentage of the total pension liability	83.09 %	93.78 %
Covered-employee payroll	$ 121,388	$ 118,775
Net pension liability as percentage of covered employee payroll	14.63 %	3.81 %

Northern Inyo Healthcare District

Schedule of Changes in the Net Pension Liability and Related Ratios and Contributions - PEPRA Plan (Continued)

Last Ten Fiscal Years (If Available)

SCHEDULE OF CONTRIBUTIONS	2019	2018
Actuarially determined contribution	$ 14,089	$ 13,662
Contributions in relation to the actuarially determined contributions	14,089	13,662
Contribution deficiency	$ -	$ -
Covered-employee payroll	$ 121,388	$ 118,775
Contributions as a percentage of covered employee payroll	11.61 %	11.50 %

Notes to Schedule

Valuation date:	January 1, 2018
Methods and assumptions used to determine contribution rates:	
Single-employer plan	Entry Age Normal Cost Method
Amortization method	Level percentage of payroll, closed
Remaining amortization period	17 years
Asset valuation method	Market value
Inflation	2.5%
Salary increases	4%, including inflation
Investment rate of return	5.00%
Retirement age	65
Mortality: Pre-retirement	**
Mortality: Postretirement (annuity elected)	***

** RP-2014 Healthy Mortality w/generational projection from 2006, Base Year using Scale MP-2017.
*** RP-2014 Healthy Mortality w/generational projection from 2006, Base Year using Scale MP-2017.

SCHEDULE OF INVESTMENT RETURNS	2019	2018
Annual money-weighted rate of return, net of investment expense	- %	- %

Supplementary Information

Northern Inyo Healthcare District

Combining Statement of Net Position of the District and Component Units

June 30, 2019 (Auxiliary May 31, 2019) (Pioneer Home Health December 31, 2018)

Assets and Deferred Outflows of Resources	Hospital	Foundation	Auxiliary	Pioneer Home Health	Eliminations	Total
Current assets:						
Cash and equivalents	$ 25,984,016	$ 357,849	$ 72,171	$ 50,771	$ -	$ 26,464,807
Receivables:						
Patient accounts - Net	18,834,240	-	-	235,311	-	19,069,551
Other - Government agency	935,509	-	-	-	-	935,509
Inventories	2,431,341	-	-	-	-	2,431,341
Prepaid expenses and other	1,901,136	-	-	188,685	(300,000)	1,789,821
Total current assets	50,086,242	357,849	72,171	474,767	(300,000)	50,691,029
Other assets:						
Noncurrent cash and investments	6,647,888	-	-	-	-	6,647,888
Investment in PMA	501,030	-	-	-	-	501,030
Goodwill in PMA	581,219	-	-	-	-	581,219
Total other assets	7,730,137	-	-	-	-	7,730,137
Capital assets:						
Nondepreciable capital assets	1,553,741	-	-	130,000	-	1,683,741
Depreciable capital assets - Net	75,847,646	-	-	310,180	-	76,157,826
Capital assets - Net	77,401,387	-	-	440,180	-	77,841,567
Deferred outflows of resources - Pensions	13,637,748	-	-	-	-	13,637,748
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$148,855,514	$ 357,849	$ 72,171	$ 914,947	$ (300,000)	$149,900,481

Northern Inyo Healthcare District

Combining Statement of Net Position of the District and Component Units

June 30, 2019 (Auxiliary May 31, 2019, Pioneer Home Health December 31, 2018)

Liabilities, Deferred Inflows of Resources, and Net Position	Hospital	Foundation	Auxiliary	Pioneer Home Health	Eliminations	Total
Current liabilities:						
Current maturities of long-term liabilities:						
Bonds payable - Current Portion	$ 2,293,000	$ -	$ -	$ -	$ -	$ 2,293,000
Capital lease obligation - Current Portion	472,517	-	-	-	-	472,517
Accounts payable	5,040,623	-	-	331,632	-	5,372,255
Accrued interest and sales tax	102,216	-	-	-	-	102,216
Accrued payroll and related liablities	8,154,456	-	-	134,714	-	8,289,170
Estimated third-party payor settlements	1,550,939	-	-	-	-	1,550,939
Unearned revenue	22,268	-	-	-	-	22,268
Total current liabilities	17,636,019	-	-	466,346	-	18,102,365
Long-term liabilities:						
Bonds payable	40,028,742	-	-	-	-	40,028,742
Accreted interest	13,520,264	-	-	-	-	13,520,264
Capital lease obligation	1,762,938	-	-	-	-	1,762,938
Net pension liability	32,705,323	-	-	-	-	32,705,323
Total long-term liabilities	88,017,267	-	-	-	-	88,017,267
Total liabilities	105,653,286	-	-	466,346	-	106,119,632
Deferred inflows of resources	3,459,270	-	-	-	-	3,459,270
Net position:						
Net investment in capital assets	32,741,974	-	-	-	-	32,741,974
Restricted for debt service	2,817,042	-	-	-	-	2,817,042
Restricted for programs	150,576	-	-	-	-	150,576
Unrestricted	4,033,366	357,849	72,171	448,601	(300,000)	4,611,987
Total net position	39,742,958	357,849	72,171	448,601	(300,000)	40,321,579
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION	$148,855,514	$ 357,849	$ 72,171	$ 914,947	$ (300,000)	$ 149,900,481

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Combining Statement of Net Position of the District and Component Units

June 30, 2018 (Auxiliary May 31, 2018)

Assets and Deferred Outflows of Resources	Hospital	Foundation	Auxiliary	Eliminations	Total
Current assets:					
Cash and equivalents	$ 20,627,520	$ 343,900	$ 62,872	$ -	$ 21,034,292
Receivables:					
Patient accounts - Net	14,684,069	-	-	-	14,684,069
Other - Government agency	3,535,824	-	-	-	3,535,824
Inventories	3,256,568	-	-	-	3,256,568
Prepaid expenses and other	1,982,299	-	-	-	1,982,299
Total current assets	44,086,280	343,900	62,872	-	44,493,052
Other assets:					
Noncurrent cash and investments	7,377,420	-	-	-	7,377,420
Investment in PMA	379,758	-	-	-	379,758
Goodwill in PMA	581,219	-	-	-	581,219
Total other assets	8,338,397	-	-	-	8,338,397
Capital assets:					
Nondepreciable capital assets	1,464,183	-	-	-	1,464,183
Depreciable capital assets - Net	75,357,824	-	-	-	75,357,824
Capital assets - Net	76,822,007	-	-	-	76,822,007
Deferred outflows of resources - Pensions	13,550,703	-	-	-	13,550,703
TOTAL ASSETS AND DEFERRED OUTFLOWS OF RESOURCES	$ 142,797,387	$ 343,900	$ 62,872	$ -	$143,204,159

Northern Inyo Healthcare District

Combining Statement of Net Position of the District and Component Units (Continued)

June 30, 2018 (Auxiliary May 31, 2018)

Liabilities, Deferred Inflows of Resources, and Net Position	Hospital	Foundation	Auxiliary	Eliminations	Total
Current liabilities:					
Current maturities of long-term liabilities:					
Bonds payable - Current Portion	$ 2,092,000	$ -	$ -	$ -	$ 2,092,000
Capital lease obligation - Current Portion	18,089	-	-	-	18,089
Accounts payable	3,656,555	-	-	-	3,656,555
Accrued interest and sales tax	140,774	-	-	-	140,774
Accrued payroll and related liabilities	6,153,360	-	-	-	6,153,360
Estimated third-party payor settlements	1,300,000	-	-	-	1,300,000
Unearned revenue	68,644	-	-	-	68,644
Total current liabilities	13,429,422	-	-	-	13,429,422
Noncurrent liabilities:					
Bonds payable	42,374,441	-	-	-	42,374,441
Accreted interest	12,193,679	-	-	-	12,193,679
Net pension liability	31,778,171	-	-	-	31,778,171
Total noncurrent liabilities	86,346,291	-	-	-	86,346,291
Total liablities	99,775,713	-	-	-	99,775,713
Deferred inflows of resources	4,037,270	-	-	-	4,037,270
Net position:					
Net investment in capital assets	32,198,861	-	-	-	32,198,861
Restricted for debt service	4,200,769	-	-	-	4,200,769
Restricted for programs	130,526	-	-	-	130,526
Unrestricted	2,454,248	343,900	62,872	-	2,861,020
Total net position	38,984,404	343,900	62,872	-	39,391,176
TOTAL LIABILITIES, DEFERRED INFLOWS OF RESOURCES, AND NET POSITION	$ 142,797,387	$ 343,900	$ 62,872	$ -	$143,204,159

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Combining Statement of Revenues, Expenses, and Changes in Net Position of the District and Component Units

For the year ended June 30, 2019 (Auxiliary May 31, 2019, Pioneer Home Health December 31, 2018)

	Hospital	Foundation	Auxiliary	Pioneer Home Health	Eliminations	Total
Revenue:						
Net patient service revenue	$ 92,243,241	$ -	$ -	$ 1,190,676	$ -	$ 93,433,917
Other operating revenue	788,346	-	10,405	111	-	798,862
Total revenue	93,031,587	-	10,405	1,190,787	-	94,232,779
Operating expenses:						
Salaries and wages	31,037,212	-	-	926,921	-	31,964,133
Employee benefits	21,367,403	-	-	167,468	-	21,534,871
Professional fees	11,308,012	1,447	-	-	-	11,309,459
Supplies	10,741,017	656	-	12,109	-	10,753,782
Purchased services	3,874,442	-	-	63,722	-	3,938,164
Depreciation	4,242,373	-	-	17,335	-	4,259,708
Other operating expenses	5,401,880	18,884	-	674,065	-	6,094,829
Total operating expenses	87,972,339	20,987	-	1,861,620	-	89,854,946
Income (loss) from operations	5,059,248	(20,987)	10,405	(670,833)	-	4,377,833
Nonoperating revenue (expense):						
Tax revenue for operations	582,378	-	-	-	-	582,378
Tax revenue for debt services	1,671,511	-	-	-	-	1,671,511
Interest income	774,619	-	-	-	-	774,619
Interest expense	(2,901,485)	-	-	(15,886)	-	(2,917,371)
Noncapital grants and contributions	2,181,090	34,936	(606)	-	-	2,215,420
Medical office building, net	(6,210,601)	-	-	-	-	(6,210,601)
Total nonoperating revenue (expense)	(3,902,488)	34,936	(606)	(15,886)	-	(3,884,044)
Excess (deficit) of revenue over expenses - carry forward	$ 1,156,760	$ 13,949	$ 9,799	$ (686,719)	$ -	$ 493,789

Northern Inyo Healthcare District

Combining Statement of Revenues, Expenses, and Changes in Net Position of the District and Component Units (Continued)

For the year ended June 30, 2019 (Auxiliary May 31, 2019, Pioneer Home Health December 31, 2018)

	Hospital	Foundation	Auxiliary	Pioneer Home Health	Eliminations	Total
Excess (deficit) of revenue over expenses - brought forward	$ 1,156,760	$ 13,949	$ 9,799	$ (686,719)	$ -	$ 493,789
Capital grants and contributions	-	-	(500)	-	-	(500)
Operating transfer (out) in	(398,206)	-	-	398,206	-	-
Increase in net position	758,554	13,949	9,299	(288,513)	-	493,289
Net contribution from Pioneer Home Health	-	-	-	737,114	(300,000)	437,114
Net position at beginning	38,984,404	343,900	62,872	-	-	39,391,176
Net position at end	$ 39,742,958	$ 357,849	$ 72,171	$ 448,601	$ (300,000)	$ 40,321,579

See accompanying notes to financial statements.

Northern Inyo Healthcare District

Combining Statement of Revenues, Expenses, and Changes in Net Position of the District and Component Units

For the year ended June 30, 2018 (Auxiliary May 31, 2018)

	Hospital	Foundation	Auxiliary	Eliminations	Total
Revenue:					
Net patient service revenue	$ 86,628,531	$ -	$ -	$ -	$ 86,628,531
Other operating revenue	1,132,187	-	44,001	-	1,176,188
Total revenue	87,760,718	-	44,001	-	87,804,719
Operating expenses:					
Salaries and wages	25,726,930	-	-	-	25,726,930
Employee benefits	20,374,657	-	-	-	20,374,657
Professional fees	13,195,860	100	-	-	13,195,960
Supplies	9,879,109	2,759	-	-	9,881,868
Purchased services	4,055,876	-	-	-	4,055,876
Depreciation	4,456,699	-	-	-	4,456,699
Other operating expenses	4,853,710	93,506	-	-	4,947,216
Total operating expenses	82,542,841	96,365	-	-	82,639,206
Total operating expenses	5,217,877	(96,365)	44,001	-	5,165,513
Nonoperating revenue (expense):					
Tax revenue for operations	682,286	-	-	-	682,286
Tax revenue for debt services	1,543,646	-	-	-	1,543,646
Interest income	306,915	-	-	-	306,915
Interest expense	(2,892,775)	-	-	-	(2,892,775)
Noncapital grants and contributions	1,606,592	44,147	49	-	1,650,788
Medical office building, net	(4,760,636)	-	-	-	(4,760,636)
Total nonoperating revenue (expense)	(3,513,972)	44,147	49	-	(3,469,776)
Excess (deficit) of revenue over expense - carry forward	$ 1,703,905	$ (52,218)	$ 44,050	$ -	$ 1,695,737

Northern Inyo Healthcare District

Combining Statement of Revenues, Expenses, and Changes in Net Position of the District and Component Units (Continued)

June 30, 2018 (Auxiliary May 31, 2018)

	Hospital	Foundation	Auxiliary	Eliminations	Total
Excess (deficit) of revenue over expense - brought forward	$ 1,703,905	$ (52,218)	$ 44,050	$ -	$ 1,695,737
Capital grants and contributions	53,472	-	(38,409)	-	15,063
Increase (decrease) in net position	1,757,377	(52,218)	5,641	-	1,710,800
Net position at beginning	37,227,027	396,118	57,231	-	37,680,376
Net position at end	$ 38,984,404	$ 343,900	$ 62,872	$ -	$ 39,391,176

See accompanying notes to financial statements.

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

Improving our communities, one life at a time.
One Team, One Goal, Your Health!

Northern Inyo Healthcare District

Workplace Violence Prevention Plan

September l, 2017
Revised: December 30, 2019

Workplace Violence Prevention Plan

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NORTHERN INYO HEALTHCARE DISTRICT

EMPLOYEE HANDBOOK – PERSONNEL POLICY

Title: Workplace Violence Prevention Policy	
Scope: Hospital Wide	Manual: Human Resources
Source: Human Resources	Effective Date: 6/22/2017

POLICY:

Northern Inyo Healthcare District (District) is committed to providing a safe and healthful work environment for the District's patients, visitors, employees, volunteers, contractors, suppliers, members of the medical staff and members of the public. The District has zero tolerance for any act of violence or any threat of violence that occurs on District property. This prohibition against threats or acts of violence applies to all District patients, visitors, employees, volunteers, and members of the medical staff, contractors, suppliers, and members of the public.

NOTE: This is a ZERO-TOLERANCE policy, meaning that the District shall take appropriate action to correct any violation of this policy, after an investigation into the facts and circumstances of each reported incident.

The District prohibits retaliation against an individual who has alleged that a workplace violence incident has occurred, who has participated in an investigation of a workplace violence incident or who has reported an incident of workplace violence to law enforcement.

PROCEDURES:

I. Workplace Violence includes, but is not limited to, the following:

A. Any act of violence or threat of violence that occurs at or towards any District worksite or District employee. Some examples of behavior that exhibit aggression/violence include, but are not limited to, the following:

1. Intimidation, including verbal attacks, humiliation in front of others, using a sincere tone to get what is wanted
2. Offensive language and/or sexual innuendos in the form of words, expressions, gestures and other social behaviors that are perceived as disrespectful
3. Verbal abuse in the form of shouting, insulting, intimidating, threatening, shaming, demeaning, or derogatory language
4. Verbal assault in the form of negative defining statements told to the person or told about a person intended to cause injury or harm that includes verbal, vocalized threats; threatening body language, and written threats
5. Physical Assault which is an intentional action by a person that creates an apprehension in another of an imminent, harmful or offensive contact and includes slapping, pushing, and shoving as well as assaults involving weapons and the risk of serious bodily injury.

B. The use of physical force against a District employee by a patient or a person accompanying a patient that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury.

C. An incident involving the use of a firearm or other dangerous weapon, regardless of whether the employee sustains an injury.

D. The following are the four (4) workplace violence types:

1. "Type 1 violence" means workplace violence committed by a person who has no legitimate business at the work site, and includes violent acts by anyone who enters the workplace with the intent to commit a crime.
2. "Type 2 violence" means workplace violence directed at employees by customers, clients, patients, students, inmates, or visitors or other individuals accompanying a patient.
3. "Type 3 violence" means workplace violence against an employee by a present or former employee, supervisor, or manager.
4. "Type 4 violence" means workplace violence committed in the workplace by someone who does not work there, but has or is known to have had a personal relationship with an employee.

II. Identifying and responding to risks:

A. Workplace Violence Prevention Assessment Team (V-PAT). The District has established the V-PAT, which shall convene on an ad hoc basis, consisting of the following, or their designee:

- Chief Operating Officer
- Chief Nursing Officer
- Chief, Finance Officer
- Director, Human Resources
- Director, Project/Property Management (includes Safety Officer and Security professionals)
- Manager of Maintenance
- Director, Administrative Staff, RHC/NIA
- Security Officer
- House Supervisor
- Director of Nursing, ED & In-Patient Services Manager, ED/Disaster Planning
- Maintenance professional
- Others as determined appropriate

B. The V-PAT is responsible for:
1. Hazard assessment
2. Workplace safety and security assessment
3. Hazard correction, control and prevention

4. Development and implementation of a Workplace Violence Prevention Plan
5. Annual evaluation of the Workplace Violence Prevention Plan

C. Hazard Assessment. A Hazard Assessment shall include a review of the following records:
1. OSHA logs
2. Unusual Occurrence Report (UOR)
3. Worker's Compensation reports
4. Environment of Care reports
5. Human Resources Department records
6. Workplace Violence UOR
7. Area crime statistics

D. Workplace Safety and Security Assessment: A workplace safety and security assessment shall be conducted to identify and evaluate safety and security risks, nature and extent of hazards, conditions, and/or situations that may exist that could place an individual in danger of violence.

NOTE: The V-PAT may seek assistance and/or input from sources to include; local law enforcement, employee assistance program counselors, NIHD liability insurance carrier, and/or a security/safety specialist.

E. Hazard Correction, Control and Prevention. Based upon information gathered during the Hazard Assessment and the Workplace Safety and Security Assessment, the V-PAT shall implement appropriate hazard corrections which may include engineering controls, new equipment, workplace design, and/or policy/procedure development.

F. Development, Implementation, and Annual Evaluation of a Workplace Violence Prevention Plan. The V-PAT shall lead the development and implementation of a Workplace Violence Prevention Plan. Once developed, the V-PAT shall lead an evaluation of the Workforce Violence Prevention Plan at least annually. Such evaluation shall be documented.

III. Training and Communication:

All employees, and others as determined by the District, shall receive training at new employee orientation and annually thereafter and this training shall be documented. Certain employees and others may receive specific training depending upon their particular job and/or work location and such training shall also be documented. When there is a change to equipment, work practices or the work environment due to hazard correction, affected employees and others shall be trained thereon and such training shall be documented.

IV. Incident Reporting and Investigations:

A. All incidents under this policy shall be documented immediately using the electronic UOR system. The Workplace Violence Incident Report Form is available online and to be used during downtime as needed.

B. All incidents under this policy shall be reported to any of the following: Security Officer, Department Head, House Supervisor, Director, Human Resources Department, any Chief, the Administrator on Call (AOC), or the Chief Executive Officer (CEO). Incidents of workplace violence may also be reported to law enforcement and/or any relevant regulatory agency.

C. All Workplace Violence Unusual Occurrence Reports (UORs) are submitted electronically through the dedicated electronic reporting system which will automatically notify, via email, Human Resources and Compliance that there is a workplace violence UOR.

D. All post-incident responses including any investigation shall be documented using the electronic UOR system. The Workplace Violence Incident Report Form and the Leader's Investigation Form are available online and to be used during downtime as needed.

V. Support for Victims of Violence:

Victims of incidents under this policy may have to contend with a variety of medical, psychological, and legal consequences. NIHD shall assist victims by:

A. Referring victims to appropriate medical care
B. Referring victims to appropriate community resources.
C. Providing flexible work hours or short-term or extended leave as appropriate.
D. Cooperating with law enforcement personnel in the investigation of any crime.

VI. Record Keeping:

The Chief Operating Officer or designee shall have access to all records contained within the electronic UOR system, and shall maintain all forms used during downtime procedures under this policy. Access to such records shall be limited to a need to know basis as determined jointly by the Director, Human Resources and the applicable Chief. Records of employee injuries shall be maintained in Human Resources in accordance with OSHA requirements. Confidentiality of patient information and employee records shall be maintained.

VII. Responsibility:

A. The Director of Human Resources is responsible for administering the Workplace Violence Prevention Plan and ensuring that this Plan is communicated to all relevant persons including other employers of employees working at a District facility.

B. Chiefs, Department Heads, and supervisory personnel are responsible for the enforcement of this policy. Chiefs, Department Heads and supervisory personnel

are required to report, in writing using the electronic UOR system, any incident of workplace violence without delay.

C. All persons including members of the medical staff, employees, suppliers, contractors, visitors, patients, and volunteers are expected to follow all policies and procedures and to report acts of violence immediately.

REFERENCES:

Workplace Violence Prevention in Health Care Regulation (Title 8, CCR, Section 3342)
Occupational Safety and Health Act of 1970
Injury and Illness Prevention Policy
The Joint Commission Standards: EC.01.01.01, EC.02.01.01, EC.02.06.01, EC.03.01.01, and EC.04.01.01

Cross Reference P&P:

Injury and Illness Prevention Policy

Committee Approval	**Date**
Human Resources	6/2/2017
Safety Committee	7/12/2017
Executive Team	6/5/2017
Board of Directors	6/22/2017
Last Board of Directors Review	6/20/2018

Developed: 5/17ecd

Revised: 12/19kd

Reviewed: 12/19kd/ta

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

Workplace Violence Incident Report Form

If you have experienced or witnessed someone experience a violent incident as defined below, complete this incident report form.
***Note**: This form is built into the electronic UOR system. Please only complete this form when the electronic system is down. Once completed, please return this form to Compliance.*

Cal/OSHA Workplace Violence Definition:
Workplace Violence means any act of violence or threat of violence that occurs at the work site. The term workplace violence shall not include lawful acts of self-defense or defense of others. Workplace violence includes the following:

a. The threat or use of physical force against an employee that results in, or has a high likelihood of resulting in, injury, psychological trauma, or stress, regardless of whether the employee sustains an injury;
b. An incident involving the threat or use of a firearm or other dangerous weapon, including the use of common objects as weapons, regardless of whether the employee sustains an injury.

Incident Date:___/____/_____ Time:____:____ AM PM **Day of Week:** Mon Tues Weds Thurs Fri Sat Sun

Department: _____ Specific Location (Ex: hallway, lobby):
_____

Incident Type (Check all that apply)
___Physical Attack (Biting, Choking, Grabbing, Hair Pulling, Kicking, Punching/Slapping, Scratching, Spitting, Striking)
___Threat or the Use of a Weapon/Object *If Yes, specify type of weapon*:_____
___ Verbal Abuse ___ Sexual Assault (Rape, attempted rape, unwanted physical sexual contact)
___ Other Threat of Physical Force ___Other, Please specify_____

Incident Circumstances:
___ Poorly lit Area ___ Rushed ___ Low Staffing Levels ___ High Crime Area ___ Isolated or Alone ___ Unable to get Help or Assistance ___ Working in a Community Setting ___ New or unfamiliar Location ___Other, Please Specify_____

Task being performed at the time:_____

Security Present at time of incident? ___Yes ___No **Security Notified?** ___Yes ___No

Law Enforcement Present at time of incident? ___Yes ___No **Law Enforcement Notified**? ___Yes ___No
If YES, agency and officer name: _____

Aggressor Arrested? ___Yes ___No **Code or Team Assistance Called**? ___Yes ___No

Crisis Development/Highest Assailant Behavior Level Reached
_____**Anxiety:** A noticeable increase of change in behavior, e.g., pacing, staring, finger drumming or fidgeting.
_____**Defensive:** The beginning stage of loss of rationality, e.g., individual is challenging authority, belligerent or hostile.
_____**Acting Out:** The total loss of control, which results in a physical acting-out episode presenting danger to self, staff & others.

Aggressor Disposition? ___Stayed on Premises ___Escorted off premises ___Left on Own
___Other, Please specify_____

Workplace Violence Incident Report Form

Aggressor Information: **Role**: ___Patient ___Family/Friend/Visitor of Patient ___Stranger ___Staff ___Manager ___Medical Staff ___Family/Friend/Significant Other of Employee ___ Former Employee ___Other:_____

Gender: ___Male ___Female **Age Group**: ___<18 ___18-24 ___25-34 ___35-44 ___45-54 ___55-64 ___65+

Name:_____

Predisposing Factors (check all that apply): ____Grief ____History of Violence ____Intoxication

____Dissatisfied with Care/Wait Time ____History of Behavioral Issues ___ Drug Seeking/ Denied Narcotics

____Other Please specify_____

Injuries*? ___Yes ___No **Type of Injury: _____** **Medical Treatment Received:** ___Yes ___No

*An injury is defined as a work-related injury requiring medical treatment beyond first aid, diagnosis by a physician, or fatality; resulting in time away from work, restricted work, or transfer to another job.

Victim Information: **Role**: ___Patient ___Family/Friend/Visitor of Patient ___Stranger ___Staff ___Manager ___Medical Staff ___Family/Friend/Significant Other of Employee ___ Former Employee ___Other:_____

Gender: ___Male ___Female **Name**:_____

Age Group: ___<18 ___18-24 ___25-34 ___35-44 ___45-54 ___55-64 ___65+ ___Prefer Not to Answer**

Injuries*? ___Yes ___No **Type of Injury: _____** **Medical Treatment Received:** ___Yes ___No

*An injury is defined as a work-related injury requiring medical treatment beyond first aid, diagnosis by a physician, or fatality; resulting in time away from work, restricted work, or transfer to another job.

**Answering this question helps us to identify high-risk groups and develop programs/assistance to mitigate risks.

Was Employee Assistance Program (EAP) Referral offered? ___Yes ___No ___N/A **If YES, date:___/___/_____**

Was EAP referral: _____Accepted _____Declined **Number of employee injuries:** ___ 0 ___1-25 __25+

Lost Work Time: _____days **Anticipated Return to Work Date**:___/___/_____

Narrative: (Briefly describe event, witnesses, records of incident i.e. police reports, video camera footage, internal/external notification of events, etc... Use additional sheets if needed.

Witnesses (OPTIONAL)
Name:_____ Title: _____ Telephone or Ext:_____
Name:_____ Title: _____ Telephone or Ext:_____
Name:_____ Title: _____ Telephone or Ext:_____

***If this incident involves a patient, attached a patient label or information (Name, MRN, DOB, Encounter number, etc.) below.**

Suggestions for preventing a similar incident in the future:

Completed by: **Date:** / /

To be Completed by a QAPI or HR Staff Member

Cal/OSHA Incident Type:

____**Type 1** (*Stranger/Non-employee* to *Workforce Member*)
Workplace violence committed by a person who has no legitimate business at the worksite, and
includes violent acts by anyone who enters the workplace with the intent to commit a crime.

____**Type 2** (*Patient/Family/Visitor* to *Workforce Member*)
Workplace violence directed at employees by customers, clients, patients, students, inmates, or
visitors or other individuals accompanying a patient.

____**Type 3** (Present/Former Workforce Member to *Workforce Member*)
Workplace violence against an employee by a present or former employee, supervisor, or manager.

____**Type 4** (*Spouse/significant relationship* to *Workforce Member*)
Workplace Violence committed in the workplace by someone who does not work there, but is known
to have a personal relationship with an employee.

____Other, Please specify_____

Was the incident **reported to Cal/OSHA** Enforcement District Office under Title 8, CCR, Section 342? ___Yes ___No

Legal Counsel Notified of Incident? ___Yes ___No

Northern Inyo Healthcare
De-escalation Team Code Response Form

This form is to be filled out by the De-escalation Team Leader in collaboration with team members and staff involved in the code. This form is not part of the medical record and must not be copied.
Note: This form is built into the electronic UOR system. Please only complete this form when the electronic system is down. Once completed, please return this form to Compliance.

De-escalation Team called: Date:___/_____/_____ Time:____:____ AM PM **Initiated By**:_____
Incident Location: _____ Unit:_____ Room:_____
Escalating Behavior By: ___Patient ___Staff ___Visitor Other _____
Escalating Behavior Directed Towards: ___Patient ___Staff ___Visitor Other _____

De-escalation Team arrived: Date:___/____/_____ Time:____:____ AM PM
De-escalation Team Leader: _____
De-escalation Team Members: _____ _____
_____ _____

Behavior Levels Prompting Team/Code Page: (Please describe behaviors or quote defensive behavior)
____Intimidation _____
____Offensive Language _____
____Verbal Abuse _____
____Verbal Assault _____
____Physical Assault _____

Behavior Levels Upon De-escalation Team Arrival: (please describe behaviors or quote defensive behavior)
____Escalating behavior (Challenging authority, hostile, beginning stage of loss of rationality)
____1. Questioning (challenging) _____
____2. Refusal _____
____3. Intimidation _____
____4. Verbal Abuse _____

____Verbally Acting Out _____
____Physically Acting Out _____

De-escalation Team Interventions:
____ Verbal Interventions: _____
____ Release Inteventions:_____
____ Personal Safety Techniques:_____
____ Security Involvement ____ Required Law Enforcement Assistance
____ Other:_____
Disposition:
____ Stayed on Premises ____ Returned to room/unit ____ Escorted off Premises

Escalating Behavior Defused ___Yes ___No *If No, explain:* _____
Clinical Debriefing Occurred ___Yes ___No
Workplace Violence Incident Report Completed? ___Yes ___No
What went right: _____
What went wrong: _____
Recommendation: _____
_____

Northern Inyo Healthcare District
150 Pioneer Lane
Bishop, California 93514

EMPLOYEE PROCEDURE WHEN RESPONDING TO AN INCIDENT

NIHD is committed to providing a safe and secure work environment for our patients, visitors, members of the medical staff, employees, volunteers, contractors and suppliers.

This prohibition against violence and/or threats of violence applies to all of the above listed people.

NOTE: This is a ZERO TOLERANCE policy, meaning that NIHD will apply appropriate corrective action for substantiated violation of this policy. Such corrective action will apply after an appropriate investigation is completed pursuant to relevant policies governing workplace behavior.

PROCEDURE I

Where an employee, volunteer, physician or other credentialed member of the medical staff, is alleged to commit an act of workplace violence as defined in the policy.

1. Notify any one of the following: your supervisor, House Supervisor, Department Head, Director, Human Resources, Chief, Administrator on Call (AOC), Chief Executive Officer (CEO), or 9-911 immediately.
2. Complete Unusual Occurrence Report via NIHD electronic system using the workplace violence fields. During downtime, complete a Workplace Violence Investigation Report Form and submit it immediately to the House Supervisor or Human Resources.
3. The House Supervisor, AOC or CEO will notify the Chief of Staff if a credentialed member of the medical staff is involved. The Chief of Staff may take whatever action is necessary under the Medical Staff bylaws where the alleged aggressor is a physician or member of medical staff, based upon results of the investigation.

   NOTE: A.3 applies where the alleged aggressor is a physician or Advanced Practice Provider (APP).

4. Take all specific threats seriously.
5. If the threat is genuine and danger is imminent, or if an incident has occurred and resulted in injury, the employee, volunteer, physician or other credentialed member of the medical staff, who is the alleged aggressor will be suspended from work if appropriate to the circumstances, pending investigation.

   i. Refer the injured party to appropriate medical treatment, via the emergency department, as soon as possible. This is handled as an injury under Workman's Compensation.
   ii. Any suspension should be done in consultation with the Chief, the CEO or AOC and Human Resources.

iii. If there is not time for consultation, notify the Chief of Staff (if a physician or other credentialed member of the medical staff is the alleged aggressor) or AOC as soon as possible.
iv. Notify Security.
v. Do not let the employee, volunteer, physician or other credentialed member of the medical staff, return to the workplace until the investigation is complete unless the employee, volunteer, physician or other credentialed member of the medical staff, needs the services of NIHD under EMTALA.

EMPLOYEE PROCEDURE WHEN RESPONDING TO AN INCIDENT

6. If time and safety allow, a prompt investigation will be conducted by the appropriate Department Head:

i. On the day shift – in consultation with Security, the appropriate Chief or the AOC.
ii. On evenings, nights, weekends and holidays – in consultation with the House Supervisor and the AOC.
iii. Verify the alleged facts contained in the report.
iv. Document (at least) the following information:
    a. The exact statement or action taken.
    b. Circumstances under which the statement or action occurred.
    c. Any knowledge the source has of the alleged aggressor.
    d. Names of others who have witnessed the incident, who have personal knowledge of other threats or unusual behavior of the same person, or who have detailed knowledge of the alleged aggressor.
v. Assure the person who reported the incident that they did the right thing. Advise the person who reported the incident that no employee, volunteer, physician or other credentialed member of the medical staff, will be disciplined, discharged or retaliated against for reporting acts of workplace violence or threats.

PROCEDURE II

In all instances where a patient, visitor, contractor, supplier or vendor is alleged to commit an act of workplace violence as defined in the policy.

1. Notify any one of the following: your supervisor, House Supervisor, Department Head, Director, Human Resources, Chief, Administrator on Call (AOC), Chief Executive Officer (CEO), or 9-911 immediately.
2. Complete a Workplace Violence Incident Report Form and submit it to the House Supervisor or to Human Resources.
3. Security will determine the need to notify local law enforcement if you have not yet done so.
4. If time and safety allow, a prompt investigation will be conducted by the appropriate Department Head:

    i. On the day shift – in consultation with Security, the appropriate Chief or the AOC.
    ii. On evenings, nights, weekends and holidays – in consultation with the House Supervisor, Security and the AOC.
    iii. Verify the alleged facts contained in the report.
    iv. Document (at least) the following information:
        a. The exact statement or action taken.
        b. Circumstances under which the statement or action occurred.
        c. Any knowledge the source has of the alleged aggressor.
        d. Names of others who have witnessed the incident, who have personal knowledge of other threats or unusual behavior of the same person, or who have detailed knowledge of the alleged aggressor.
    v. Assure the person who reported the incident that they did the right thing. Advise the person who reported the incident that no employee, volunteer, physician or other credentialed member of the medical staff, will be disciplined, discharged or retaliated against for reporting acts of workplace violence or threats.

5. If a contractor or vendor is involved, Security will contact the relevant Chief.

    i. The relevant Chief will notify the company involved.
    ii. In conjunction with the executive team, the decision may be made to cancel the contractual relationship with the vendor or contractor.

TRAINING PLAN

1. Human Resources in collaboration with District Education Coordinator is responsible for assessing the need for training, and developing an effective training program as it relates to workplace violence and its prevention.

2. Workplace Violence Prevention training will be provided to all employees at orientation and then annually thereafter. This training will include:

    i. What to do in the event of a violent incident, including

        a. Incident reporting procedures
        b. How to respond to alarms
        c. How to initiate a De-escalation team
        d. What assistance is available if an incident occurs

    ii. What the causes are and how to recognize escalating violent behavior
    iii. What to do if outsiders are seen in the "wrong" areas
    iv. What to do if a colleague's behavior suddenly changes
    v. How to prevent and diffuse hostile situations
    vi. Why it is important to inform Human Resources of any problem with domestic parties
    vii. How and where to get medical or counseling treatment after an incident
    viii. Common sense reminders such as:
        a. Exercising extra care in elevators, stairways and parking lots
        b. Checking cars before entering
        c. Parking in designated areas

3. Other training may be required for certain employees based on their job and/or work location, such as:

    i. Clinical employees may be trained to identify potentially violent patients through assessment and recognition of:

        a. Historical cues
        b. Diagnostic cues
        c. Psychiatric cues
        d. Behavioral cues
        e. Dependency cues
        f. Stalked Patients

    ii. Emergency Department employees and others determined to be at risk may be trained in self-defense. Self-defense will only be taught by qualified trainers.

4. Recordkeeping Requirements
Human Resources will be responsible for documenting all training records.

GUIDELINES FOR HANDLING THREATS OR VIOLENT SITUATIONS

This document summarizes guidelines for employees, volunteers, contractors, physicians and other members of the medical staff on what to do in case of threats or acts of workplace violence.

1. General Security Practices
   i. Call Security if confronted with a potentially violent situation.
   ii. Do not attempt to physically restrain or physically remove a threatening individual by yourself. Doing so puts you in danger and leaves you and the District vulnerable to possible lawsuits.
   iii. Always report violent threatening or harassing behavior.
   iv. Alert Security to the presence of strangers in your work area or the presence of any suspicious packages.

2. Guidelines for Responding to Telephone or Written Threats
   i. Telephone threats
      a. Inform your supervisor immediately. Note the time, date and telephone number at which the threat was received.
      b. If the threat is a Bomb Threat, refer to the Rainbow Chart.
      c. If the threat involves an imminent act of violence, report it immediately by dialing 2400 or 71 to overhead page. Admission Staff who answer 2400 will notify Security.
      d. If the threat is not imminent, report it to Security and your supervisor.
      e. The supervisor or Department Leader will complete an Unusual Occurrence Report (UOR) via the NIHD electronic system. During downtime, Workplace Violence Incident Report Form shall be used.

   ii. Written Threats (including online or through social media outlets)
      a. Inform your supervisor immediately. Handle the written material as little as possible. Place the written material and the envelope into a larger envelope. Note the names of anyone who handled the material after it arrived.
      b. Follow same steps as in telephone threats referenced above in Sections 2(i)(a) – 2(i)(e).

3. Reporting Workplace Violence
   i. All employees, volunteers, contractors, physicians and other members of the medical staff are required to report immediately, any acts of or threats of violence to their supervisor, Department Head, House Supervisor, Chief, AOC, CEO, Security, or law enforcement via 9-911.
      a. A UOR must be completed.
      b. No employee will be disciplined, discharged or retaliated against for reporting any threats or acts of violence.

   ii. Intimate Partner Violence
      a. Employees, volunteers, contractors, physicians and other members of the medical staff are encouraged to notify Human Resources if they are the victims of intimate partner violence or observe it occur in the workplace. Any such reports will be kept confidential.
      b. If an employee, volunteer, contractor, physician and other members of the medical staff obtains a restraining order against another person and informs their Department Head or Human Resources, a description of the individual and a copy of the restraining order will be filed in Human Resources and shared appropriately to ensure a safe work environment.

4. Injury from acts of Workplace Violence
   i. Get medical treatment as soon as possible at the Emergency Department,
   ii. Complete work injury forms
   iii. Report your injury to Human Resources

5. Coping with threatening or violent individuals.
   i. Identifying potentially violent individuals. The following may be attributes of a violent person:
      a. Talks and complains loudly, uses profanity or makes sexual demands.
      b. Demands for unnecessary and/or unusual service.
      c. States that he/she is going to lose control.
      d. Appears tense and angry.
      e. Challenges authority.
      f. Appears intoxicated.
      g. Has a history of violence.
      h. Have multiple life stressors, such as divorce, death in family, financial problems.
      i. Continually uses excuses or blames others.
      j. Has or is doing any of the following:
         1. Flushed face and/or sweating
         2. Twitching face and/or lips
         3. Shallow breathing
         4. Head down
         5. Furrowed eyebrows
         6. Pacing

   ii. Manage these individuals by:
      a. Signaling a co-worker that you need help. Don't call yourself if you are being directly confronted. Co-worker will page "De-escalation team".
      b. Avoid arguing or provoking a hostile person. Some eye contact may be advisable, but avoid staring.
      c. Keeping out of the person's personal space.
      d. Maintaining a relaxed attentive posture.
      e. Keeping two to three arm's lengths away, and avoid being backed into a corner. Leave room for escape.
      f. Do not approach with hands on hips or arms crossed. Palms up is the least threatening posture.
      g. Do not reject the person's demands immediately, act impatient or make him/her look foolish.
      h. Do not treat the situation trivially.
      i. Do not bargain or make promises you cannot keep.
      j. Establish ground rules and describe consequences.
      k. Ignore challenges - do not over react.
      l. Do not make personal comments.
      m. Move and speaking slowly, quietly and confidently.
      n. Do not act cold or condescending.
      o. Do not try heroic action to subdue the individual.
      p. Separate the person from patients, if possible.

   iii. If the individual has a weapon:

GUIDELINES FOR HANDLING THREATS OR VIOLENT SITUATIONS

a. Stay calm.

b. Never try to grab the weapon.
c. Quietly signal that you need help. Do not call for help yourself.
d. Be courteous and patient. Keep talking but follow the instructions from the person who has the weapon. Stall for time, but do not risk harm to yourself or others.
e. Watch for a chance to escape to a safe area.

iv. If violence does erupt:
   a. Know how to protect yourself (e.g. block a punch).
   b. Assume a self-defensive stance leaning 45 degrees toward the person, feet apart at shoulder width, weight evenly distributed, knees slightly bent, arms at side, hands open.
   c. Do not become the aggressor.
   d. Stay out of range of a violent person's hands and feet.
   e. Do not attempt to subdue the person.
   f. Keep patients away from the incident.

DEPARTMENT HEAD'S GUIDE

1. What to do if workplace violence occurs:

    i. IMMEDIATELY
        a. Take actions appropriate for situation to prevent harm to people or property, and continue, if reasonable, to conduct hospital business.
    ii. When a threat or violent action occurs:
        a. Do not make counter threats or humiliate the person,
        b. Provide security or call law enforcement (9-911) as needed for the individual threatened, as well as co-workers and the work site, and
        c. Maintain confidentiality.
    iii. Immediately after an incident occurs:
        a. Record in writing all information regarding the incident including:
            1. Verbal comments/threats
            2. Behavior including gestures and threats
            3. Witnesses name(s) and statements
        b. Notify your Chief or AOC,
        c. Notify Security if appropriate,
        d. Ensure that an Unusual Occurrence Report is completed via the NIHD electronic system. During downtime, complete the Workplace Violence Incident Report Form,
        e. See that any injured party receives medical treatment as appropriate:
            1. In the Emergency Department
            2. Remind employee to follow up with Employee Health
        f. Consult with the appropriate Chief or AOC and take appropriate action to correct the behavior, which may include suspension of an employee, volunteer, contractor, physician and other member of the medical staff from work pending completion of your investigation.
        g. Ensure that affected parties receive appropriate post-incident care including debriefings, referral to Employee Assistance Program (EAP), etc.

2. Early Warning Signs for a Potential for Violence in the Workplace

    There are many signs often exhibited by individuals in a pattern of escalation leading to violence in the workplace. One or even several of these signs does not mean that the employee, volunteer, contractor, physician and other member of the medical staff will become violent, but should increase concern. The following are some early warning signs for potential violence in the workplace. A leader should follow up with an employee, volunteer, contractor, physician and other member of the medical staff to inquire if any help is needed for that employee, volunteer, contractor, physician and other member of the medical staff:
        a. A history of a violent behavior before or after employment here.
        b. An extreme interest in or obsession with weapons, especially if this behavior starts spontaneously or is out of character for the employee.
        c. Making direct or verbal threats of harm (i.e. predicting that bad things are going to happen to a co-worker or supervisor).
        d. Intimidating others or instilling fear in co-workers or supervisors (this can be physical or verbal), e.g. making harassing phone calls or stalking.

e. Having an obsessive involvement with the job. The workplace becomes the person's sole identity. Please note the characteristic may apply to some of your best workers, including those who would never commit a violent act.
f. Being a loner with little involvement with co-workers, with the exception of a romantic interest in a co-worker.
g. Being paranoid, panicking easily and often.
h. Does not take criticism well, holds a grudge, especially against a supervisor, and will often verbalize hope for something to happen to the person against whom the individual holds a grudge.
i. Expressing extreme desperation over recent family, financial or personal problems.
j. Fascination with other recent incidents of workplace violence, and approval of use of violence under similar conditions.
k. An escalating propensity to push the limits of normal conduct, with a disregard for the safety of co-workers.
l. Workplace events that cause great stress such as disciplinary actions, layoffs, etc.

DISTRICT-WIDE* SAFETY AND SECURITY ANALYSIS

SAFETY AND SECURITY ANALYSIS

	Yes	No	N/A	Comments
Physical Walk Through				
1. Did the physical walkthrough include evaluation of:				
a. Access control, including window and door security?	☐	☐	☐	_____
b. Staffing levels during different times of day?	☐	☐	☐	_____
c. Room layout that could cause entrapment or furniture that could be used as a weapon?	☐	☐	☐	_____
d. Overcrowding situations?	☐	☐	☐	_____
e. Quality of lighting, including:	☐	☐	☐	_____
i. Identifying situations where lighting is insufficient?	☐	☐	☐	_____
ii. Identifying where there is glare?	☐	☐	☐	_____
iii. Identifying situations where lighting is creating shadows?	☐	☐	☐	_____
iv. Evaluating whether light at exits is consistent with the lighting outside?	☐	☐	☐	_____
f. Location and function of alarm systems and panic buttons?	☐	☐	☐	_____

***Segments of the District may be subject to a separate safety and security analysis as deemed warranted by the V-PAT.**

DISTRICT-WIDE* SAFETY AND SECURITY ANALYSIS

SAFETY AND SECURITY ANALYSIS

	Yes	No	N/A	Comments
g. Situations where HCWs (Health Care Worker's) are required to work alone?	☐	☐	☐	
i. Is there a system to protect HCWs who work alone (e.g., use of open walkie-talkie connected to main desk)?	☐	☐	☐	
h. Situations where HCWs may be working alone with vulnerable or unconscious patients (e.g. , recovery rooms)?	☐	☐	☐	
i. Staff knowledge of emergency codes and how to respond?	☐	☐	☐	
j. Questioning of HCWs regarding other concerns or fears?	☐	☐	☐	
k. Neighborhoods where home HCWs are required to visit?	☐	☐	☐	
2. Are access control measures used to reduce the amount of people wandering around the facility?				
a. Is there a receptionist at the main entrance to greet all visitors or suppliers?	☐	☐	☐	
b. Are non-visitor entrances secure on the outside (e .g. , require use of key pad or swipe card) and unlocked on the inside in accordance with any fire and building code requirements?	☐	☐	☐	

DISTRICT-WIDE* SAFETY AND SECURITY ANALYSIS

SAFETY AND SECURITY ANALYSIS

	Yes	No	N/A	Comments
c. Is there a procedure to control visitor and supplier access to the facility (e.g ., color-coded visitor passes or identification {ID} cards that only authorize access to certain areas)?	☐	☐	☐	_____
d. Is access to certain areas restricted (e.g, nursery, pharmacy)?	☐	☐	☐	_____
e. Do HCWs know what to do if they find an unauthorized individual in an area?	☐	☐	☐	_____
3. Are all HCWs required to wear ID tags with photographs, names, and departments (except in the surgical suite)?	☐	☐	☐	_____
a. Are ID tags (and swipe cards) collected from terminated employees and other HCWs who are no longer authorized to be on the premises?	☐	☐	☐	_____
b. Are keypad codes changed when HCWs are no longer employed with the facility?	☐	☐	☐	_____
4. Are curved mirrors used at appropriate corners (e.g., in stairwells and locations identified as high risk, such as where an HCW is working out of sight of anyone else)?	☐	☐	☐	_____

DISTRICT-WIDE* SAFETY AND SECURITY ANALYSIS

SAFETY AND SECURITY ANALYSIS

	Yes	No	N/A	Comments
Construction				
1. During the planning process for construction and renovation project, is consideration automatically given to workplace redesign features that could reduce identified risks of violence (e.g., enclosing nursing stations, installing deep service counters, installing bulletproof glass in the emergency department?	☐	☐	☐	_____
Records Review				
1. Were the following records reviewed:				
a. OSHA Logs?	☐	☐	☐	_____
b. Law enforcement crime statistics for area?	☐	☐	☐	_____
c. Workers' Compensation and other insurance reports or claims?	☐	☐	☐	_____
d. Incident reports and post incident reports?	☐	☐	☐	_____
e. Safety committee minutes?	☐	☐	☐	_____
f. HCW suggestions?	☐	☐	☐	_____
g. Training records for any HCWs trained in violence prevention, de-escalation, etc.?	☐	☐	☐	_____
h. Employee termination records?	☐	☐	☐	_____

DISTRICT-WIDE* SAFETY AND SECURITY ANALYSIS

SAFETY AND SECURITY ANALYSIS

	Yes	No	N/A	Comments
i. Supervisor's reports, providing that appropriate confidentiality is maintained?	☐	☐	☐	
j. Existing security- or violence related policies and procedures?	☐	☐	☐	
k. Any relevant union agreements regarding disciplinary actions?	☐	☐	☐	
2. Did the team determine the number of violent incidents committed on facility property last year?	☐	☐	☐	
a. Were these incidents broken down by category (e.g ., rape, physical assault, verbal threat, stalking)?	☐	☐	☐	
b. Were these incidents broken down by type of injury to victim and lost work days (if an employee was involved)?	☐	☐	☐	
3. Did the team determine the number of violent incidents committed in the surrounding community last year?	☐	☐	☐	
4. Did the team determine how often the assailant was one of the following:				
a. HCW?	☐	☐	☐	
b. Family, friend, or employee of HCW?	☐	☐	☐	
c. Patient?	☐	☐	☐	

DISTRICT-WIDE* SAFETY AND SECURITY ANALYSIS

SAFETY AND SECURITY ANALYSIS

	Yes	No	N/A	Comments
d. Family, friend, or employee of patient?	☐	☐	☐	
e. Outsider?	☐	☐	☐	
5. Did the team determine how often the victim was one of the following:				
a. HCW?	☐	☐	☐	
b. Family, friend, or employee of HCW?	☐	☐	☐	
c. Patient?	☐	☐	☐	
d. Family, friend, or employee of patient?	☐	☐	☐	
e. Outsider?	☐	☐	☐	
6. Did the team determine conditions in the facility that put individuals at risk for violence (e.g., job description, time of day, working alone)?	☐	☐	☐	
7. Did the team determine:				
a. Whether HCWs are properly and regularly filling out incident reports	☐	☐	☐	
b. Whether the facility's violent incident report form provides spaces for all the information requested above?	☐	☐	☐	

EMPLOYEE SECURITY SURVEY

This survey will help detect security problems in your work area or at an alternate work site.

Please fill out this form and return to a member of our leadership team so that we can review it to see where the potential for security problems lie.

NAME: _____

WORK LOCATION: _____
(In Building or Alternate Worksite)

1. Do either of these two conditions exist in your building or at your alternate work site?

_____Work alone during working hours.
_____No notification given to anyone when you finish work.

Are these conditions a problem? If so when, please describe. (For example, Mondays, evenings, daylight savings time):

2. Check the appropriate line below:

Yes___ No___ Does your work place have a written policy to follow for addressing general problems?
Yes___ No___Does your work place have a written policy on how to handle a violent client?
Yes___ No___Do you know when and how to request the assistance of a co-worker
Yes___ No___Do you know when and how to request the assistance of police
Yes___ No___Do you know what to do about a verbal threat
Yes___ No___Do you know what to do about a threat of violence
Yes___ No___Do you know what to do about harassment
Yes___ No___Do you working alone
Yes___ No___Do you have an alarm system(s) in your work area
Yes___ No___Do you know how to call security when you are in or out of your work location
Yes___ No___Is there security in the parking lot
Yes___ No___Have you been assaulted by a co-worker? If so, please share the details:_____
Yes___ No___To your knowledge have incidents of violence ever occurred between your co- workers? If so, please share the details:_____
_____

3. Are violence related incidents worse during shift work, on the road or in other situations? Please specify:_____

4. Where in the building or work site would a violence related incident most likely to occur (check all that apply)?

- ☐ Employee Lounge or Break Room (specify location):_____
- ☐ Exits (specify location):_____
- ☐ Delivery area

- ☐ Loading Docks
- ☐ Entrances (specify location):_____
- ☐ Private Offices
- ☐ Parking Lots
- ☐ Bathrooms
- ☐ Other (specify location):_____

5. Have you ever noticed a situation that could lead to a violent incident?

6. Have you missed work because of a potential violent act(s) committed during your course of employment?

7. Do you receive workplace violence related training or assistance of any kind?

8. Has anything happened recently at your work site that could have led to violence? Can you share details?_____
   _____

9. Has the number of violent clients increased?

NORTHERN INYO HOSPITAL
POLICY

Title: Obtaining Blood Bank Samples From Patients in Surgery	
Scope: Transfusion Services	Departments: Laboratory, Surgery
Author: Immunology Coordinator	Effective Date:
Copy Location:	Revised Date: October 2019

PURPOSE:

This policy explains how specimens for blood bank work are collected from patients already in surgery.

POLICY:

There are three methods for obtaining blood bank samples from patients already in surgery:

1. A member of the laboratory team gowns up and enters the surgery suite; identifies the patient, draws and labels the sample, then bands the patient.
2. A member of the surgery team draws and labels the sample with the patient's name, date of birth and medical record number. A member of the laboratory team waiting at the entrance to the surgical suite accepts the specimen, verbally confirms the patient ID with the surgery team, prepares the blood bank band and hands the blood bank band to the surgical team to place on the patient.
3. A member of the surgery team draws and labels the sample with the patient name, date of birth, medical record number and blood bank label, then bands the patient with the blood bank band and sends the sample to the lab.

The method for obtaining blood bank samples depends on the time of day and available personnel:

1. Phlebotomists are on site from 5am to midnight 7 days a week. During this period, the preferred method is method (1). Employ methods (2) and (3) if necessary.
2. Between midnight and 5am, one Clinical Laboratory Scientist is on site and one phlebotomist is on call. The Clinical Laboratory Scientist does not draw blood. During this period, employ methods (2) or (3).

NOTES:

1. Orders originating from surgery for blood bank work are phoned orders. Laboratory personnel will enter orders in the information system and fill out necessary paperwork.
2. Use the following contact numbers:
   a. Between 6am and 5pm extension 3679
   b. Between 5pm and 6am extension 2113 or radio
3. When notifying the lab for a needed blood draw, specify the patient name and the surgery suite number.

Cross-Reference P&P:

1. Blood Bank – Emergency Requests
2. Blood Bank – How to order Tests
3. Blood Bank- Obtaining Blood Products
4. Operating Room Attire
5. Blood and Blood Product Transfusion – Lippincott Manual

Reviewed by	Date
CCOC	12/16/19
Surgery, Tissue, Transfusion, Anesthesia Committee	10/23/19

NORTHERN INYO HOSPITAL
POLICY

Title: Obtaining Blood Bank Samples From Patients in Surgery	
Scope: Transfusion Services	**Departments: Laboratory, Surgery**
Author: Immunology Coordinator	**Effective Date:**
Copy Location:	**Revised Date: October 2019**

Medical Executive Committee	12/3/19
Board of Directors	
Board of Directors Last Review	

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

Medical Staff Services

Department: Medical Staff Administration
Pillars of Excellence: FY July 1, 2019-June 30, 2020
2nd quarter

Indicator	Baseline	Goal	Jan-Mar 2019 Q3	Apr-Jun 2019 Q4	Jul-Sep 2019 Q1	Oct-Dec 2019 Q2	YTD
Service							
1. Customer satisfaction							
a. Average Credentialing TAT (from receipt of complete application)	10 days	<21 days	12 d	7 d	19 d	34 d	16 d
b. Average Privileging TAT (from receipt of complete application)	36 days	<60 days	39 d	42 d	35 d	83 d	45 d
c. Percent on-time start	80%	100%	46%	100%	100%	80%	80%
2. Application times							
a. Average time for any application materials to be returned	18 days	<14 days	19 d	14 d	20 d	49 d	22 d
b. Average time for complete application to be returned	32 days	<45 days	28 d	33 d	69 d	83 d	49 d
Quality							
1. Credentialing/Privileging							
a. Percent processed within time frame specified in bylaws	97%	100%	91%	100%	100%	100%	97%
b. Percent of applicants granted temporary/expedited privileges	37%	<33%	36%	33%	67%	0%	39%
People							
1. Active Staff	42	N/A	42	42	40	41	
2. All Medical Staff Members and Allied Health Professionals (+ tele)	108	N/A	109	108	110	114	
3. Locums/Temporary Staff	12	N/A	9	12	10	6	
4. Resignations	5	N/A	4	5	8	9	
Finance							
1. Total initial applications processed	35/year	N/A	11	9	9	5	34
2. Number of initial locum tenens applications	14/year	N/A	5	4	3	0	12
3. Number of initial applications abandoned/discontinued	9/year	N/A	1	4*	0	0	5

*4 discontinued and an additional 4 placed on hold until further notice

LEGEND	
	Exceeds goal; 100%
	Meets goal
	Close to goal
	Does not meet goal

Dev. 2/17

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

Medical Staff Services

Q2: FY 2020

Narrative Notes:

The department did not meet its goals under the Service Pillar for Q2 of the 2020 fiscal year. Credentialing and privileging times were longer than usual, but on the other hand, zero percent of the applications were granted expedited privileges (meaning all applications went through the full committee review process, thus contributing to the longer privileging times). Additionally, this quarter had a longer than usual average time for application materials to be submitted and completed. Contributing to this high average were two outliers who requested applications from our department months in advance of when the practitioner was anticipated to start seeing patients in the practice, and so did not begin working on their applications until much later.

Of note, the pillars included in this report relate only to *initial* applications. The department was busy during Q2 with the *reappointment* applications of 53 of our existing physicians and providers who were due for their biennial renewal of privileges. These applications also take a considerable amount of time and resources to recredential and move through the approval process, which likely contributed to the extended credentialing times observed in Q2. Other contributing factors this quarter were the loss of one staff member in the medical staff services department, and the additional 10 applications processed for the extensions of temporary privileges and staff category changes in the hospitalist service this quarter which are not reported here.

List Q2 Resignations:

1. Jennie Walker, MD (*emergency medicine*) – effective 10/1/19
2. Jessica Paulson, MD (*emergency medicine*) – effective 10/15/19
3. Jennifer Figueroa, PA-C (*family practice*) – effective 10/23/19
4. H. Charlie Wolf, MD (*emergency medicine*) – effective 12/31/19
5. Sarkis Kiramijyan, MD (*cardiology*) – effective 12/31/19
6. Gabriel Overholtzer, DDS (*dentistry*) – effective 12/31/19
7. Thomas McNamara, MD (*radiology*) – effective 12/31/19
8. Brian Mikolasko, MD (*internal medicine*) – effective 12/31/19
9. Taema Weiss, MD (*family practice*) – effective 12/31/19

Dianne Picken, MS
Medical Staff Support Manager
1/3/2020

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

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

TO: NIHD Board of Directors
FROM: William Timbers, MD, Chief of Medical Staff
DATE: January 7, 2020
RE: Medical Executive Committee Report

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

A. Policies and Procedures (*action items*)
    1. *Emergency Medication and Code Blue Crash Cart Policy*
    2. *Fiberoptic Endoscopic Evaluation of Swallowing Policy*
    3. *Steris Gravity – Prevacuum Sterilizer Surgery (Autoclave)*

B. Modification to Medical Staff Application Packets (*action item*)
    1. Addition of criminal background checks

C. Advanced Practice Provider Appointments (*action items*)
    1. Sarah Malloy, FNP (*family practice*)

D. Medical Staff Reappointments for Calendar Years 2020-2021 (*action items*)
    1. Daniel K. Davis, MD (*orthopedic surgery*) – Provisional Consulting Staff
    2. Kevin Deitel, MD (*orthopedic surgery*) – Provisional Consulting Staff
    3. Elizabeth Maslow, MD (*infectious disease*) – Telemedicine Staff

E. Extension of Temporary Privileges for 120 days (*action item*)
    1. Shiva Shabnam, MD (*internal medicine*) – temporary/locum tenens privileges

F. Additional Privileges (*action items*)
    1. Tammy O'Neill, PA-C (*physician assistant*) – addition of OR physician assistant protocol

G. Advancement (*action item*)
    1. Monika Mehrens, DO (*family medicine/hospitalist*) – recommendation for advancement from Provisional Active staff to Active Staff.

H. Pediatrics Core Privilege form update (*action item*)

I. Annual Reviews (*action items*)
    1. Critical Indicators
        i. Neonatal
        ii. Perinatal
        iii. Pediatrics
        iv. ICU
        v. RHC
        vi. Medical Services

J. Physician recruitment update (*information item*)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Emergency Medication and Code Blue Crash Cart Policy	
Scope: Hospital Wide	**Department:**
Source: Pharmacy Director	**Effective Date:** 9/21/18

PURPOSE:

The purpose of this policy is to ensure that all emergency medications and code blue crash cart equipment and supplies in the hospital are consistently available, controlled, and secure. Included in the term "Crash Cart" is the adult crash cart and the Broselow crash cart.

POLICY:

1. The Director of Pharmacy shall ensure the availability of a sufficient inventory of medical staff approved emergency drugs in the pharmacy and patient care areas.

2. All code blue crash carts will be arranged similarly and contain identical medications and supplies, to ensure the most efficient use of these by all hospital staff. The only differences in crash carts will be between the adult crash cart and the Broselow crash cart.

3. Emergency drugs shall be readily available to the patient-care staff but not accessible to patients, visitors, and unauthorized personnel.

4. Adult crash carts will be functional for anyone exceeding the Broselow tape length or weight of greater than 36 Kg and the Broselow crash cart will be functional for pediatric patients from 3 Kg through 36 Kg. The Adult crash carts will have the ACLS algorithms attached and the Broselow cart will have the Broselow tape and PALS algorithms attached for emergency therapy.

~~5. Crash carts will be functional for all ages – pediatric through geriatric. All crash carts will have ACLS and PALS algorithms for emergency therapy.~~

~~6.~~5. Neo-natal emergency medications will be kept in the Obstetrical Department.

~~7.~~6. Perinatal emergency medications will be kept in the Obstetrical Department.

~~8.~~7. All non-medication containing drawers on the Broselow cart will be secured with a yellow securement device, and the last three numbers of each drawer's securement device will be individually checked and documented daily.
   a. If a yellow securement device is missing or broken, it will be reported to the house supervisor, the contents will be rechecked and a new yellow securement device placed on the drawer.

~~9.~~8. Emergency drugs supplies shall not be used as a routine source, but shall be reserved for emergency use when immediate availability is necessary.

~~10.~~9. The Pharmacy and Therapeutics Committee, with advice from the ED and ICU Committees, will determine the drugs and quantity of each to be kept in the Code Blue Crash Carts (Emergency Drug Supply).

~~11.~~10. The Pharmacy and Therapeutics Committee, with advice from the ED and ICU Committees, will review the drugs and quantity of each to be kept in the Code Blue Crash Carts (Emergency Drug Supply) at least yearly.

Title: Emergency Medication and Code Blue Crash Cart Policy	
Scope: Hospital Wide	**Department:**
Source: Pharmacy Director	**Effective Date:** 9/21/18

~~12.~~11. Emergency medications in the crash carts shall be located in drawers (currently the supply is divided into 4 separate drawers). Each drawer shall contain a clearly marked portable container (called a tray), which is sealed by a pharmacist in such a manner that a seal must be broken to gain access to the drugs within.

~~13.~~12. The adult and Broselow crash cart drawers containing medications shall be further sealed with a red breakaway lock. Such locks shall be stored in the pharmacy and shall be available only to a pharmacist.

~~14.~~13. The contents of the container shall be listed on the outside cover and shall include the earliest expiration date of any drugs within.

~~15.~~14. If the medications are used during regular working hours, the pharmacist will replace the tray(s) used and will reseal the crash cart with one or more breakaway red locks.

~~16.~~15. If the medications are used after pharmacy hours, the shift supervisor will replace the used tray with a pre-filled and sealed replacement tray.

~~17.~~16. The shift supervisor will replace the used drawers with locked drawers from the locked supervisor cabinet.

~~18.~~17. The next morning, a pharmacist will inspect the drawer contents, update the outdate list on the crash cart, and re-seal the medication drawers with a red pharmacy lock.

~~19.~~18. The department/unit staff will check the crash cart at least once daily whenever the department is open. They will check and record the lock number(s) of the medication drawers and of the supply section on the checklist.

a. Broken or missing medication drawer locks will be reported to the pharmacist on duty, or the shift supervisor immediately.
b. If the supply section lock is broken or the number does not match the checklist, the supplies will be checked and relocked. The new lock number will be recorded on the checklist.

~~20.~~19. In addition to crash cart locations for emergency drug supplies, the following departments store special emergency drug supplies:

a. PACU – Lipid Rescue Kit
b. Emergency Department – Lipid Rescue Kit, Sexual Assault Kit. Hyperthermia Cart
c. Outpatient Infusion – Adverse Drug Reaction Kit
d. Obstetrical Unit - Eclampsia Box, Neonatal Boxes, and Post-partum Hemorrhage Kit in each birthing room, Neonatal Box in the nursery, Lipid Rescue Kit
e. Medical/Surgical floor – Lipid Rescue Kit
f. Surgery Unit - 2 Anesthesia Carts, one Lipid Rescue Kit
g. Radiology - an Adverse Drug Reaction box.
h. CT – Adverse Drug Reaction Box
i. MRI – an Adverse Drug Reaction box
j. EKG – Regadenoson Rescue Kit

k. RHC – Emergency Supply Cart

~~21.~~20. A pharmacist shall seal these special emergency drug supplies with a red lock, and the contents with expiration dates shall be listed on the outside of the box.

~~22.~~21. A pharmacist shall inspect the emergency drug supply at least every 30 days. Records of such inspections shall be kept for at least three years.

Contents of the Emergency Crash Cart are listed in the attachments to this policy. ~~include:~~

	~~CRASH CART MEDICATION LIST~~	
~~DRAWER~~	~~DRUG~~	~~QTY~~
~~1~~	~~EPINEPHRINE 1:10,000 10 ML PFS~~	~~5~~
~~1~~	~~SODIUM BICARBONATE 50 MEQ/50 ML PFS~~	~~3~~
~~2~~	~~ATROPINE SULFATE 1MG/10 ML PFS~~	~~3~~
~~2~~	~~CALCIUM CHLORIDE 10% (1GM/10 ML) PFS~~	~~2~~
~~2~~	~~DEXTROSE 50% (25 GM/50 ML) PFS~~	~~2~~
~~2~~	~~LIDOCAINE 1% (50 MG/5ML) PFS~~	~~3~~
~~2~~	~~LIDOCAINE 2% (100MG/5ML) PFS~~	~~1~~
~~3~~	~~ADENOSINE 6 MG/2 ML~~	~~3~~
~~3~~	~~AMIODARONE 150MG/3ML~~	~~3~~
~~3~~	~~DIPHENHYDRAMINE 50 MG/1 ML~~	~~2~~
~~3~~	~~EPINEPHRINE 1:1000 (1 MG/1ML)~~	~~3~~
~~3~~	~~METOPROLOL 5MG/5mL VIAL~~	~~3~~
~~3~~	~~FLUMAZENIL 0.5 MG/5 ML~~	~~1~~
~~3~~	~~METHYLPREDNISOLONE 125MG/2 ML~~	~~2~~
~~3~~	~~NALOXONE 0.4 MG/ML 10ML~~	~~1~~
~~3~~	~~PHENYLEPHRINE 10 MG/1 ML~~	~~2~~
~~3~~	~~PROCAINAMIDE 1 GM/2 ML~~	~~2~~
~~3~~	~~VERAPAMIL 10MG/4ML~~	~~2~~
~~3~~	~~SODIUM CHLORIDE 0.9% 20 ML VIAL~~	~~2~~
~~4~~	~~DEXTROSE 25% (2.5GM/10ML) PFS~~	~~2~~
~~4~~	~~EPINEPHRINE 1:10,000 10 MLPFS w/syr &3wsc~~	~~2~~
~~4~~	~~SODIUM BICARBONATE 5 MEQ/10ML PFS~~	~~2~~
~~5~~	~~NACL 0.9% 1000 ML~~	~~2~~
~~5~~	~~NACL 0.9% 500ML~~	~~1~~
~~5~~	~~D5W 50ML~~	~~2~~
~~5~~	~~DOPAMINE 400 MG/250 ML (1600 MCG/ML)~~	~~1~~
~~5~~	~~LIDOCAINE 2 GM/500 ML (4 MG/ML)~~	~~1~~
~~5~~	~~NACL 0.9% 250 ML~~	~~1~~
~~5~~	~~MAGNESIUM SULFATE 2GM/50mL~~	~~2~~
~~5~~	~~NACL 0.9% 50 ml~~	~~2~~
~~-~~	~~IV START KITS DRAWER 3~~	
~~-~~	~~NS PFS 10 ml~~	~~6~~

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Emergency Medication and Code Blue Crash Cart Policy	
Scope: Hospital Wide	**Department:**
Source: Pharmacy Director	**Effective Date:** 9/21/18

REFERENCES:

1. Pennsylvania Patient Safety Authority: Clinical Emergency: Are You Ready in Any Setting? *Pennsylvania Patient Safety Advisory*, June 2010;7(2)52-60.
2. M Davies, et al: A Simple Solution for Improving Reliability of Cardiac Arrest Equipment Provision in Hospital. Resuscitation, 2014(85)1523-1526.
3. S Sones: Is Your Code Cart Ready? *Outpatient Surgery*, October 2008

CROSS REFERENCES:

1. Access to Medications in the Absence of a Pharmacist
2. Emergency Medication Trays Policy

Committee Approval	Date
CCOC	9/23/19
Pharmacy and Therapeutics Committee	12/19/19
Medical Executive Committee	01/07/20
Board of Directors	
Last Board of Directors Review	6/19/19

Revised: 10/05, 3/11, 4/14
Supersedes: 02/01

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Fiberoptic Endoscopic Evaluation of Swallowing (FEES) Policy	
Scope: Rehab. (Speech-language Pathologists), Pharmacy, Infection Control, Dietary, EOC-Biomed	Manual:
Source: Director of Rehab or Lead SLP	Effective Date:

PURPOSE: To establish a standard for the safe and objective evaluation of swallowing disorders utilizing the Fiberoptic Endoscopic Evaluation of Swallowing (FEES) and provide criteria for use by Speech Language Pathologists (SLP). Fiberoptic endoscopic evaluation of swallowing is a technique that allows for the assessment of pharyngeal dysphagia and the implementation of rehabilitation interventions with the goal of promoting safe and efficient swallowing.

POLICY:

1. **Statement:** Northern Inyo Healthcare District (NIHD) is committed to providing safe quality care for its patients. This includes utilizing appropriate instrumentation for objective evaluation and treatment ~~for patients with dysphagia~~.

2. **Application:** This policy applies to speech-language pathologists (SLPs) working in the acute inpatient unit, outpatient rehab clinic, and inpatient rehabilitation services.

3. **Training:** All speech-language pathologists must demonstrate competency according to criteria established by the State of California's Speech-Language, Audiology and Hearing Aid Dispensers Board and SLP's must have their Certificate of Clinical Competency and have completed training and proctoring as outlined below.

    A. A minimum of 25 passes have been signed off on by an Otolaryngologist as required by state regulating agencies.

    B. If SLP has previous training or experience in the use of FEES:
        i. A letter from the program director or prior supervisor certifying competency must be provided;
        ii. A minimum of one case within a one-hundred-eight (180) day period must be concurrently proctored by another SLP with current NIHD-validated competence in the procedure and/or a physician with endoscopy privileges at NIHD.

    C. For SLP's without prior FEES experience:
        i. a minimum of 1.5 CEU's completed prior to observations which includes didactic and hands-on training on a live person. (Certificate of Completion on file). And
        ii. Completion of 25 passes, verified and observed by another SLP with experience in the procedure and at least one pass observed by an Otolaryngologist (verification of observations on file).
        iii. Training and at least one observation by pharmacist on use of Lidocaine during the procedure (verification of training on file).
        iv. Proctoring for a minimum of three cases by both an SLP with current NIHD-validated competence in the procedure and/or a physician with endoscopy privileges at NIHD.

D. Each SLP must complete at least 5 cases annually or their competency must be re-validated by another SLP with current NIHD-validated competence in the procedure or a physician with endoscopy privileges at NIHD. These 5 cases will be recorded and stored alongside the competency grid used to validate initial and recurring competency.

4. **Location of Procedure:**
   A. The mobile unit may be used on the in-patient floor of the hospital in ICU, Med-Surg, and or in OB as ordered by the physician. The admitting physician may or may not be present on the floor during the procedure. If there is complication, an admitting physician will be called and nursing will assist in the plan for treatment of the complication. For a more immediate response a rapid response team will be paged.

   B. If required in the ~~ER~~ ED the ~~ER~~ ED physician will be called for any complication during the procedure.

   C. The mobile unit may be used for outpatient services in the PACU as ordered by the primary care physician. If a complication occurs, a physician will be called and nurses in PACU may assist in the plan for treatment of the complication.

5. **Patients are appropriate for FEES when:**
   A. Transport to radiology is risky; a medically fragile patient
   B. Fluoroscopy is not available
   C. Patient is obese and will not fit in the fluoroscopy chair
   D. Positioning patient in fluoroscopy chair is too difficult
   E. There is a concern for radiation exposure
   F. Patient has severe dysphagia and needs a conservative exam (i.e., brainstem CVA or NPO for prolonged period)
   G. There is compromised pulmonary clearance and need for a conservative exam
   H. There is a question of aspiration of secretions
   I. The larynx needs to be visualized (i.e., the voice suggests laryngeal involvement or if there are anatomical changes/ laryngeal trauma/post intubation, etc.)
   J. Need to visualize velopharyngeal competence
   K. Sensation in the laryngopharynx needs direct assessment
   L. Biofeedback is needed in therapy
   M. The Modified Barium Swallow does not answer all the clinical questions
   N. There is an allergy to barium

6. **Patients who may not be appropriate for FEES include:**
   A. Patients who are too anxious to cooperate for the exam
   B. Patients immediately post-surgery to the nose

C. Patients with a significant bleeding disorder
D. Patients with a history of syncope/vasovagal response
E. Patients with a history of laryngospasms

7. **Potential Complications and Risks Associated with FEES:**
   A. The FEES will be terminated prior to administering all test items in order to reduce risk for aspiration or if the study is determined to be unsafe for any reason, at the discretion of the SLP, nursing, or at the request of the patient.
   B. Potential complications may include:
      i. Discomfort
      ii. Gagging
      iii. Nosebleed
      iv. Allergic reaction to topical anesthetic, if used
      v. Laryngospasm
      vi. Vasovagal response

PROCEDURE:

1. **Set up needed for FEES:**
   A. The SLP will set up the equipment needed for the procedure. This includes attaching the laryngoscope to recording system, white balance of laryngoscope, input into recording system of patient name, medical record number, per manufacturer's guidelines and in-services.

   B. The SLP obtains and prepares food/liquid of variety of consistencies and mixes with food coloring for visualization. Food items may be substituted as indicated by patient's diet, allergies, or to answer specific clinical questions.

2. **Patient Preparation**
   A. Confirm the patient's identity using at least two patient identifiers.

   B. Explanation and purpose of FEES is provided to the patient/family by SLP and all questions answered. Written consent is obtained and becomes a part of the medical record.

   C. The SLP will assess the patient's medical status at the time of the exam and note any changes in treatment, included but not limited to medical status, mental status, medications or ongoing treatments. The exam may be deferred if clinically indicated.

   D. Perform proper hand hygiene.

   E. The SLP may apply lubrication to the scope to allow easier insertion of the scope.

F. If the SLP determines that a decongestant or topical anesthetic is needed for comfortable passage of the scope, the speech-language pathologist shall inform the patient of the advantage of having a topical anesthetic, and of the right to have a physician (instead of the speech-language pathologist) administer the topical anesthetic. The patient may refuse either or both of these medications and the examination can proceed without it.

G. The SLP who administers topical anesthetic will administer up to a maximum of 2 sprays of oxymetazoline hydrochloride (Afrin) or phenylephrine hydrochloride (Neosynephrine) and 2 sprays of lidocaine in one nares, if no contraindications or history of allergic reaction are present. Medications will be administered pursuant to an appropriate medication procedure described in Lippincott, "Nasal aerosol drug instillation."

3. **FEES Procedure/Steps**

A. The process begins with a clinical dysphagia evaluation and/or Modified Barium Swallow.

B. The Speech-Language Pathologist (SLP) determines the need for further objective assessment.

C. The SLP contacts the referring physician or medical team and obtains an order for FEES if this has not already occurred.

D. The SLP will attempt to complete the FEES within 24 – 48 hours for inpatients and in less than 10 days for outpatients.

.

E. The exam is completed at bedside for inpatients or in the PACU for outpatients. Food is dyed for visualization and administered by nursing staff/aide or the patient if able. The study will begin and progress with textures determined by the SLP. The SLP will evaluate several factors throughout the examination, including but not limited to patient's complaints, clinical need, and patient's tolerance of the exam.

F. The FEES exam will be recorded to a local recorder and/or the NIHD external network drive for storage and review purposes.

G. Maintenance and storage of recorded exams will occur per medical records policy.

H. The SLP reviews and interprets the study results and makes appropriate recommendations for diet texture, compensatory strategies and therapeutic exercises. The SLP may recommend additional consultations or assessments.

Title: Fiberoptic Endoscopic Evaluation of Swallowing (FEES) Policy	
Scope: Rehab. (Speech-language Pathologists), Pharmacy, Infection Control, Dietary, EOC-Biomed	Manual:
Source: Director of Rehab or Lead SLP	Effective Date:

I. The SLP documents findings and recommendations in EMR, following FEES template as indicated.

j. The endoscope will initially be wiped clean as per manufacturer's instructions using approved germicidal/alcohol wipes by the SLP. Then Rehab staff will transport the scope in the appropriate biohazard case to NIHD sterile processing for cleaning. It will be transported back in the appropriate case and labeled biohazard.

REFERENCES:

1. Langmore Foundation FEES Course
   a. Location: University of Colorado Health
   b. Faculty: Susan E. Langmore, PhD, CCC-SLP, BCS-S
   c. Date: July 28, 2018 – July 29, 2018

2. California Department of Consumer Affairs: https://www.speechandhearing.ca.gov/serp.shtml?q=fiberoptic+exams&cx=001779225245372747843%3Aon_pmvnmgkw&cof=FORID%3A10&ie=UTF-8&submit.x=0&submit.y=0

3. Centers for Disease Control and Prevention. (2002). Guideline for hand hygiene in health-care settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force. *MMWR Recommendations and Reports, 51*(RR-16), 1–45. Accessed April 2018 via the Web at https://www.cdc.gov/mmwr/pdf/rr/rr5116.pdf (Level II)

4. World Health Organization. (2009). "WHO guidelines on hand hygiene in health care: First global patient safety challenge, clean care is safer care" [Online]. Accessed April 2018 via the Web at http://apps.who.int/iris/bitstream/10665/44102/1/9789241597906_eng.pdf (Level IV)

CROSS REFERENCE P&P:

1. Medical Records: Entries in the Medical Record.
2. Rehabilitation Services: Diet Texture Ordering Protocol.
3. Lippincott: Disinfection, semicritical patient care equipment.
4. Lippincott: Nasal aerosol drug instillation.
5. EOC-Biomed: Inspection, Testing, & Maintenance of New Medical Equipment
6. Lippincott: Related Procedures for aspiration precautions and impaired swallowing and aspiration precautions.

Title: Fiberoptic Endoscopic Evaluation of Swallowing (FEES) Policy	
Scope: Rehab. (Speech-language Pathologists), Pharmacy, Infection Control, Dietary, EOC-Biomed	Manual:
Source: Director of Rehab or Lead SLP	Effective Date:

7. Lippincott: Endoscope reprocessing, automated reprocessor
8. P&P: Credentialing-da Vinci Robotic Surgery
9. P&P: Rapid Response Team

Approval	**Date**
CCOC	8/26/19
Pharmacy/Therapeutic Committee	10/17/19
Med. Services/ICU	10/3/19
Infection Control	1/3/20
Medical Executive Committee	1/7/20
Board of Directors	
Last Board of Directors Review	

Developed: 7/2019 rh
Reviewed:
Revised:8/2019 rh, 10/2019 clk
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Steris Prevacuum Sterilizer Surgery (Autoclave)	
Scope: Sterile Processing/Surgery	Manual: Infection Control- Patient Care (ICP), Sterile Processing, Surgery
Source: DON Perioperative Services	Effective Date:

PURPOSE:
To provide sterile supplies and instruments for hospital patient care areas**. There are 4 autoclaves in the perioperative area: the Sterile Processing unit houses two large autoclaves (Steris gravity / prevacuum sterilizers) and there are 2 smaller autoclaves (Steris gravity / prevacuum sterilizers) in the Surgery area, off of OR 1 and between ORs 2 and 3. These autoclaves are designed for sterilization of heat-and moisture-stabile materials.**

POLICY:
- All autoclave operators must review and become familiar with the warnings, cautions and instructions contained in the Operator Manual as well as complete orientation training on operating a steam sterilizer with return demonstration of performance. Orientation period will include completion of eh Central Supply Workbook by IAHCSMM, and proctoring by a mentor until understanding and proficiency has been achieved. At no time will any employee operate a steam sterilizer without appropriate training.
- **The Sterile Processing and Surgery staff will attend inservices appropriate to the operation of the Steris autoclaves as needed / offered,**
- Prior to sterilization, all materials and articles must be thoroughly cleaned
- After sterilization, goods should be stored in conditions that will not compromise the barrier quality of their wrapping materials.
- As part of the operator's verification of the sterilization process, biological indicators will be used daily and with each load of implants to demonstrate that sterilization conditions have been met (See Policy).

SAFETY PRECAUTIONS:
Following is a list of the Safety warnings and precautions which must be observed when operating this equipment. Carefully read them before proceeding to use or service the unit.

WARNING – BURN HAZARD:
- ❖ When sterilizing liquids, to prevent personal injury or property damage resulting from bursting bottles and hot fluid, you must use the following procedures:
  - Use the liquid cycle only; no other cycle is safe for processing liquids.
  - Use only vented closures, not screw caps or rubber stoppers with crimped seals.
  - Use only Type 1 borosilicate glass bottles; do not use ordinary glass bottles or any container not designed for sterilization.
  - Do not allow hot bottles to be jolted or moved if any boiling or bubbling is present.
- ❖ It is inappropriate for a healthcare facility to sterilize liquids for direct patient contact.

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- ❖ Sterilizer, racks, shelves and loading car will be hot after the cycle is run. Always wear protective gloves and apron when removing a processed load. Protective gloves and apron must be worn when reloading sterilizer following the previous operation.
- ❖ After manual exhaust, steam may remain inside the chamber. Always wear protective gloves, apron and a face shield when following emergency procedure to unload sterilizer. Stay as far back from the chamber opening as possible when opening the door.
- ❖ Allow sterilizer to cool to room temperature before performing any cleaning or maintenance procedures.
- ❖ Failure to shut off the steam supply before cleaning or replacing strainers can result in serious injury. Jacket pressure must be 0 psig before performing any work on the steam trap.
- ❖ Proper testing of the safety valve should be performed by qualified service personnel only.
- ❖ Steam may be released from the chamber when door is opened. Step back each time the door is opened.

WARNING – ELECTRIC SHOCK AND BURN HAZARD:

- ❖ Disconnect all utilities to sterilizer before servicing. Do not service the sterilizer unless all utilities have been properly locked out.

WARNING – EXPLOSION HAZARD:

- ❖ This sterilizer is not designed to process flammable compounds.

WARNING – SLIPPING HAZARD:

- ❖ To prevent falls keep floors dry by immediately wiping up any spilled liquids or condensation in sterilizer loading or unloading area.

WARNING – PERSONAL INJURY AND/OR EQUIPMENT DAMAGE HAZARD:

- ❖ Regularly scheduled preventive maintenance is required for safe and reliable operation of this equipment.
- ❖ When closing the chamber door, keep hands and arms out of the door opening and ensure opening is clear of obstructions.

WARNING – STERILITY ASSURANCE HAZARD:

- ❖ Load sterility may be compromised if the biological indicator or air leak test indicates a potential problem. If these indicators show a potential problem, refer the situation to a qualified service technician before using the sterilizer further.
- ❖ According to AAMI standards, a measured leak rate greater than 1.0mm Hg/minute indicates a problem with the sterilizer. Refer the situation to a qualified service technician before using the sterilizer further.
- ❖ The express cycle is not intended for processing porous items (except the tray wrapper).
- ❖ The express cycle is only intended for use with a single instrument in a single wrapped instrument tray.
- ❖ The flash cycle is not intended for processing porous items.

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CAUTION – POSSIBLE EQUIPMENT DAMAGE:

- ❖ Gasket must be fully retracted prior to operating sterilizer door.
- ❖ If zero dry time is selected, sterilizer automatically initiates a vapor removal phase in place of drying. This phase can still draw a vacuum to 5.0 inHg. Consult device manufacturer's recommendations to ensure devices being processed can with stand this depth of vacuum.
- ❖ Never use a wire brush, abrasives, or steel wool on door and chamber assembly. Do not use cleaners containing chloride on stainless-steel surfaces. Chloride-based cleaners will deteriorate stainless steel, eventually leading to failure of the vessel.
- ❖ Do not use cleaners containing chlorides on loading cars. Chloride-based cleaners will deteriorate the loading car metal.
- ❖ Sterilization of chloride-containing solutions (e.g., saline) can cause chamber corrosion and is not recommended by the manufacturer. If, however, chloride-
- ❖ Do not attempt to open sterilizer door during manual operation unless chamber is a 0 psig.
- ❖ Immediately wipe up saline solution spills on loading car, to prevent damage to stainless steel.

PROCEDURE:

BEFORE OPERATING THE STERILIZER

DART (BOWIE-DICK) TEST: Refer to instructions packaged with DART indicator.

- This cycle is used to conduct the Bowie-Dick test on the sterilizer.
- These tests are designed to document the removal of residual air from a sample challenge load.
- A DART cycle should be run daily before processing any loads.
- The chamber must be at operating temperature when DART cycle is performed.
- The DART warm-up cycle should be completed prior to performing DART cycle.
- Review and verify critical cycle parameters were achieved during processing, and then sign printout to indicate verification.

VACUUM LEAK TEST (PREVACUUM STERILIZER ONLY) This test is not a substitute for a Bowie-Dick test.

- This cycle is used for testing vacuum integrity of the sterilizer's piping, and may be used to confirm the piping is intact after performing repairs.
- A vacuum leak test cycle should by run on the sterilizer at least once each week, preferably the beginning of each week (Mondays)
- If the sterilizer fails the leak test, it must be inspected by a service technician.
- Review and verify critical cycle parameters were achieved during processing, and then sign printout to indicate verification.
- Once the sterilizer completes and passes the leak test, the unit can be used.
- Proceed to loading the sterilizer and running cycles.

See the Operator Manual for instructions for using the autoclaves.

Title: Steris Prevacuum Sterilizer Surgery (Autoclave)	
Scope: Sterile Processing/Surgery	Manual: Infection Control- Patient Care (ICP), Sterile Processing, Surgery
Source: DON Perioperative Services	Effective Date:

The Amsco Century Steam Sterilizer is equipped with the following factory-programmed sterilization cycles and cycle values:

PREVACUUM CONFIGURATION

CYCLES	**RECOMMENDED LOADS**	**STERILIZE TEMP.**	**STERILIZE TIME**	**DRY TIME**
IMMEDIATE USE	Immediate use container with a single instrument.	270˚ F	3.0 Min.	1.0 Min.
IMMEDIATE USE	Immediate use container with non-porous multiple instruments, maximum weight 17lbs.	270˚ F	10 Min.	1.0 Min.
EXPRESS	Single wrapped instrument tray with a single instrument. Non-porous goods only.	270˚ F	4.0 Min.	3.0 Min.
PREVAC	Up to two double wrapped instrument trays, maximum weight 17lbs. Up to six fabric packs.	270˚ F	4.0 Min.	20 Min.
PREVAC	Up to two double wrapped instrument trays, maximum weight 17lbs.	275˚ F	3.0 Min.	16 Min.

GRAVITY CONFIGURATION

CYCLES	**RECOMMENDED LOADS**	**STERILIZE TEMP.**	**STERILIZE TIME**	**DRY TIME**
IMMEDIATE USE	Immediate Use Container with a single instrument.	270˚ F	3.0 Min.	1.0 Min.
IMMEDIATE USE	Immediate Use Container with non porous multiple instruments, maximum weight 17 lbs.	270˚ F	10 Min.	1.0 Min.
GRAVITY	Up to two double wrapped trays, maximum weight 17 lbs.	270˚ F	15 Min.	30 Min.
GRAVITY	Up to six Fabric Packs.	250˚ F	30 Min.	15 Min.

The sterilization cycles listed in tables have been validated using techniques documented in AAMI ST-8 AND AAMI ST -37.

Title: Steris Prevacuum Sterilizer Surgery (Autoclave)	
Scope: Sterile Processing/Surgery	Manual: Infection Control- Patient Care (ICP), Sterile Processing, Surgery
Source: DON Perioperative Services	Effective Date:

The autoclaves in Sterile Processing:

Table 1. Factory-Set Cycles and Cycle Values

The Amsco Century Medium *Prevacuum* Sterilizer is equipped with the following factory programmed sterilization cycles and cycle values (**Table 1A**).

Cycles:	Sterilize Temp.	Sterilize Time	Dry Time	Recommended Load	Validation Standard
1. PREVAC	270°F (132°C)	4 MIN.	5 MIN.	Single Fabric Pack	ST-8
2. PREVAC	270°F (132°C)	4 MIN.	20 MIN.	Double-wrapped instrument trays, max. weight of 17 lbs (7.7 kg) each. Fabric packs. *Refer to **Table 2** for recommended quantities.*	ST-8
3. GRAVITY	250°F (121°C)	30 MIN.	15 MIN.	Fabric packs. *Refer to **Table 2** for recommended quantities.*	ST-8
4. LIQUID	250°F (121°C)	45 MIN.	0 MIN.	*Refer to **Table 3** for guidelines.*	ST-8
5. PREVAC	275°F (135°C)	3 MIN.	16 MIN.	Double-wrapped instrument trays, max. weight of 17 lbs (7.7 kg) each. *Refer to **Table 2** for recommended quantities.*	ST-8

The Amsco Century Medium *SFPP* Sterilizer is equipped with the following factory programmed sterilization cycles and cycle values (**Table 1B**).

Cycles:	Sterilize Temp.	Sterilize Time	Dry Time	Recommended Load	Validation Standard
1. WRAP/ SFPP	270°F (132°C)	4 MIN.	20 MIN.	Double-wrapped instrument trays, max. wt.: 17lbs (7.7kg) each. Non-porous Goods, only. *Refer to **Table 2** for recommended quantities.*	ST-8
2. SFPP	270°F (132°C)	4 MIN.	20 MIN.	Fabric Packs *Refer to **Table 2** for recommended quantities.*	ST-8
3. PREVAC	270°F (132°C)	4 MIN.	20 MIN.	Double-wrapped instrument trays, max. wt.: 17lbs (7.7kg) each. Fabric Packs. *Refer to **Table 2** for recommended quantities.*	ST-8
4. GRAVITY	250°F (121°C)	30 MIN.	15 MIN.	Fabric packs. *Refer to **Table 2** for recommended quantities.*	ST-8
5. PREVAC	275°F (135°C)	3 MIN.	16 MIN.	Double-wrapped instrument trays, max. weight of 17 lbs (7.7 kg) each. *Refer to **Table 2** for recommended quantities.*	ST-8

Test Cycles for All Units	Sterilize Temp.	Sterilize Time	Dry Time	Recommended Load	Validation Standard
6. Leak Test[1]	270°F (132°C)	N/A	N/A	N/A	ST-8
7. DART Test[1]	270°F (132°C)	3-1/2 MIN.	1 MIN.	DART or Bowie-Dick Test Pack	ST-8
8. DART Warm-up[1]	270°F (132°C)	3 MIN.	1 MIN.	N/A	N/A

[1] *Not adjustable.*

Table 2. Recommended Loads by Sterilizer Chamber Size [1]

Chamber Size	Wrapped Instrument Trays	Fabric Packs
26x37.5x36" (660x950x910)	9	18
26x37.5x48" (660x950x1220)	12	30
26x37.5x60" (660x950x1520)	15	36

[1] *Refer to **Tables 1A** and to determine cycle use guidelines.*

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The autoclaves in Surgery:

Cycle Type	Load	Sterilize Temperature	Sterilize Time	Dry Time	Prevac Default	Prevac Optional	Gravity Default	Gravity Optional
Gravity*	Full Load Fabric Packs	270°F	25 min	15 min		X		X
Gravity*	Full Load Fabric Packs	250°F	30 min	15 min		X	X	
Gravity*	Full Load Instrument Trays	270°F	15 min	30 min		X	X	
Gravity*	Full Load Instrument Trays	250°F	30 min	30 min		X		X
Liquid*	Three 1000ml Bottles	250°F	45 min	N/A		X		X
Prevac*	Single Fabric Pack	270°F	4 min	5 min		X	N/A	N/A
Prevac*	Full Load Instrument Trays	270°F	4 min	20 min	X		N/A	N/A
Prevac*	Full Load Instrument Trays	275°F	3 min	16 min	X		N/A	N/A
Flash**	Unwrapped, Non-porous Instrument Tray	270°F	3 min	1 min	X		X	
Express**	Single-wrapped Instrument Tray	270°F	4 min	3 min	X		N/A	N/A
Flash	Unwrapped, Non-porous Instrument Tray	270°F	10 min	1 min	X		X	
DART*	Bowie-Dick Test Pack	270°F	3½min	1 min	X		N/A	N/A
Leak* Test	None	N/A	N/A	N/A	X		N/A	N/A

THE EXPRESS CYCLE

Appropriate parameters for sterilization are preset by STERIS. It is designed to permit sterilization using a single instrument in a single wrapper (non-woven or textile, but not a peel pouch) on the instrument tray.

RATIONALE: The single wrapper serves to confine and contain the sterilized item from environmental contaminants that may be encountered enroute from the sterilizer to the point of use.

A single wrapped item sterilized with the express cycle does not have a shelf life.

The express cycle is useful in providing quick turnaround of an instrument using the wrapped technique for transport from the sterilizer to the point of use.

Instrument trays processed using the Express cycle are intended for immediate use.

1. Decontaminate, open and disassemble surgical instrument, place in a sterilization container for immediate use. Only non-porous items should be processed using this cycle. These include forceps, needle holders, scissors and other metal instruments.
2. Items, including towels, rubber or plastic items, items with lumens or sliding parts, **must not** be processed using this cycle.
3. Wear sterile gloves and use sterile towels as “pot holders” when removing goods from the sterilizer. Drying time has been reduced in the Express cycle, a single wrapper will appear dry but the content of the package will, in all probability, still be wet.

4. Place the tray on a previously draped sterile surface field that is impervious and able to withstand contact with hot surfaces.
5. Wrapper is opened by circulating nurse.
6. Never place the wrapped tray on an unsterile surface.

THE IMMEDIATE USE CYCLE (refer to Immediate Use Policy)

RATIONALE: The Immediate Use Cycle is intended for sterilizing an unwrapped item intended for immediate use (e.g. a dropped instrument). In any method of sterilization, it is important to adhere to good processing practices. This is particularly important in immediate use sterilization.

As prescribed in AAMI ST-37, prior to immediate use sterilization of a dropped instrument, ensure the item is free of soil by the appropriate decontamination procedure. The immediate use sterilized item then must be transferred immediately, using aseptic technique, from the sterilizer to the actual point of use, usually the sterile field in an ongoing sterile procedure.

Use items processed in an Immediate Use Cycle immediately.

DOCUMENTATION:

TIME AND TEMPERATURE CHARTS

All computer tapes, documenting sterilization times and loads for each day will be monitored daily, parameters checked per policy, initialed by employee and maintained accessible for review for at least one year.

VERIFY STEAM STERILIZATION SYSTEM

All load information from daily loads will be monitored and maintained accessible for review for at least one year. The sterilization tapes are stored in the VerDoc Steamload Release Envelopes, and information for each load is indicated on the outside.

BIOLOGICAL MONITORING

Biological monitoring log books will be monitored daily and with every load containing implants, and maintained accessible for review for at least one year.

REFERENCES:

1. Current and relevant JCAHO and Title 22 Standards
2. Steris Operating Instruction for Amsco Century Gravity and Prevauum Sterilizers
3. Central Supply Technical Workbook
4. ANSI/AAMI ST79
5. AORN Recommended Practices of Sterilization

CROSS REFERENCES:

Biological Monitoring for Steam Sterilizers

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

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Scope: Sterile Processing/Surgery	Manual: Infection Control- Patient Care (ICP), Sterile Processing, Surgery
Source: DON Perioperative Services	Effective Date:

Approval	**Date**
CCOC	12/16/19
MEC	
Board of Directors	
Last Board of Director review	

Developed:
Reviewed:
Revised: 6/20/12 PM, 5/2015 BS, 11/19aw
Supersedes:
Index Listings: Sterilizer, Steam Prevacuum

BACKGROUND CHECK DISCLOSURE FORM

Info Cubic, LLC and its designated agents and representatives may conduct a comprehensive review of your background through a consumer report and/or an investigative consumer report to be generated for employment, promotion, reassignment or retention as an employee. The scope of the consumer report/investigative consumer report may include information about your character, general reputation, personal characteristics, and mode of living as well as information that is not limited to, the following areas: names and dates of previous/current employment, work experience, Bureau of Workers Compensation/Claims, criminal history records (from local, state, federal, international and other law enforcement agencies' records), sexual offenders lists, wants and warrants records, motor vehicle records, military records, educational verification, license verification, credit history, civil cases, OIG/GSA, USA PATRIOT Act/OFAC, any sanction lists, FBI finger printing, internet searches, social media information, and drug testing. These reports may be obtained by Info Cubic, LLC at any time after receipt of your authorization. You may request more information about the nature and scope of any investigative consumer reports by contacting Info Cubic, LLC. Info Cubic, LLC will supply a copy of the completed consumer report along with a copy of an individual's rights under the Fair Credit Reporting Act.

Signature: _____ **Date:** _____
(Electronic signatures are **NOT** acceptable!
This document must be physically signed by applicant)

Print Full Name

_____

Rev. 12/2013

RELEASE OF LIABILITY

I hereby irrevocably and unconditionally waive and release Info Cubic, LLC ("Info Cubic" or the "Company") and its agents, officials, representatives, or assigned agencies, including officers, directors, subsidiaries, parents, employees, and/or related personnel, both individually and collectively, from any and all claims, demands, or liabilities of any nature whatsoever, whether arising statutorily, in tort or contract, known or unknown, suspected or unsuspected, on account of any injury or damage, including, but not limited to, defamation and invasion of privacy, which I may have at any time now or in the future, arising out of or in any way related to the investigation contemplated by this authorization, or from reliance on the information furnished. I ACKNOWLEDGE and AGREE that I have read and understand this Release of Liability and that I freely and voluntarily sign this document. I further agree that Info Cubic has made no representations, inducements or statements other than those in writing in this document and in other written disclosures provided to me, about the background investigation. I further agree and certify that the information that I provide in this form is true and correct, and that my application or employment shall be terminated based on any false, omitted, or fraudulent information.

Signature: _____ **Date:** _____
(Electronic signatures are **NOT** acceptable!
This document must be physically signed by applicant)

_____
Print Full Name (First Middle Last)

_____
Current Address

_____ _____ _____
City State ZIP/Postal Code

Rev. 12/2013

BACKGROUND CHECK AUTHORIZATION FORM

I, _____ authorize the complete release of these records or data pertaining to me which an individual, company, firm, corporation, institution, school or university, law enforcement or public agency may have. I authorize the full release of the information described in the background check disclosure, without any reservation, throughout any duration of my employment at _____ (company name) (hereinafter referred to as the "Company"). I certify that all information provided below is true and accurate to the best of my knowledge. This authorization and consent shall be valid in original, facsimile ("fax"), or copy form.

In consideration for reviewing my application for employment, I hereby authorize the Company and Info Cubic, LLC, and any other individual or entity retained by it, pursuant to the provisions of the Fair Credit Reporting Act (15 U.S.C. §§ 1681 *et seq*.) and any other applicable federal, state and local laws, to conduct a thorough pre-employment background screening, including investigation of my references, work record, educational background, governmental agency records, and any other matters related to my suitability for such employment, including, but not limited to, the right to verify my social security number, and conduct a criminal records search.

I understand and acknowledge that it is my right to receive, within 7 days of receipt by the Company, a copy of any "public records" obtained by the Company as part of any pre-employment background screening the Company conducts with respect to my employment application. By initialing here, I waive my right to receive a copy of such public records: _____. I understand and acknowledge that if the Company takes any adverse action against me with respect to my employment application as a result of any public record obtained during any pre -employment background screening it conducts, that the Company will provide me a copy of such public record regardless of the foregoing waiver.

I understand and acknowledge that an "investigative consumer report" may include information as to my character, general reputation, personal characteristics, and mode of living, which may be obtained by interviews with individuals with whom I am or have been acquainted, or who may have knowledge concerning any such items of information. I understand and acknowledge that, upon my written request, the Company shall make a complete and accurate written disclosure of the nature and scope of the consumer investigation it has requested with respect to my employment application. I further understand and acknowledge that I have the right to request a copy of any investigative consumer report obtained with respect to my employment application.

I understand and acknowledge that the Company shall have the right, in its sole discretion, to review data from the sources referred to above, and that satisfactory completion of my background investigation shall be a condition to my employment. In the event the Company determines, in its sole discretion, that I am not suitable for the position applied for, then the Company shall have no further responsibility with regard to my application for employment or any conditional offer of employment which may have been provided to me.

I acknowledge receipt of the BACKGROUND CHECK DISCLOSURE AND RELEASE OF LIABILITY FORMS and certify that I have read and understand both of these documents. By signing this authorization form I am acknowledging that I have received and signed each of these forms.

Signature: _____ **Date:** _____

The following information is required by law enforcement agencies and other entities for identification purposes when checking records. It is confidential and will not be used for any other purpose. PLEASE PRINT LEGIBILY:

_____ _____
Print Full Name (First Middle Last) Maiden/AKA/Previous Name(s)

_____ -- _____ -- _____ _____
Social Security Number Email Address

_____/_____/_____
Date of Birth (MM/DD/YYYY) (This will not affect hiring decision)

_____ _____
Driver License Number State

_____ (_____)_____
Current Address Phone

_____ _____ _____
City State ZIP/Postal Code

☐ ***California, Minnesota, Massachusetts, Maine and Oklahoma Applicants: please check this box to have a copy of your report emailed directly to you***

Notice to California Applicants: Under section 1786.22 of California Civil Code, you have the right to request from Info cubic, upon proper identification, the nature and substance of all information in files pertaining to you, including the sources of information, and recipients of any reports on you, which Info Cubic has previously furnished within the two-year period preceding your request. You may view the file maintained on you by Info Cubic during normal business hours. You may also obtain a copy of this file upon submitting proper identification. Upon making a written request, you may receive a summary of your report.
Notice to Maine Applicants: Under Chapter 210 Section 1314 of Maine revised Statutes, you have the right, upon request, to be informed within 5 business days of such a request to whether or not an investigative consumer report was requested. If such report was obtained, you may contact the Consumer Reporting Agency and request a copy.
Notice to Massachusetts Applicants: Under Mass. Ann. Laws chapter. 93 §§ 50, a Consumer Reporting Agency may furnish a report if intended to be utilized for employment purposes.
Notice to New York Applicants: Under Article 25 Section 380-c (b) (2) of the New York General business Law, you have the right, upon written request, to be informed of whether or not an investigate consumer report was requested. Under Article 25 Section 380-g of the New York General Business Law, should a consumer report received by an employer contain criminal conviction information, the employer must provide to the applicant or employee who is the subject of the report, a printed or electronic copy of Article 23-A of the New York Correction Law, which governs the employment of persons previously convicted of one or more criminal offenses.

Please initial here to acknowledge receipt of Article 23-A of New York Correction Law_____

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

PEDIATRICS

Instructions: Please check box next to each core privilege/special privilege requested.

INITIAL CRITERIA	
Education/Formal Training: • Completed accredited residency training in Pediatrics. • Board Certified/Board Eligible by the American Board of Pediatrics or equivalent.	
INPATIENT CORE PRIVILEGES PALS and NRP required. STABLE preferred.	
Request	
☐	• Admit, evaluate, diagnose, treat, perform H&P, and provide consultation to patients from birth to young adulthood (21 years of age) with acute and chronic disease including routine newborn care. • Attendance at delivery to assume care of newborns including stabilization and coordination of transfer of sick or premature infant. • Endotracheal intubation.
OUTPATIENT CORE PRIVILEGES BLS and PALS required.	
Request	
☐	• Assess, evaluate, stabilize and/or provide treatment to patients from birth to young adulthood (21 years of age) who presents to the outpatient pediatric clinic with any illness, condition, or symptom. • Evaluate, diagnose, perform H&P, consult, and provide non-surgical treatment to patients.

SPECIAL PRIVILEGES
(requires experience within last 2 years and recommendation by Chief of Pediatrics)

☐ Arthrocentesis and joint injection	☐ Microscopic examination (urine, vaginal wet mount and skin preparations)
☐ Application of cast/splint	☐ Nail removal
☐ Circumcision with clamp	☐ Perform simple skin biopsy or excision
☐ Conscious sedation (requires tutorial and current ACLS certificate)	☐ Peripheral nerve blocks
☐ Digital nerve/ring block anesthesia	☐ ~~Ligation of extra digit~~Removal of extra digit
☐ Frenotomy	☐ Lumbar puncture
☐ Incision and drainage of abscess requiring local anesthesia	☐ Placement of anterior and posterior nasal hemostatic packing
☐ Insertion/removal of implanted contraceptive device (e.g. Nexplanon)	☐ Skin tag removal requiring local anesthesia
	☐ Suprapubic bladder tap
	☐ Umbilical catheterization

CONSULTING PRIVILEGES (for Consulting Staff only)	
Request	
☐	• Provide consultation, order, interpret, and evaluate diagnostic tests to identify and assess patients' clinical problems and health care needs on request from Active or Provisional Staff members or Temporary Privileges Practitioners.

Please sign acknowledgement on next page.

Northern Inyo Hospital Medical Staff
Clinical Privilege Request Form

Appointment cycle _____
(Office use only)

Practitioner Name: _____ Date: _____
Please Print

Acknowledgment of Practitioner:
I have requested only those privileges for which by education, training, health status, current experience and demonstrated performance I am qualified to perform and for which I wish to exercise and I understand that:

(a) In exercising any clinical privileges granted, I am constrained by any Medical Staff Bylaws, Rules and Regulations, and policies and procedures applicable.
(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

_____ _____
Practitioner Signature *Date*

APPROVALS

COMMENTS/MODIFICATIONS TO REQUESTED PRIVILEGES:

_____ _____
_____ _____
Chief of Pediatrics *Date*

_____ _____
Chief of Surgery *Date*

Approvals	*Committee Date*
Credentials Committee	
Medical Executive Committee	
Board of Directors	

(Office use only)

Neonatal Critical Indicators

2020

1. APGAR score less than 7 at 1 or 5 minutes
2. Neonatal resuscitation (PPV or beyond)
3. Infant in Neonatal Peds status
4. Birthweight less than 2000g
5. Infant of a diabetic mother
6. Gestation less than 36 weeks
7. Infant re-admitted within 48 hours of discharge
8. Transfer to NICU
9. Pediatrician attended delivery
10. Any chart brought forward by ~~a RN~~staff due to concerns

Approved:

Peri-Peds Committee: 12/5/19
Medical Executive Committee: 1/7/20
Board of Directors:

Perinatal Critical Indicators

2020

1. Maternal death or resuscitation
2. Fetal demise beyond 20 weeks gestation
3. Transfer to a higher level of care
4. APGAR score less than 7 at 1 or 5 minutes
5. Neonatal trauma
6. Maternal seizure
7. Vaginal deliveries coded with shoulder dystocia
8. 3rd and 4th degree lacerations
9. Postpartum hemorrhage requiring transfusion
10. Postpartum readmission
11. Disruption or infection of obstetrical wound
12. Delivery of infant less than 36 weeks gestation
13. Maternal admission to ICU
14. Maternal induction of labor less than 39 weeks without documented indication
15. Staff concerns.

Approvals:

Peri-Peds Committee: 12/5/19
Medical Executive Committee: 1/7/20
Board of Directors:

Pediatric Critical Indicators

2020

1. Patient transfer to a higher level of care or referral center
2. Readmission to the hospital within 30 days for the same or related diagnosis
3. Respiratory or cardiac arrest (Apnea >15 seconds)
4. Death
5. Abuse
6. Dehydration requiring Intravenous Fluid
7. Neonates < 28 days, admitted to the Acute/Sub Acute Services
8. Length of stay exceeding 48 hours
9. IV/IM antibiotics
10. Nursing concerns

Approved:

Peri-Peds Committee: 12/5/19
Medical Executive Committee: 1/7/20
Board of Directors:

ICU Critical Indicators

2020

1. Unexpected Deaths
2. Ventilator Associated Complications
3. Unexpected Complications After Discharge or Transfer from ICU
4. Staff Concerns

Approvals:

Medicine/ICU Committee: 12/5/19
Medical Executive Committee: 1/7/20
Board of Directors:

Rural Health Clinic Critical Indicators

2020

1. Transfer to NIH for emergency care.
2. All admissions of RHC patients.
3. Upon request of the patient/family, provider staff, nursing or ancillary RHC staff, or Medical Staff member.

Approvals:

Medicine/Intensive Care Service Committee: 12/5/19
Medical Executive Committee: 1/7/20
Board of Directors:

Medical Services Critical Indicators

2020

1. Readmit to hospital w/in 30 days-same or related problem
2. Medical death
3. Hospice inpatient
4. Use of restraints
5. Unexpected transfers to the ICU
6. Staff Concerns

Approvals:

Medicine/ICU Committee: 12/5/19
Medical Executive Committee: 1/7/20
Board of Directors:

CEO Report to the Northern Inyo Healthcare District Board of Directors November 2019

The last several months have been filled with a number of 'hellos' and 'goodbyes'. All have helped the District reassess and move forward in one way or another.

HR- NIHD received the final report from MRG and has begun to implement many of the proposed changes. Year-end has already seen the retirement of two HR staff members and the hiring of a new generalist. Additionally, starting in January of 2020 HR as a department will report up through the District COO, Kelli Davis. This previously planned change accomplishes two goals; it allows for new leadership with new direction to assume control and it allows for professional growth and challenge for Mrs. Davis. While the Board has received regular updates from the Workforce Experience Committee this past year what has not been highlighted is the fact that the District now has approximately 10 applicants for each position posted. NIHD continues to be an employer of choice!

Physician retirements/resignations- Dr. Robinson has completed her last day of work at NIHD. Dr. Souders still has several shifts left over the course of January. He has been helpful in working with the District in designing improvements for the Breast Health Program moving forward, highlighting areas of potential expansion and service enhancement. To that end, Tahoe Carson Radiology has agreed to the District request that onsite service be no less than five days every other week (an increase from current access), that the same level of clinical contact/care be kept, that coordination with Dr. Harness' schedule be followed and that the same service lines be covered (Mammography, 3-D Mammography, ABUS and breast MRI). Of note in keeping with the District commitment to the service line offering new MRI equipment has been ordered for preservation of some of the lines of service.

The District and the Chief of Staff continue to coordinate efforts for requirement of physicians. Successes include Dr. Pflum in OB/GYN. She will fill the work schedule allocated to Dr. Wise. Like Dr. Wise she provides OB care and general GYN care. She also has an expanded skill-set that included Uro-Gyn (advanced pelvic surgery) via the diVinci surgical system. We are hopeful that she will enjoy 2020 with us enough to stay on after Dr. Wise returns from his one-year sabbatical. During this planned sabbatical, Dr. Wise will be training in a fellowship program in New Jersey. He plans to return to the District upon completing this program.

The District also had a very good visit with Dr. Ricci, a pediatric resident. She is scheduled to complete her training this summer. We remain optimistic that after she completes several other interviews she will realize NIHD is the ideal position and location for her and her husband.

IT Services- NIHD has completed its discussions with our Inyo County healthcare partners and created a Cybersecurity Officer position. This position will have a home location of NIHD while Toiyabe,

SIHD and PHH will all 'rent' the staff services to maintain security and network support for their IT departments.

Selecting a new EHR/HIS is progressing nicely. NIHD has had phenomenal participation amongst its staff and amongst the physicians at the District. All are coming to meetings and presentations prepared and all are following up on debriefing meetings and communications. The participation is in alignment with what was seen last time but the focus seems to be much sharper.

Organizational Structure going into the 3rd Quarter- The start of 2020 will see a realignment of several departments in regards to reporting structure (as described in the last report). It will also see the creation of a new department- Project Management. This department will not own projects but rather it is intended to be the necessary support structure to help leaders achieve the goals of the projects undertaken.

Partnerships- This continues to be a major focus for NIHD. Most recently, the California Hospital Association appointed me to serve a full three year term on the Board of Directors as well as the Executive Committee. This is a great honor and reflects the credibility NIHD is garnering around the state as an example of what can be accomplished by a dedicated team.

Additionally, SIHD is planning to approve at their Board meeting a request to LAFCO for NIHD to help provide local pediatric services in Lone Pine.

Strategic Plan- The focus over the past several months has been on solidifying the concept and in positioning the District to be ready for the work. Behavioral Health demand is on the cusp of exceeding the District ability to meet the need. As noted in the Strategic Plan development a critical component to the Districts ability to deliver behavioral health is its ability to expand revenue-generating services to cover the cost. To that end, Urology access is expanding and now stabilizing. Drs. Ercolani & Su will be the interventionalists and Dr. Miller will be the medical specialist. This combination will allow NIHD to offer onsite Urologic care during the start and the end of each month. This is similar to how access is now structured for Breast Health/Mammography.

Physician Leadership- The District has now established a contractual relationship with three physicians (Drs. Brown, Helvie and R. Meredick) for Medical Director Services. ESEP provides Medical Director Services for the ED via Dr. Bourne. This group now has met several times to review the CMO position and once that is completed, have agreed to meet regularly to help lead the District and provide physician insight into planning.

For informational purposes, there is a sharp difference between a Medical Director and a Chief of Service. These differences include:

1. Medical Director is a District paid position hired by the District and derives its existence and authority from the District By-laws.

2. Chief of Service is a Medical Staff elected position that derives its existence and authority from the Medical Staff By-laws.
3. Medical Director helps lead departments through partnership with District leaders of that department in regards to planning, operations management, project ownership, staffing models and budget management.
4. Chief of Service is charged with Governance, Quality Management and Physician Behavior.
5. Medical Director term is defined in the contract.
6. Chief of Service term is one year but without term limits.

Respectfully submitted

Kevin S. Flanigan, MD MBA

CEO


HDR
NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.
SLO-MO
VIDEO
PHOTO
SQUARE
PANO
ITS

2019 SUPERSTARS

Robin

Bryan

Scott

Teresa

Most of the …….

I

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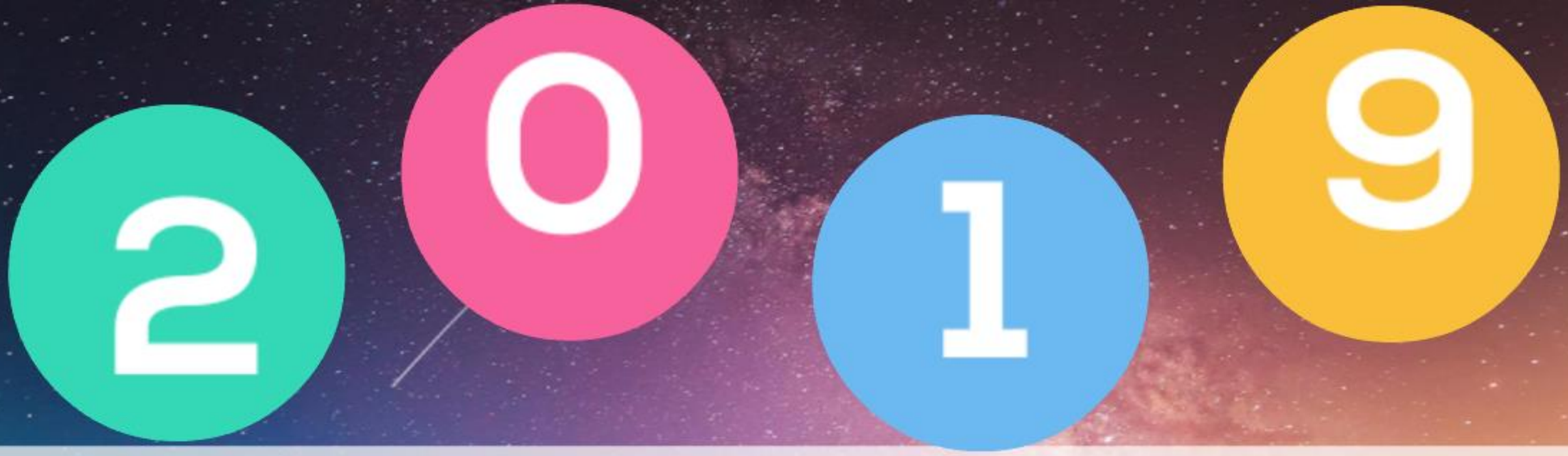
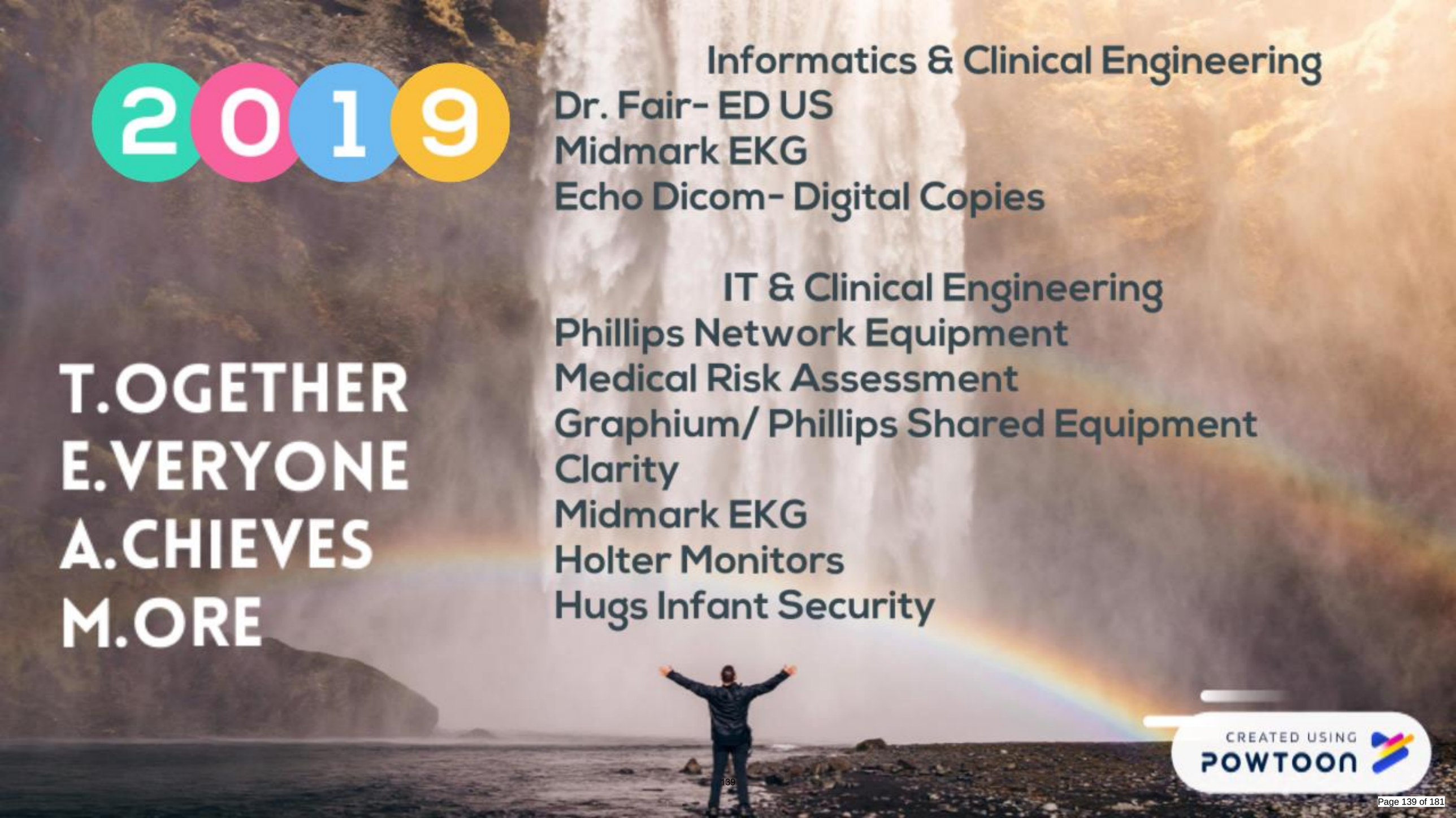


New Equipment

Phillips Patient Monitoring
Urology Tower
Bladder Scanner
ED Ultrasound

Metaneb
Stryker Neptune 3
Pediatric ABPM


2019
T.OGETHER
E.VERYONE
A.CHIEVES
M.ORE
Informatics & Clinical Engineering
Dr. Fair- ED US
Midmark EKG
Echo Dicom- Digital Copies
IT & Clinical Engineering
Phillips Network Equipment
Medical Risk Assessment
Graphium/ Phillips Shared Equipment
Clarity
Midmark EKG
Holter Monitors
Hugs Infant Security
CREATED USING
POWTOON

Nursing Informatics & ITS

2019

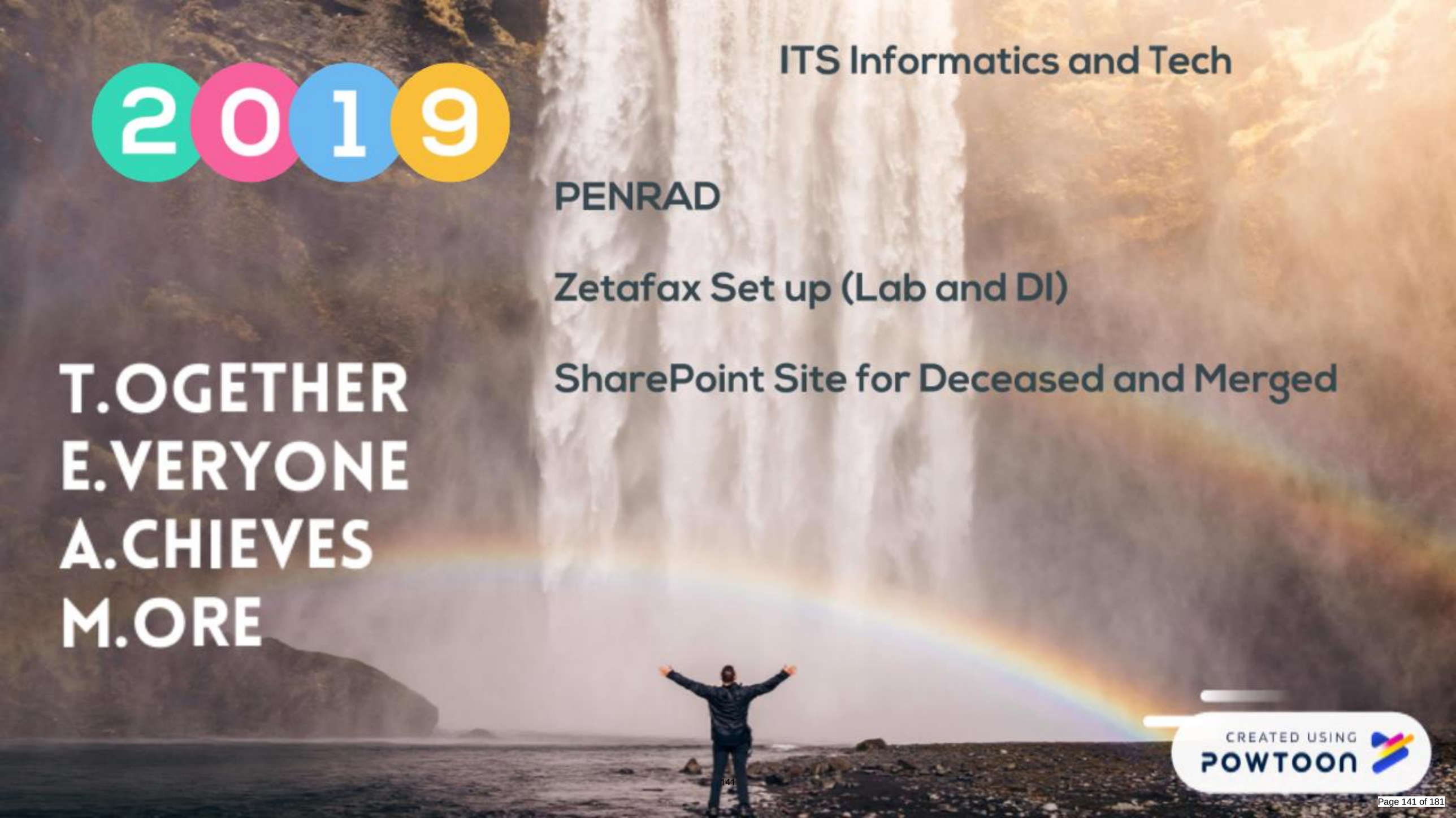
T.OGETHER
E.VERYONE
A.CHIEVES
M.ORE

Anesthesia Workflow Consumables/design & monitoring

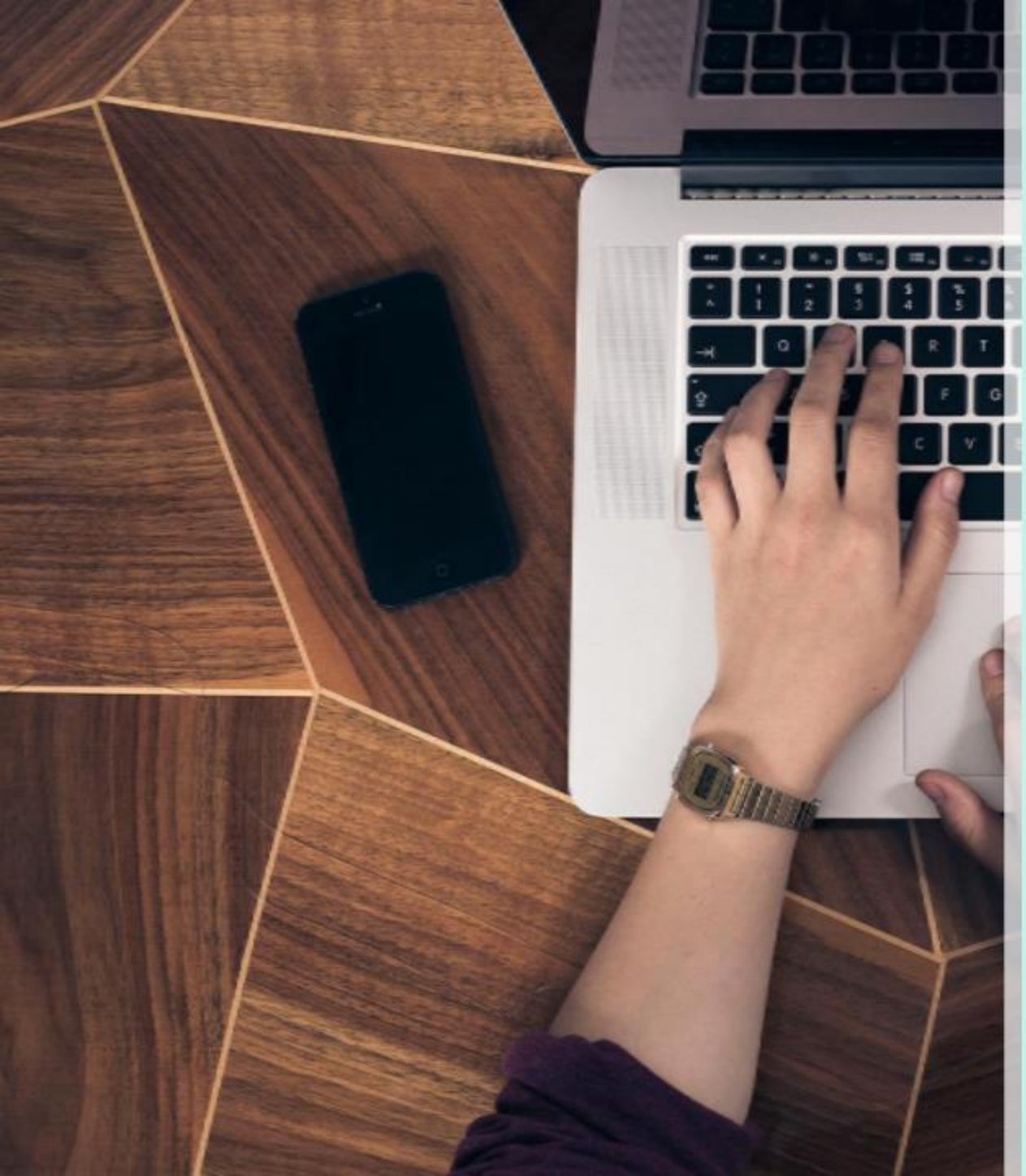
OB Hearing screener, 45%passing rates to over 90%

Cost Analysis on contract vs in house repair, Periop, Scopes, Disinfectors

CPN- Rework CPN Interfaces to autosend documents


2019
ITS Informatics and Tech
PENRAD
Zetafax Set up (Lab and DI)
SharePoint Site for Deceased and Merged
T.OGETHER
E.VERYONE
A.CHIEVES
M.ORE
CREATED USING
POWTOON


2019
IT
Flash Drive workflow instead of burning CDs
3M Upgrade
Upgrade Orchard Test Systems
T.OGETHER
E.VERYONE
A.CHIEVES
M.ORE
CREATED USING
POWTOON



CLINICS

Additional Provider Training
RHC Coord & New Hire Training
Downtime Assignments
Flu Campaign
TraumaCad Set up and Training
Behavioral Health Workflow 1/1/20
Confidential Workflow 2/1/20

Peds Table Research
ABPM research, setup, training
XM Radio Issues

ITS INFORMATICS

- Organized Informatics Team Meeting
- Designed Electronic workflow for DI & Lab using Zetafax
- Implemented Allergy workflow
- Built Intelligence Interpreter Application
- Outpatient Diagnostics Department in Athena
- Worked with CP on workflow, paperless and effectiveness
- Pioneer Home Health- Athena Training
- CPN CSection Workflow
- Report Card Organization for new EHR
- Designed, Created and Implemented Pathology Workflow
- Mammography workflow with TCR
- Surgery and DI CARM workflow

ITS- INFASTRUCTURE

Fortigate Firewalls (10gb)
Fortigage Remote VPN (Offsite users)
Password Force Reset
LAPS (Local Admin Password change policy) every 24 hours
Birch Street Printer setup
Open VAS (vulnerability scanner)
Secure Printing
Switch Project (replace 49 switches and 2 routers) + Updated Management
Deploy (2) new SharePoint 2016 servers
Windows updates (90% compliant and ongoing) industry average 35%-40%
Windows 10 rollout -20% complete (168-631)
Windows group policy updates
Remove legacy printer script and use Group Policy
Security Honey pots and RITA (Real intelligence threat analytic)

Cost Savings – It’s Raining $ Bills

$ Printer Contract Negotations (Saving 20k yr)

$ NetApp Contract Negotations (saving 10k yr)

$ CISCO Smart Contract Negotations (saving 18k yr)

$ Citrix Contract Negotations (saving 1k yr)

$ Pathology module- created (saving 120K)

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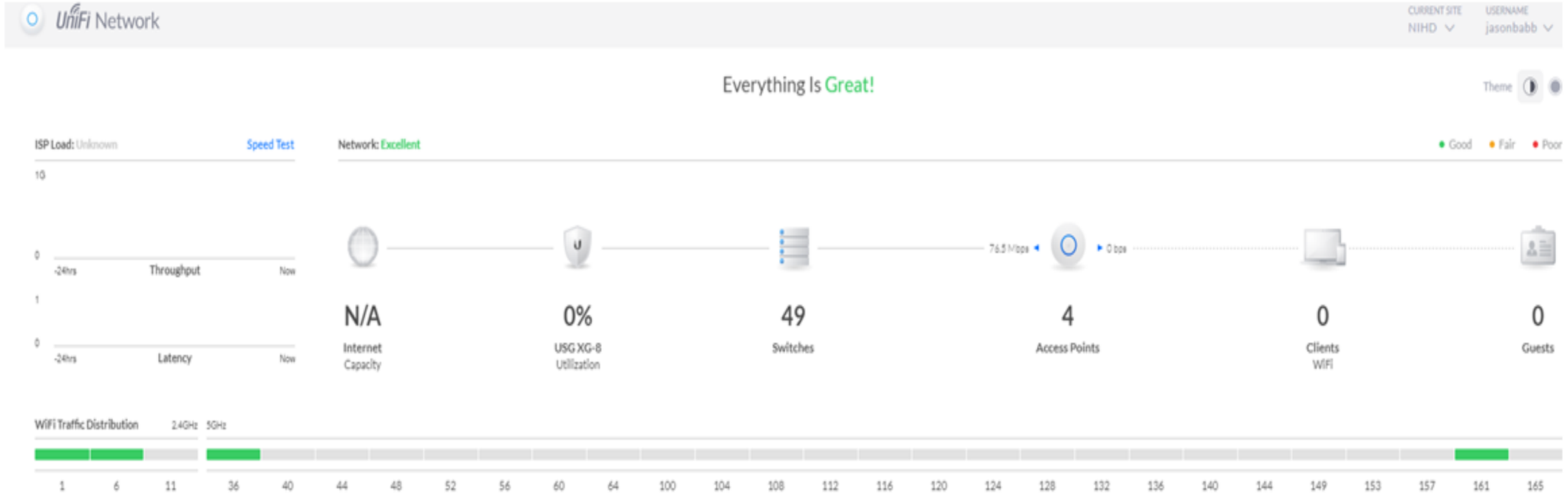
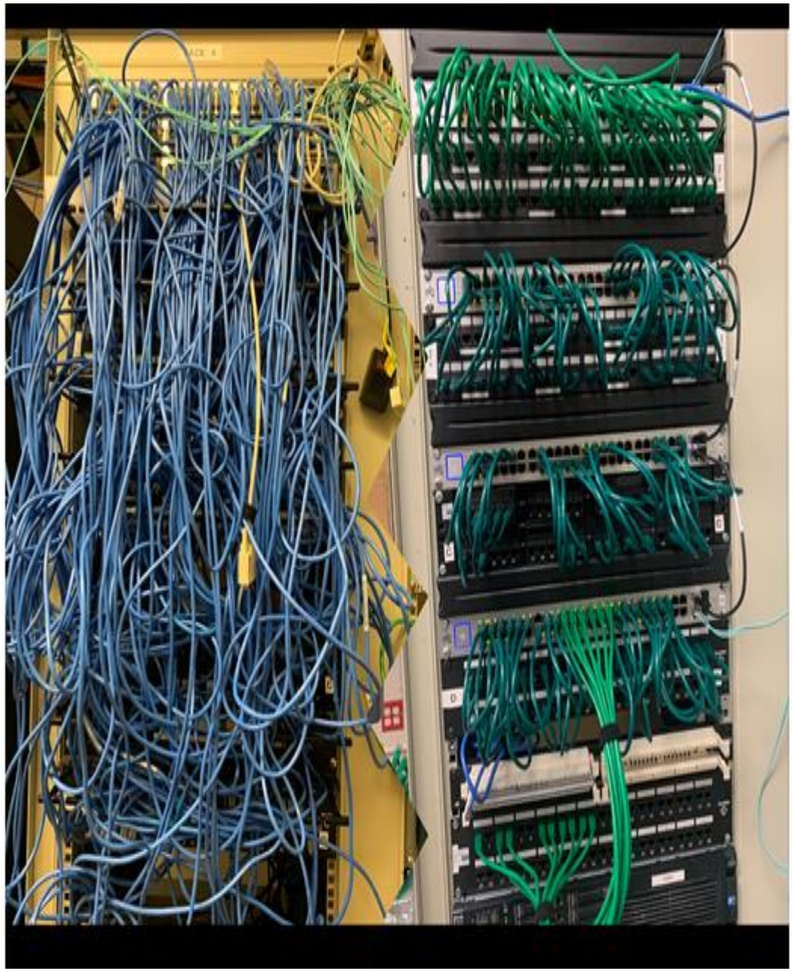
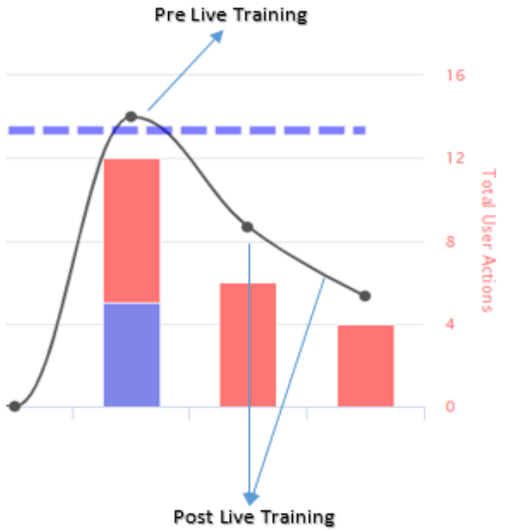
Switch Project



NOC and Data Center Clean Up



Security Awareness Training



YOUR LAST PHISH-PRONE%	0.8%
INDUSTRY PHISH-PRONE%	2%

Industry:	Healthcare & Pharmaceutica
Company Size:	Medium (250-1000 users)
Program Maturity:	1 Year

Pre Live Training

W2 Time *One time from categories: Healthcare, HIPAA Security Hints & Tips (Not PST), Human Resources, Custom*	*All Users*	*1*	*28.5%*	*01/16/2018 11:03 AM*	closed
Christmas *One time from category: Holiday*	*All Users*	*1*	*6.1%*	*12/22/2017 1:13 PM*	closed

Post Live Training

Random emails from category: Reported Phishes of the Week	Closed	12/25/2019	589	0.8%
Random emails from category: Reported Phishes of the Week	Closed	12/11/2019	582	1.3%

2019

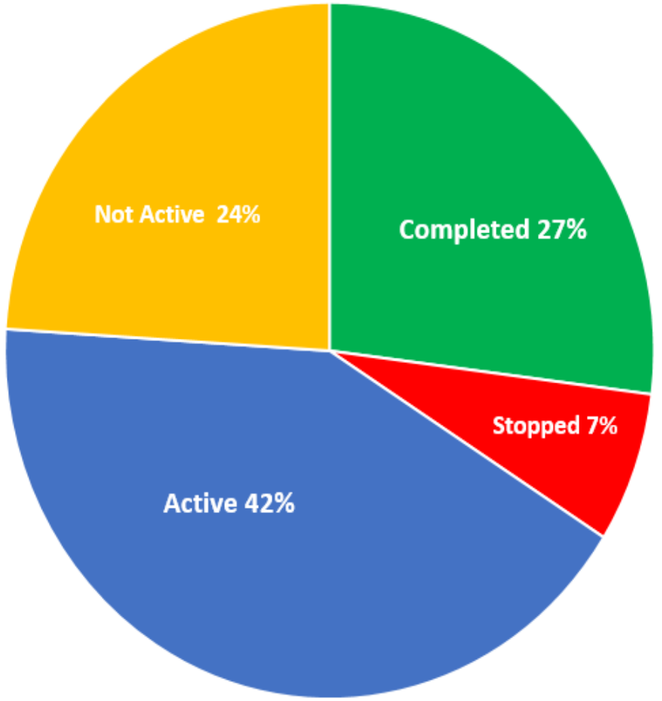
Lab
contract Analysis for Hoods and
Microtome
Printer Project for Hematology saga

Pharmacy
IV Pump Project
New Pharmacy - Storage Research
Advise on Omnicell contract

2019 Project Management

Project Activity	pre 2017	2018	2019	Totals	%	NOTES
Entered Projects on Project list	NA*	27*	64	91		This does not include the Olympus Project -ADP, Jump, Intacct, athena, CPN, 7Medical, GeauxTech, Orchard, Dragon, interfaces
Projects Started	5*	9*	50	64	70%	
Completed	NA*	1*	24	25	27%	
Stopped	NA*	NA*	6	6	7%	
Active	NA*	NA*	38	38	42%	of those 5 are on HOLD
Not Active	NA*	NA*	22	22	24%	of those 10 are on hold by the Project Lead or Chief

*March 2019 PM started to help manager the Project list



2019

Open Tickets 23,497
Closed Tickets 23,320
Current Open Tickets 177

NORTHERN INYO HEALTHCARE DISTRICT

One Team. One Goal. Your Health.


ITS ROADMAP
We're going to move mountains!!!
2020
CREATED USING
POWTOON

Strive to assist the organization with finding the best EHR for our district


Hardware Refresh
Improved Onboard Training
Improved Ticketing System
Single Sign On
Survive New EHR Implementation
Windows 10 Upgrade
Consistent and Ongoing Training Plan
2020 GOALS
Integration of Medical Devices
Wireless Project
CREATED USING POWTOON

Questions?

Thank you!

While all areas continue to focus on day-to-day workflow and workforce needs, Athena & related system navigation, new electronic health record search, specialized department projects and budget preparation, additional highlights for include:

Staffing Update

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Continuing to navigate the many challenges with Athena, scanning and ROI.

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Laboratory: 9 full-time employees, 1 part-time, 2 per diem. 2 open positions.

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Resignations of Certified Laboratory Scientists, Karl and Camille Elivera, has created a hardship on the Lab as these are hard to fill positions; we have contracted with 2 CLS travelers in the interim while we work to recruit full-time replacements.

Pharmacy: 8 full-time employees, 0 part-time, 1 per diem.

Frank Laiacona, Pharmacy Director, and Jeff Kneip, Pharmacist, attended the American Society of Health System Pharmacists (ASHP) mid-year conference and exhibition in Las Vegas in December for opportunities with networking, electronic health record (EHR) information and much more. Both are very thankful for the opportunity NIHD provided for them to attend.

New Pharmacy project planning and input continues. New role development for Pharmacist and Pharmacy Tech staff is underway.

Human Resources:

Weekly teleconferences with MRG Consulting continues to ensure areas of the consultant report are being discussed and action plans are being developed. Don Turko and Charlie Wilson, HR Consultants, are providing resources for industry best practices with job descriptions for vacant roles and posting/recruiting/interviewing and hiring points. HR will transition from our CEO to Operations and will report directly to Kelli Davis effective January 6th.

Safety –

The Safety Huddle meets Monday through Friday (except on holidays) at 8:00am. This group of leaders and designees report on departmental volumes for the day, organizational safety concerns that have occurred within the last 24 hours, are currently happening and/or are anticipated to occur within the next 24 hours and local/state/national happenings that the District should be aware of. In the months of September and October, there were 89 safety related concerns, ideas or events that were reported and worked through the Safety Huddle.

These ranged from violent behavior risks, fall risks, unlocked doors, signage issues, parking & speeding, food recalls, system downtimes, equipment issues and so forth.

Employee Occupational Safety meets as an ad hoc of the Safety Committee with a focus of providing feedback/recommendations to Safety Committee on occupational safety efforts for NIHD workforce.
The most recent meeting inspiration included *"If you put good people in bad systems, you get bad results. You have to water the flowers you want to grow – Stephen Covey*
This group continues to focus on the following agenda items:

- Video Taping of Ergonomics/Safe Patient Handling Training
- Departmental Ergonomic Assessments
- Cal-OSHA Hazard Assessments
- Musculoskeletal Injury Prevention Plan

Individual departments are currently being surveyed for safety and risk prevention. Once complete, the department teams develop corrective action plans to reduce risk and promote the safety and wellbeing of all departmental employees, visitors & others.

Violence Prevention Assessment Team (VPAT) meets on a monthly basis to review and discuss workplace violence (WPV) events that have occurred, (the cause, participants, resolution and risk prevention), District training, regulatory updates and policy. November saw 7 WPV events reported. Recent meetings have included the annual review of the NIHD Workplace Violence Prevention Plan, with the annual Board of Director review occurring this month.

Monthly Operations' Team Meetings – November Focus Areas (December was cancelled due to multiple schedule conflicts including the EHR Vendor Demo Project).

NORTHERN INYO HEALTHCARE DISTRICT
OPERATIONS TEAM MONTHLY MEETING
AGENDA

<table>
<tr><td colspan="2">Name of Group:
NIHD Operations Team</td><td>Date of Meeting:
November 19, 2019</td><td>Time of Meeting: 2:00 – 3:00pm
Location: AMR</td></tr>
<tr><td colspan="4">Title of Meeting: Monthly Operations Team Meeting</td></tr>
<tr><td colspan="2">Meeting Called By: Kelli Davis, Chief Operating Officer</td><td colspan="2">Location: AMR</td></tr>
<tr><td colspan="4">Participants:</td></tr>
<tr><td>Amy Stange
Cheryl Brooks
Cori Stearns
Denice Hynd
Frank Laiacona</td><td>Jalaine Beems
Larry Weber
Lindsey Hughes
Rich Miears
Sarah Yerkes</td><td colspan="2">Guest(s):
Mary Mae Kilpatrick</td></tr>
<tr><td colspan="4">Meeting Objectives(s): Communication, Collaboration & Education Amongst Operations' Team Members</td></tr>
</table>

Pillar	***Agenda/Minutes***	

NIHD Board of Director's Monthly Meeting

Chief Operating Officer Report

January 15, 2020

1. People	*"As we express our gratitude, we must never forget that the highest appreciation is not to utter words, but to live by them". John Fitzgerald Kennedy* • Welcome • Effective Meetings 5 Best Meeting Practices Every Leader Should Follow – Article Welcome to the 72-Hour Work Week - Article	Kelli Davis Group Discussion
2. Quality	• EHR Selection Update	Group Discussion
3. Growth	• Leadership – 21 Irrefutable Laws of Leadership – Book Club Update • Leadership is a Profession, Not a Position - Article	Group Discussion Group Discussion
4. Finance	• The Economic Consequences of Millennial Health – BCBS Report	Information Item
5. Round Table	• Upcoming Department Events/Changes - Success Stories - Projects - Challenge Areas/Need for Support - Staffing – Incoming/Departing	Group Discussion **"Improving our communities, one life at a time: One Team. One Goal. Your Health."**

Operations Team Book Club: As a team, we chose the book "21 Irrefutable Laws of Leadership" by John Maxwell, for our book review. We meet weekly to discuss 1-2 chapters that we've read independently. Great discussion, insight and "ah ha" moments have come during our weekly time together. The chapters read and reviewed thus far include:

1. The Law of the Lid – "Leadership Ability Determines a Person's Level of Effectiveness"

2. The Law of Influence – "The True Measure of Leadership is Influence – Nothing More, Nothing Less
3. The Law of Process – "Leadership Develops Daily, Not in a Day"
4. The Law of Navigation – "Anyone Can Steer the Ship, But It Takes a Leader to Chart the Course"
5. The Law of Addition – "Leaders Add Value by Serving Others"
6. The Law of Solid Ground – "Trust is the Foundation of Leadership"
7. The Law of Respect – "People Naturally Follow Leaders Stronger than Themselves"
8. The Law of Intuition – "Leaders Evaluate Everything with a Leadership Bias"
9. The Law of Magnetism – "Who You Are, Is Who You Attract"
10. The Law of Connection – "Leaders Touch a Heart Before They Ask for a Hand"

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Resignations of Certified Laboratory Scientists, Karl and Camille Elivera, has created a hardship on the Lab as these are hard to fill positions; we have contracted with 2 CLS travelers in the interim while we work to recruit full-time replacements.

Pharmacy: 8 full-time employees, 0 part-time, 1 per diem.

Frank Laiacona, Pharmacy Director, and Jeff Kneip, Pharmacist, attended the American Society of Health System Pharmacists (ASHP) mid-year conference and exhibition in Las Vegas in December for opportunities with networking, electronic health record (EHR) information and much more. Both are very thankful for the opportunity NIHD provided for them to attend.

New Pharmacy project planning and input continues. New role development for Pharmacist and Pharmacy Tech staff is underway.

Human Resources:

Weekly teleconferences with MRG Consulting continues to ensure areas of the consultant report are being discussed and action plans are being developed. Don Turko and Charlie Wilson, HR Consultants, are providing resources for industry best practices with job descriptions for vacant roles and posting/recruiting/interviewing and hiring points. HR will transition from our CEO to Operations and will report directly to Kelli Davis effective January 6th.

Safety –

The Safety Huddle meets Monday through Friday (except on holidays) at 8:00am. This group of leaders and designees report on departmental volumes for the day, organizational safety concerns that have occurred within the last 24 hours, are currently happening and/or are anticipated to occur within the next 24 hours and local/state/national happenings that the District should be aware of. In the months of September and October, there were 89 safety related concerns, ideas or events that were reported and worked through the Safety Huddle.

These ranged from violent behavior risks, fall risks, unlocked doors, signage issues, parking & speeding, food recalls, system downtimes, equipment issues and so forth.

Employee Occupational Safety meets as an ad hoc of the Safety Committee with a focus of providing feedback/recommendations to Safety Committee on occupational safety efforts for NIHD workforce.
The most recent meeting inspiration included *"If you put good people in bad systems, you get bad results. You have to water the flowers you want to grow – Stephen Covey*
This group continues to focus on the following agenda items:

- Video Taping of Ergonomics/Safe Patient Handling Training
- Departmental Ergonomic Assessments
- Cal-OSHA Hazard Assessments
- Musculoskeletal Injury Prevention Plan

Individual departments are currently being surveyed for safety and risk prevention. Once complete, the department teams develop corrective action plans to reduce risk and promote the safety and wellbeing of all departmental employees, visitors & others.

Violence Prevention Assessment Team (VPAT) meets on a monthly basis to review and discuss workplace violence (WPV) events that have occurred, (the cause, participants, resolution and risk prevention), District training, regulatory updates and policy. November saw 7 WPV events reported. Recent meetings have included the annual review of the NIHD Workplace Violence Prevention Plan, with the annual Board of Director review occurring this month.

Monthly Operations' Team Meetings – November Focus Areas (December was cancelled due to multiple schedule conflicts including the EHR Vendor Demo Project).

NORTHERN INYO HEALTHCARE DISTRICT
OPERATIONS TEAM MONTHLY MEETING
AGENDA

<table>
<tr><td colspan="2">Name of Group:
NIHD Operations Team</td><td>Date of Meeting:
November 19, 2019</td><td>Time of Meeting: 2:00 – 3:00pm
Location: AMR</td></tr>
<tr><td colspan="4">Title of Meeting: Monthly Operations Team Meeting</td></tr>
<tr><td colspan="2">Meeting Called By: Kelli Davis, Chief Operating Officer</td><td colspan="2">Location: AMR</td></tr>
<tr><td colspan="4">Participants:</td></tr>
<tr><td>Amy Stange
Cheryl Brooks
Cori Stearns
Denice Hynd
Frank Laiacona</td><td>Jalaine Beems
Larry Weber
Lindsey Hughes
Rich Miears
Sarah Yerkes</td><td colspan="2">Guest(s):
Mary Mae Kilpatrick</td></tr>
<tr><td colspan="4">Meeting Objectives(s): Communication, Collaboration & Education Amongst Operations' Team Members</td></tr>
</table>

Pillar	***Agenda/Minutes***	

1. People	*"As we express our gratitude, we must never forget that the highest appreciation is not to utter words, but to live by them". John Fitzgerald Kennedy* • Welcome • Effective Meetings 5 Best Meeting Practices Every Leader Should Follow – Article Welcome to the 72-Hour Work Week - Article	Kelli Davis Group Discussion
2. Quality	• EHR Selection Update	Group Discussion
3. Growth	• Leadership – 21 Irrefutable Laws of Leadership – Book Club Update • Leadership is a Profession, Not a Position - Article	Group Discussion Group Discussion
4. Finance	• The Economic Consequences of Millennial Health – BCBS Report	Information Item
5. Round Table	• Upcoming Department Events/Changes - Success Stories - Projects - Challenge Areas/Need for Support - Staffing – Incoming/Departing	Group Discussion **"Improving our communities, one life at a time: One Team. One Goal. Your Health."**

Operations Team Book Club: As a team, we chose the book "21 Irrefutable Laws of Leadership" by John Maxwell, for our book review. We meet weekly to discuss 1-2 chapters that we've read independently. Great discussion, insight and "ah ha" moments have come during our weekly time together. The chapters read and reviewed thus far include:

1. The Law of the Lid – "Leadership Ability Determines a Person's Level of Effectiveness"

2. The Law of Influence – "The True Measure of Leadership is Influence – Nothing More, Nothing Less
3. The Law of Process – "Leadership Develops Daily, Not in a Day"
4. The Law of Navigation – "Anyone Can Steer the Ship, But It Takes a Leader to Chart the Course"
5. The Law of Addition – "Leaders Add Value by Serving Others"
6. The Law of Solid Ground – "Trust is the Foundation of Leadership"
7. The Law of Respect – "People Naturally Follow Leaders Stronger than Themselves"
8. The Law of Intuition – "Leaders Evaluate Everything with a Leadership Bias"
9. The Law of Magnetism – "Who You Are, Is Who You Attract"
10. The Law of Connection – "Leaders Touch a Heart Before They Ask for a Hand"

Overview: Organizational billed charges were poor in November with negative variances in all three service types. The month of December is a similar with continued slowness in outpatient and clinics.

	Charges	Budget
October, 2018	12,311,788	12,324,875
November, 2018	12,965,830	13,205,209
December, 2018	11,320,722	13,205,209
January, 2019	13,649,585	13,645,381
February, 2019	11,808,879	12,324,875
March, 2019	12,927,842	13,645,381
April, 2019	14,479,237	13,205,209
May, 2019	13,190,872	13,645,381
June, 2019	12,985,554	13,205,327
July, 2019	14,142,468	13,645,381
August, 2019	14,486,110	14,095,678
September, 2019	12,636,290	13,640,980
October, 2019	14,348,923	14,095,678
November, 2019	12,900,439	13,640,980
December, 2019	13,481,900	14,095,678

Gross Accounts Receivables in Athena continue to be unacceptably high at $51,533,089; 116.4; Gross Days in AR. Remaining Gross Accounts Receivable in Paragon is $2,310,545 and Centricity is $377,198.

Salaries and Wages for Hospital operations were lower even after Holiday bonuses accrual as temporary labor expenses were higher by $84,000 in the month of November due to open positions.

	Salaries & Wages	Cost Per Day
January, 2019	2,550,818	82,284
February, 2019	2,457,730	87,776
March, 2019	2,674,515	86,275
April, 2019	2,555,902	85,199
May, 2019	2,616,111	84,391
June, 2019	2,509,763	83,659
July, 2019	2,585,146	83,392
August, 2019	2,638,465	85,112
September, 2019	2,530,883	84,363
October, 2019	2,536,968	81,838
November, 2019	2,496,760	83,224
December, 2019	2,468,754	79,638

Audit Update: The audit draft is included in the Board packet. Please note that Pioneer Home Care and Hospice has been added as a consolidated entity. The support that the District provides to Pioneer is reflected as Non-Operating Other Expense on the monthly and year to date financial results.

November Financial Results: November's services provided being ($740,000) below budget combined with high health claims, purchased services and contract labor resulted in a net loss.. A loss on the replacement of the surgical waste system and central monitoring equipment was incurred of ($31,762) as the original assets did not last as long as its expected life.

Submitted by John Tremble

Compliance Policy for annual renewal

January 2020

1. Communicating PHI via Electronic Mail (Email)
2. Compliance Program for NIHD
3. Investigation and Reporting of Unlawful Access, Use or Disclosure of Protected Health Information
4. Sending Protected Health Information by Fax
5. Using and Disclosing PHI for Treatment, Payment, and Healthcare Operations

CALL TO ORDER	The meeting was called to order at 5:30 pm by Mary Mae Kilpatrick, President.
PRESENT	Mary Mae Kilpatrick, President Jean Turner, Vice President Robert Sharp, Secretary M.C. Hubbard, Treasurer Jody Veenker, Member at Large Will Timbers MD, Chief of Staff Kevin S. Flanigan MD, MBA, Chief Executive Officer Kelli Davis, MBA, Chief Operating Officer John Tremble, Chief Financial Officer Tracy Aspel RN, BSN, Chief Nursing Officer
OPPORTUNITY FOR PUBLIC COMMENT	Ms. Kilpatrick stated at this time persons in the audience may speak on any items not on the agenda for this meeting on any matter within the jurisdiction of the District Board. Speakers will be limited to a maximum of three minutes each, and members of the audience will have an opportunity to address the Board on every item on the agenda. Ms. Kilpatrick also informed those present that the Board of Directors is prohibited from generally discussing or taking action on any item not included on the agenda. Comments and concerns were heard from the following: - Dorothy and Lloyd Wilson - Jerome Remick
BOARD MEMBER REPORTS	Ms. Kilpatrick asked if any members of the District Board of Directors wished to comment on any items of interest. She then read aloud a letter from former Board member and Board President John Ungersma, MD, addressed to outgoing Board member MC Hubbard. The Northern Inyo Healthcare District (NIHD) Board and District Administration expressed their thanks to Ms. Hubbard for her many years of dedicated service.
STRATEGIC PLAN UPDATE, WORKFORCE EXPERIENCE COMMITTEE	The NIHD Workforce Experience Committee provided an update on the Workforce Experience related goals of the District's Strategic Plan. The Committee's report included the following: - Report on the group's main areas of focus of staff turnover and staff development - Review of the main drivers that affect staff turnover - Review of efforts underway to assist the District in hiring the right people - Implementation of both stay and exit interviews for District staff - Review of NIHD staff turnover and churnover statistics - Review of mandatory training completion rates
GOVERNANCE CONSULTANT FOR NIHD	Chief Executive Officer (CEO) Kevin S. Flanigan, MD, MBA requested

permission to pursue the possibility of engaging Gallagher Governance to provide governance consultation services for the NIHD for an amount not to exceed $12,000. James Rice with Gallagher Governance was a presenter at the Association of California Healthcare District's (ACHD) annual meeting, and NIHD leadership believes the District would benefit from retaining his services. Following brief discussion it was moved by Robert Sharp, seconded by Jody Veenker, and unanimously passed to allow Doctor Flanigan to engage Gallagher Governance to provide governance consultation services for an amount not to exceed $12,000.

COMPETITIVE BIDDING RESULTS, NIHD MDV PLAN STOP LOSS POLICY

Chief Financial Officer (CFO) John Tremble presented the results of a competitive bidding process conducted for NIHD's Medical, Dental, and Vision (MDV) Stop Loss insurance policy coverage. Mr. Tremble stated following review of the bidding results it is his recommendation that the District select Voya Financial to be its MDV Stop Loss Carrier for 2020 (with a $200,000 self-funding threshold), in order to realize an annual premium savings of approximately 40%. It was moved by Ms. Veenker, seconded by Jean Turner, and unanimously passed to approve Voya Financial to be the District's MDV Plan Stop Loss insurance carrier for the 2020 calendar year.

REVIEW OF NEW YORK LIFE AS DEFINED BENEFIT PLAN PENSION BROKER

Mr. Tremble also reported the District engaged the firm of Hooker & Holcombe to review the performance of New York Life as the Administrator and Trustee of the NIHD Defined Benefit Retirement Plan. Upon review of Hooker and Holcombe's analysis District leadership requests authority to go out to bid and look at other options for the Defined Benefit Retirement Plan Administrator and Trustee, in order to potentially reduce fees and increase investment diversity. Following review of the information provided it was moved by Mr. Sharp, seconded by Ms. Turner, and unanimously passed to approve allowing a 6 to 9 month RFP for review of the NIHD Defined Benefit Plan pension broker and trustee, to include the Plan's current broker, New York Life. Director Sharp noted the importance of acting in the best interest of District retirees, and Director Hubbard stated it is important that the District Board be aware of the risk tolerance issues associated with this topic. Mr. Sharp additionally suggested the District may want to adopt a policy of reviewing pension plan performance on an every five years basis, in the interest of creating routine oversight.

NURSING ASSESSMENT AND REASSESSMENT POLICY & PROCEDURE

Chief Nursing Officer Tracy Aspel called attention to an updated Policy and Procedure titled *Nursing Assessment and Reassessment*, the purpose of which is to determine the care, treatment, and services that will meet a patient's needs based on the initial RN assessment, then determine RN reassessment throughout the course of care. It was moved by Ms. Hubbard, seconded by Ms. Veenker, and unanimously passed to approve the Policy and Procedure titled *Nursing Assessment and Reassessment* as presented.

BOARD MEMBER FOR NIHD QUALITY COUNCIL	Ms. Aspel additionally called attention to the need to appoint a member of the District Board to serve as a member of the NIHD Quality Council. It was moved by Ms. Turner, seconded by Mr. Sharp, and unanimously passed to appoint Director Kilpatrick to serve as a member of the NIHD Quality Council.
CHANGE OF DATE FOR FEBRUARY 2020 BOARD OF DIRECTORS MEETING	Doctor Flanigan called attention to the possibility of changing the date of the February 2020 regular Board meeting in order to avoid a conflict with the Association of California Healthcare District's annual meeting. It was moved by Ms. Turner, seconded by Ms. Veenker, and unanimously passed to hold the February 2020 regular meeting of the District Board at 6:00 pm on Tuesday, February 18 2020.
REPORTING STRUCTURE RE-ORG	Doctor Flanigan provided an overview of changes that will be made to the District's internal reporting structure, effective as of the January 5 2020 employee pay cycle. The intent of the reorganization is to better align the work of the District Chiefs with their direct reports, and to encourage the professional development of NIHD's Chief officers.
WIPFLI AUDIT RESULTS	Doctor Flanigan also reported that Wipfli LLP will report the results of the Healthcare District's audit for the fiscal year ending June 30 2019 at the January regular Board meeting. Wipfli will also provide a report on the handling of NIHD's Clinics and billing process at the January meeting.
PRESENTATION MONITOR OPTIONS FOR BOARD ROOM	Discussion took place on the Board of Directors' level of satisfaction with the current presentation monitors in the District Board meeting room, with the intent of determining whether or not the Board wishes to spend additional money in order to improve upon the current setup. Following brief discussion of the ideal size and location for presentation monitors to best serve the overall needs of the District (including facilitating Healthy Lifestyles presentations), a decision was made to table a decision on possible changes to the setup for presentations in the NIHD Board room to a future date.
APPOINTMENT OF OFFICERS FOR THE 2020 CALENDAR YEAR	Ms. Kilpatrick called attention to the appointment of District Board officers for the 2020 calendar year, then made a motion to appoint the following slate of officers: – President: Jean Turner – Vice President: Robert Sharp – Secretary: Jody Veenker – Treasurer: Mary Mae Kilpatrick Ms. Kilpatrick's motion was seconded by Director Sharp and unanimously approved as presented. It was noted that the person chosen to fill the District Zone 5 vacancy of M.C. Hubbard will be asked to serve as Member-At-Large for the 2020 calendar year.
REAL ESTATE TRANSACTION, 153 PIONEER LANE, BISHOP CALIFORNIA	Doctor Flanigan reported that a benefactor has stepped forward who is interested in using the Bishop area designation as an 'Opportunity Zone' to

invest in an NIHD building development. Doctor Flanigan, Stacey Brown MD, and other District representatives have met with the benefactor on several occasions and all are excited to see the opportunity come to fruition. Doctor Flanigan noted there will be several phases to the proposed building development process, the first being the sale of the lot on which the NIHD Rural Health Clinic (RHC) is located (153 Pioneer Lane) for an amount not less than $1,000,000, followed by a District lease back of the land to continue current operations while a new building for the RHC is designed and built. Following discussion of the proposed transaction it was moved by Ms. Kilpatrick, seconded by Ms. Hubbard, and unanimously passed to approve allowing Doctor Flanigan to negotiate the sale of 153 Pioneer Lane for not less than $1,000,000, with a lease back of the land at a commercially reasonable rate.

HR CONSULTANT REPORT

Doctor Flanigan called attention to a Human Resources Department Assessment provided by Municipal Resource Group LLC (MRG), explaining that the District's January 2019 Reduction in Workforce (RIF) was particularly hard on the NIHD Human Resources Department, and that MRG was engaged to provide oversight regarding how to bring the department to the next (higher) level of functionality. The Board indicated its' desire for HR staff to understand that they are valued and that their hard work is appreciated, and also expressed their desire to see the NIHD Human Resources Department work in cooperation with the Chief of Staff on Medical Staff recruitment efforts. NIHD Human Resources Generalist Lori Bengochia expressed her dismay with the report provided by MRG, stated her belief that publication of the report has created a public relations problem for the HR department and has significantly damaged their credibility. Ms. Bengochia also stated her belief that the MRG report never should have become a public document.

GRAND JURY RESPONSE

Doctor Flanigan informed the Board that NIHD has submitted its response to a Grand Jury inquiry regarding the District's vetting and selection of management personnel. Director Hubbard reported that similar Grand Jury inquiries were also sent to other local government entities.

CHIEF OF STAFF REPORT

Chief of Staff William Timbers, reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following District-Wide policies and procedures:

POLICY AND PROCEDURE APPROVALS

1. *Obtaining Blood Bank Samples from Patients in Surgery*
2. *Pain Management and Documentation*
3. *Standards of Care in the Perioperative Unit*
4. *Sterilization Challenge Pack (Verify Assert)*
5. *Disaster Management Committee*
6. *Interdisciplinary Team - Clinical Screens Built into the Initial Nursing Assessment*
7. *Bed Bug Infestation and Management*
8. *Infection Prevention Plan*

9. Linen Laundry Processes AB 2679

It was moved by Ms. Turner, seconded by Mr. Sharp, and unanimously passed to approve Policies and Procedures 1 through 9 as presented, including staff review of the language included in the *Infection Prevention Plan*.

REAPPOINTMENT TO NEW STAFF CATEGORY

Dr. Timbers additionally reported the Medical Executive Committee recommends the following reappointment to a new Staff Category:

1. Michael Rhodes, MD (*internal medicine/hospitalist*) - change from Temporary Staff to Provisional Staff, privileges active through December 31, 2020

It was moved by Mr. Sharp, seconded by Ms. Hubbard, and unanimously passed to approve the reappointment to a new Staff Category for Doctor Michael Rhodes, MD as recommended.

MEDICAL STAFF RESIGNATION

Doctor Timbers also requested approval of the following Medical Staff resignation:

1. Jennifer Figueroa, PA-C (*Family Practice*) - effective 10/23/19

It was moved by Ms. Veenker, seconded by Mr. Sharp, and unanimously passed to approve the resignation of Jennifer Figueroa, PA-C as requested.

EXTENSION OF APPOINTMENTS

Doctor Timbers also reported the Medical Executive Committee recommends extension of appointment - bylaws 6.13.3 for the following:

- Daniel Davis, MD (*Orthopedics*)
- Kevin Deitel, MD (*Orthopedics*)

It was moved by Ms. Hubbard, seconded by Ms. Veenker, and unanimously passed to approve both extensions of appointment as requested.

MEDICAL STAFF AND APP REAPPOINTMENTS FOR 2020-2021

Doctor Timbers additionally reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends the following Medical Staff and Advanced Practice Provider Reappointments for 2020-2021:

1. Farres Ahmed, MD - *Radiology*
2. Jon Bowersox, MD - *Surgery*
3. Stacey L. Brown, MD - *Family Medicine*
4. Bryce Thomas, MD - *Radiology*
5. Brandon Chan, MD - *Radiology*
6. Alissa Dell, NP - *Family Practice*
7. Michael L. Dillon, MD - *Emergency Medicine*
8. John Y. Erogul, MC - *Radiology*
9. Aamer Farooki, MD - *Radiology*
10. Daniel Firer, MD - *Family Medicine*
11. Nancy E. Fong, NP - *Family Practice*
12. Benjamin Ge, MD - *Radiology*
13. Jay K. Harness, MD - *Surgery*
14. *Nickoline M. Hathaway, MD - Internal Medicine*

15. John Adam Hawkins, DO - *Emergency Medicine*
16. Andrew D. Hewchuck, DPM - *Podiatry*
17. Kristin N. Irmiter, MD - *Pediatrics*
18. Asao Kamei, MD - *Internal Medicine*
19. Jared Kasper, MD - *Radiology*
20. Martha Kim, MD - *OB/GYN*
21. Rita Klabacha, PA-C - *Family Practice*
22. Sheila Lezcano, MD - *Rheumatology*
23. Stephen Loos, MD - *Radiology*
24. Azadeh L. Majlessi, MD - *Rheumatology*
25. Erik J. Maki, MD - *Radiology*
26. Rainier Manzanilla, MD - *Interventional Cardiology*
27. Richard Meredick, MD - *Orthopedics*
28. Jennifer Norris, CNM - *Nurse-Midwife*
29. Tammy O'Neill, PA-C - *Orthopedics*
30. Nilem Patel, MD - *Endocrinology*
31. Wilbur Peralta, MD - *Internal Medicine*
32. Michael W. Phillips, MD - *Emergency Medicine*
33. Edmund P. Pillsbury, MD - *Radiology*
34. Kinsey R. Pillsbury, MD - *Radiology*
35. David Pomeranz, MD - *Emergency Medicine*
36. Truong Quach, MD - *Internal Medicine*
37. Thomas K. Reid, MD - *Ophthalmology*
38. Christopher Rowan, MD - *Cardiology*
39. Amy Saft, CRNA - *Nurse Anesthesia*
40. Curtis Schweizer, MD - *Anesthesiology*
41. Richard Seher, MD - *Cardiology*
42. Robert N. Slotnick, MD - *OB/GYN*
43. Laura Sullivan, MD - *Cardiology*
44. Robert Swackhamer, MD - *Cardiology*
45. Carolyn Tiernan, MD - *Emergency Medicine*
46. Ian Tseng, MD - *Radiology*
47. Gary Turner, MD - *Radiology*
48. Rajesh Vaid, MD - *Radiology*
49. Anne K. Wakamiya, MD - *Internal/Geriatric Medicine*
50. Eva S. Wasef, MD - *Pathology*
51. Stephen Wei, MD - *Radiology*
52. Christopher Wilson, MD - *Cardiology*
53. Sarah Zuger, MD - *Family Medicine*

It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve reappointments 1 through 53 for 2020-2021 as requested, with a correction being made to indicate that the specialty for Tammy O'Neill, PA-C is Family Medicine rather than orthopedics.

PHYSICIAN RECRUITMENT UPDATE

Doctor Timbers additionally reported the following as an update on physician recruitment:

- The Medical Staff recently had a promising interview with Lindsey Ricci, MD, a potential hospitalist candidate

- Surgical oncologist Louis Rivera, MD is progressing through the credentialing process
- Urologist Joe Miller, MD will begin seeing patients in the NIHD Specialty Clinic tomorrow
- A Family Practice resident is potentially interested in joining the Medical Staff if 2021
- Recruitment efforts continue to obtain an additional general surgeon

Dr. Timbers additionally stated that Tahoe Carson Radiology will provide mammography physicians following the departure of Stuart Souders, MD. Doctor Timbers also thanked the NIHD Board of Directors for hosting a holiday dinner for NIHD physicians.

CONSENT AGENDA

Ms. Kilpatrick called attention to the Consent Agenda for this meeting which contained the following items:

- *Approval of the minutes of the November 20 2019 regular meeting*
- *Financial and statistical reports as of October 2019*

It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve both Consent Agenda items as presented.

ADJOURNMENT TO CLOSED SESSION

At 8:08 pm Ms. Kilpatrick announced that the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. Conference with Labor Negotiators; Agency Designated Representative: Kevin S. Flanigan, MD, MBA; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).
B. Confer with Legal Counsel regarding threatened litigation, 2 matters pending (*pursuant to Government Code Section 54956.9) d)(2*)).
C. Discussion of a personnel matter, Chief Financial Officer and ITS Service Desk Technician (*pursuant to Government Code Section 54957*).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:41 pm the meeting returned to Open Session. Ms. Kilpatrick reported that the Board took no reportable action

ADJOURNMENT

The meeting was adjourned at 8:42 pm.

_____
Mary Mae Kilpatrick, President

Attest: _____
Robert Sharp, Secretary

Northern Inyo Healthcare District
Income Statement Summary
As of November 30, 2019

	Month To Date 11/30/2019	Month To Date 10/31/2019	Year To Date 11/30/2019	Year To Date 11/30/2018
Operating Revenues				
Inpatient Revenue	3,092,670.42	2,969,027.16	13,551,281.88	14,858,455.62
Outpatient Revenue	9,301,404.92	10,838,533.15	52,366,807.07	46,089,577.74
Clinic Revenue	506,363.59	541,362.91	2,565,049.05	2,646,698.01
Total Gross Patient Service Revenue	12,900,438.93	14,348,923.22	68,483,138.00	63,594,731.37
Deductions from Revenue	(6,002,790.06)	(6,806,927.65)	(33,582,891.87)	(31,920,273.42)
Other Patient Revenue	24,480.94	412.97	65,477.43	0.00
Total Net Patient Revenue	6,922,129.81	7,542,408.54	34,965,723.56	31,674,457.95
Income/Expense from Cost Reporting	23,594.00	0.00	47,151.00	2,800,641.66
Other Operating Revenue	702,760.51	945,243.00	3,874,245.45	3,887,522.93
Gross Income from Operations	7,648,484.32	8,487,651.54	38,887,120.01	38,362,622.54
Operating Expenses				
Repairs and Maintenance	54,740.58	3,907.00	102,079.09	283,125.52
Leases and Rental Expenses	35,295.52	35,045.36	103,293.00	349,571.50
Salary & Wages	2,496,759.84	2,536,958.41	12,460,773.32	11,887,229.84
Benefits	1,735,509.40	1,687,353.29	8,266,823.03	8,753,193.47
Non-Benefit Expenses	23,702.60	13,240.09	69,500.48	72,662.58
Professional Fees	920,625.66	778,633.00	4,195,833.21	5,413,995.22
Supplies	775,620.49	811,420.95	4,113,707.42	4,545,815.21
Contract Services	838,172.15	1,179,896.76	3,429,549.42	1,930,072.83
Other Department Expenses	115,586.50	113,028.51	522,216.63	400,796.35
Hospital Insurance Expenses	36,592.02	(17,203.12)	150,976.04	238,966.94
Utilities	109,534.93	123,127.85	668,139.77	681,735.56
Depreciation and Amortization	373,786.09	356,051.66	1,773,111.96	1,708,695.64
Other Fees	(152,110.19)	(91,063.27)	441,390.13	688,256.68
Interest Expense - Operating	231,047.46	233,132.91	1,160,429.04	1,177,945.16
Total Operating Expenses	7,594,863.05	7,763,529.40	37,457,822.54	38,132,062.50
Total Net Operating Profit (Loss)	53,621.27	724,122.14	1,429,297.47	230,560.04
Non-Operating Revenue				
Other Income				
Tax Payer General Support	48,743.07	48,743.07	243,715.35	243,715.35
Bond/ Tax Payer Bond Support	137,595.79	137,595.79	687,978.95	579,051.10
Fin Chgs-Pt Ar - Int Incm-Payors	917.48	1,048.64	2,898.86	8,794.57
Interest Income	36,638.01	52,894.63	250,223.28	259,066.94
Interest on Patient Account	493.25	5,034.68	6,988.19	0.00
Total Other Income	224,387.60	245,316.81	1,191,804.63	1,090,627.96
Grant Revenue	0.00	5,000.00	36,468.23	55,715.72
Other Non-Operating Income	1,596.00	1,596.00	6,384.00	12,264.00
Net Medical Office Activity	(582,789.27)	(694,313.30)	(2,589,439.84)	(2,645,882.91)
340b Net Activity	55,535.32	67,721.48	254,583.87	104,448.16
Donations	19,713.13	0.00	63,773.13	3,300.00
Rental Income	4,881.41	7,032.82	24,407.05	11,691.88
Gain/Loss on Sale of Assets	(31,762.26)	0.00	(31,762.26)	0.00
Gain - Investments - Other Income	4,524.00	0.00	18,911.00	2,939.00
Total Non-Operating Revenue	(303,914.07)	(367,646.19)	(1,024,870.19)	(1,364,896.19)
Non-Operating Expenses	50,000.00	0.00	180,000.00	0.00
Total Net Non-Operating Profit	(353,914.07)	(367,646.19)	(1,204,870.19)	(1,364,896.19)
Total Net Income (Loss)	(300,292.80)	356,475.95	224,427.28	(1,134,336.15)

Northern Inyo Healthcare District
Balance Sheet
As of November 30, 2019

Assets	
Current Assets	
Cash and Liquid Capital	5,145,785.23
Short Term Investments	12,748,749.34
PMA Partnership	679,758.00
Accounts Receivable, Net of Allowance	
Accounts Receivable	55,299,748.86
Allowances against Receivables	(33,188,373.35)
NIA Accrued Allowances	(788,428.65)
Total Accounts Receivable, Net of Allowance	21,322,946.86
Other Receivables	6,719,521.95
Inventory	2,066,979.71
Prepaid Expenses	1,581,963.10
Total Current Assets	50,265,704.19
Assets Limited as to Use	
Internally Designated for Capital Acquisitions	1,193,798.87
Short Term - Restricted	150,576.55
Limited Use Assets	
LAIF - DC Pension Board Restricted	804,601.26
DB Pension	13,632,410.00
PEPRA	5,338.00
Total Limited Use Assets	14,442,349.26
Revenue Bonds Held by a Trustee	3,632,529.02
Total Assets Limited as to Use	19,419,253.70
Long Term Assets	
Long Term Investment	1,754,584.81
Fixed Assets, Net of Depreciation	
Fixed Assets	126,757,351.42
Accumulated Depreciation	(51,353,613.39)
Construction in Progress	1,438,346.86
Total Fixed Assets, Net of Depreciation	76,842,084.89
Total Long Term Assets	78,596,669.70
Total Assets	148,281,627.59
Liabilities	
Current Liabilities	
Current Maturities of Long-Term Debt	1,446,088.92
Accounts Payable	6,087,937.63
Accrued Payroll and Related	6,982,123.07
Accrued Interest and Sales Tax	420,742.88
Due to 3rd Party Payors	3,542,304.36
Due to Specific Purpose Funds	(25,097.72)
Other Deferred Credits - Pension	3,481,539.70
Total Current Liabilities	21,935,637.19
Long Term Liabilities	
Long Term Debt	39,253,947.15
Bond Premium	462,975.20
Accreted Interest	14,073,007.75
Other Non-Current Liability - Pension	32,705,323.00
Total Long Term Liabilities	86,495,253.10
Suspense Liabilities	(88,583.67)
Total Liabilities	108,342,306.62
Fund Balance	
Fund Balance	38,634,093.44
Temporarily Restricted	1,605,520.33
Net Income (Loss) in November	(300,292.80)
Total Fund Balance	39,939,320.97
Liabilities + Fund Balance	148,281,627.59

Northern Inyo Healthcare District
Balance Sheet
As of November 30, 2019

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Northern Inyo Healthcare District - Summary of Key Ratios & Debt Covenants

Unit of Measure	11/30/2019	10/31/2019	9/30/2019	8/31/2019	7/31/2019	6/30/2019
Cash, CDs & LAIF Investments:	$ 19,088,332	$ 21,751,578	$ 24,551,976	$ 24,237,671	$ 26,353,608	$ 27,264,480
Days Cash on Hand	81.63	93.02	105.00	103.65	112.70	116.60
Athena Gross Accounts Receivable	$ 51,533,089	$ 50,776,886	$ 48,766,032	$ 48,766,032	$ 44,505,205	$ 42,891,066
Average Daily Revenue	$ 437,962	$ 444,616	$ 430,894	$ 440,084	$ 432,425	$ 420,533
Gross Days in AR	117.67	114.20	113.17	110.81	102.92	101.99
Key Statistics						
Acute Census Days	203	203	211	191	240	2,803
Swing Bed Census Days	14	14	23	15	7	454
Observation Days	32	44	36	38	39	485
Total Inpatient Utilization	249	261	270	244	286	3,742
Average Daily Inpatient Census	8.02	8.43	8.71	7.87	9.23	10.25
Average Acute Daily Charge	$ 14,251.94	$ 13,682.15	$ 10,846.13	$ 10,281.36	$ 11,472.19	$ 10,982.78
Adjusted Daily Census (with OP)	36.75	40.88	35.91	41.27	41.54	38.29
Emergency Room Visits	726	767	641	868	889	9,153
Emergency Room Visits Per Day	24.2	24.7	21.4	28.0	28.7	25.1
Operating Room Inpatients	16	23	20	19	23	230
Operating Room Outpatient Cases	92	118	104	90	93	1,240
RHC Clinic Visits	2,423	2,377	2,439	2,377	2,675	29,446
NIA Clinic Visits	1,951	2,030	1,864	2,027	1,924	
Hospital Operations						**Fiscal 2019**
Inpatient Revenue	$ 3,092,670	$ 2,969,027	$ 2,537,994	$ 2,117,960	$ 2,833,630	$ 35,770,899
Outpatient Revenue	9,301,405	10,838,533	9,608,636	11,774,827	10,843,405	110,939,678
Clinic (RHC) Revenue	506,364	541,363	458,568	593,322	465,433	6,784,060
Total Revenue	$ 12,900,439	$ 14,348,923	$ 12,605,198	$ 14,486,109	$ 14,142,468	$ 153,494,636
Revenue Per Day	$ 430,015	$ 462,868	$ 420,173	$ 467,294	$ 456,209	$ 420,533
% Change (Month over Month)	-7.1%	10.2%	-10.1%	2.4%	1.8%	
Salaries	$ 2,496,760	$ 2,536,958	$ 2,422,139	$ 2,528,362	$ 2,476,554	$ 25,697,886
PTO Expenses	294,562	266,736	254,834	254,720	269,335	3,255,428
Total Salaries Expense	$ 2,791,322	$ 2,803,694	$ 2,676,974	$ 2,783,082	$ 2,745,889	$ 28,953,314
Expense Per Day	$ 93,044	$ 90,442	$ 89,232	$ 89,777	$ 88,577	$ 79,324
% Change	2.9%	1.4%	-0.6%	1.4%	2.8%	
Operating Expenses	$ 4,198,689	$ 4,370,650	$ 4,330,335	$ 3,930,250	$ 4,051,730	$ 49,294,043
Operating Expenses Per Day	$ 139,956	$ 140,989	$ 144,344	$ 126,782	$ 130,701	$ 135,052
Capital Expenses	$ 604,834	$ 589,185	$ 590,014	$ 589,257	$ 560,212	$ 7,103,119
Capital Expenses Per Day	$ 20,161	$ 19,006	$ 19,667	$ 19,008	$ 18,071	$ 19,461
Total Expenses	$ 7,594,845	$ 7,763,529	$ 7,597,323	$ 7,302,590	$ 7,357,830	$ 85,350,476
Total Expenses Per Day	$ 253,162	$ 250,436	$ 253,244	$ 235,567	$ 237,349	$ 233,837
Gross Margin	$ 53,621	$ 724,122	$ (522,456)	$ 435,083	$ 522,819	$ 1,772,471
Gross Margin Per Adjusted Day	$ 48.63	$ 571.43	$ (484.97)	$ 340.09	$ 406.01	$ 126.82
Debt Compliance						
Current Ratio (ca/cl) > 1.50	2.29	2.21	2.20	2.26	2.19	2.12
Quick Ratio (Cash & Net AR/cl) >1.33	1.78	1.76	1.87	1.96	1.93	1.87
Days Cash on Hand > 75	81.63	93.02	105.00	103.65	112.70	116.60
Debt Service Coverage > 1.5	1.37	1.54	1.38	2.18	2.19	1.54
Debt Service Coverage > 1.25 > 75 cash	1.37	1.54	1.38	2.18	2.19	1.54