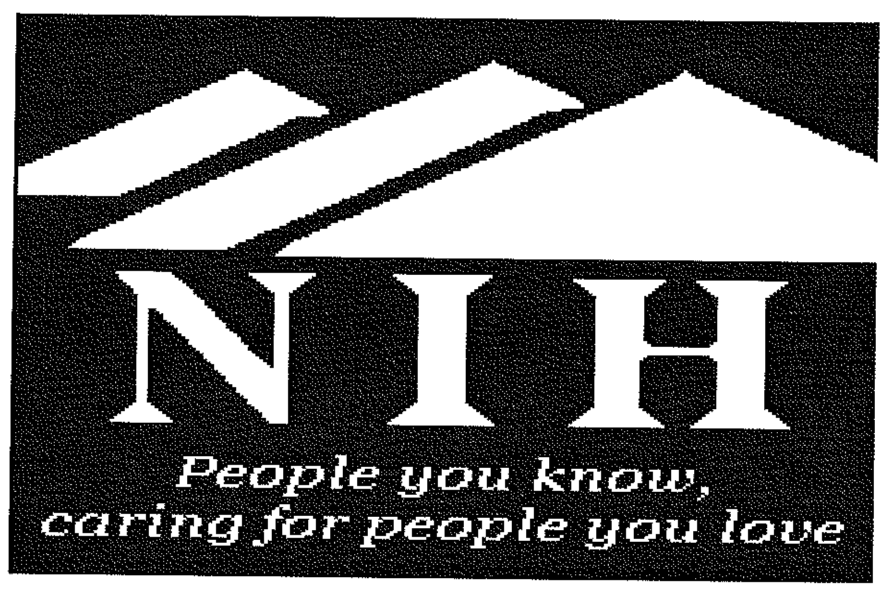

Northern Inyo County Local Hospital District

Board of Directors Regular Meeting

Wednesday May 19, 2010; 5:30pm

Board Room
Northern Inyo Hospital

DRAFT AGENDA

NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT
BOARD OF DIRECTORS MEETING

May 19, 2010 at 5:30 P.M.

In the Board Room at Northern Inyo Hospital

1. Call to Order (at 5:30 P.M.).
2. Opportunity for members of the public to comment on any items on this Agenda.
3. Approval of minutes of the April 21 2010 regular meeting.
4. Financial and Statistical Reports for the month of March 2010; John Halfen.
5. Administrator's Report; John Halfen.
   A. Building Update (cash flow)
   B. Security Report
   C. Ramadan Clinic certification
   D. S & P Global Credit Portal
   E. Other
6. Chief of Staff Report; Charlotte Helvie, M.D.
   A. Leave of Absence, D. McAuley FNP, CNM (*information item*).
   B. Policy and Procedure approvals (*action items*):
      1. *Warfarin Monitoring Protocol*
      2. *Annual Clinic Evaluation; RHC*
   C. Standardized Procedures (*action items*):
      1. *General Policy for Rural Health Clinic Nurse Practitioner*
      2. *Adult Health Maintenance*
      3. *Obstetric Care*
      4. *Pre-Employment Physical Exams*
      5. *Medical Screening Examination for the Obstetrical Patient Performed by Registered Nurse*
   D. Response to Joint Commission survey findings (*action items*):
      1. Policy/Procedure: *Credentialing Health Care Practitioners in the Event of a Disaster*
      2. Policy/Procedure: *Medical Staff Peer Review*
   E. Other
7. Old Business
   - None -
8. New Business

A. Beta Healthcare rates and dividends for liability insurance (*action item*).

B. Guest speaker: *The Importance of Net Income from Operations*, Jack Burroughs, ACHD.

C. Board Vacancy (*discussion item*).

D. Purchase of Omnicell-based bar code system, $40,725 (*action item*).

E. 2010 – 2011 Fiscal Year Budget (*action item*).

F. Policy and Procedure approval, Sending *Protected Health Information by Fax* (*action item*).

9. Reports from Board members on items of interest.
10. Opportunity for members of the public to comment on any items on this Agenda, and/or on any Items of interest.
11. Adjournment to closed session to:

A. Hear reports on the hospital quality assurance activities, and hear a report from the Medical Staff Executive Committee (Section 32155 of the Health and Safety Code, and Government Code Section 54962).

B. Confer with legal counsel regarding action filed by John Nesson M.D. against Northern Inyo County Local Hospital District and other Defendants (Government Code Section 54956.9(a)).

C. Confer with legal counsel regarding action filed by Stephen Johnson and Elizabeth Manahan-Johnson against Northern Inyo County Local Hospital District and other Defendants (Government Code Section 54956.9(a)).

12. Return to open session, and report of any action taken in closed session.
13. Opportunity for members of the public to address the Board of Directors on items of interest.
14. Adjournment.

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CALL TO ORDER — The meeting was called to order at 5:30 p.m. by John Ungersma M.D., Vice President.

PRESENT — John Ungersma M.D., Vice President
M.C. Hubbard, Secretary
Michael Phillips M.D., Treasurer
D. Scott Clark M.D., Director
Charlotte Helvie M.D., Chief of Staff

ALSO PRESENT — John Halfen, Administrator
Douglas Buchanan, Esq., Hospital District Legal Counsel
Sandy Blumberg, Administration Secretary

ABSENT — Peter Watercott, President

ALSO PRESENT FOR RELEVANT PORTION(S) — Dianne Shirley R.N., Performance Improvement Coordinator

PUBLIC COMMENTS ON AGENDA — Doctor Ungersma asked if any members of the public wished to address the Board on any items listed on the agenda for this meeting. No comments were heard.

MINUTES — The minutes of the March 17 2010 regular meeting were approved.

FINANCIAL AND STATISTICAL REPORTS — Mr. Halfen called attention to the financial and statistical reports for the month of February 2010. He noted the statement of operations shows a bottom line excess of expenses over revenues of $64,442. Mr. Halfen additionally called attention to the following:

- *Inpatient service revenue was under budget*
- *Outpatient service revenue was under budget*
- *Total expenses were under budget*
- *Salaries and wages and employee benefits expense were both under budget*
- *Professional fees expense was over budget*
- *The Balance Sheet showed no significant change*
- *Year-to-date net revenue totals $1,172,903*

Mr. Halfen noted cash and cash equivalents fluctuated during the month as a result of moving money in order to help fund the hospital rebuild project. He also reviewed the status of the hospital's investments which remain stable at this time, and noted accounts receivable currently average 62.5 days. Mr. Halfen additionally noted that revenue is down overall in comparison to last year, due in part to the state of the economy. He also noted cash flow is still adequate to provide funding needed for the hospital rebuild project. Following review of the reports provided it was moved by D. Scott Clark, M.D., seconded by M.C. Hubbard, and passed to approve the financial and statistical reports for the month of February

ADMINISTRATOR'S REPORT	as presented.
BUILDING UPDATE	Turner Construction project manager John Hawes reported structural steel work is progressing smoothly and Turner has been able to implement Office of Statewide Healthcare Planning and Development (OSHPD) changes with no disruption to the building project timeline. Workers will begin spreading deck next Monday and work on the central plant will also begin in the near future. Mr. Hawes also noted there will be a topping-out celebration in the next couple of weeks when the final piece of structural steel is set in place. Hospital employees, Board members, and the local media will be invited to attend the event.
SECURITY REPORT	Mr. Halfen called attention to the monthly Security report, which revealed no significant security issues.
BONDS UPDATE	Mr. Halfen reported the revenue bond issue has been sold at a 4.2 to 6.75 percent interest rate, depending on the length of ownership. The bonds were sold to a limited number of buyers, none of whom were local investors.
JOINT COMMISSION RESPONSE	Leo Freis, Compliance Officer and Administrative Support Services referred to results of the full survey by the Joint Commission that was conducted on February 17 and 18 2010. The survey revealed no significant deficiencies, and the Hospital was given 45 days to respond to problems noted and make necessary corrections. Mr. Freis reported the Hospital responded in a timely manner, and only a couple of life/safety issues still require attention. Mr. Freis also noted the survey and results were considered to be "routine", and as a result Northern Inyo Hospital (NIH) will receive Joint Commission accreditation for three more years.
INTERPRETER KUDOS	Mr. Halfen reported NIH's Language Services Director Jose Garcia has been named Interpreter of the Year by the California Healthcare Interpreter's Association (CHIA). The recognition is a significant honor awarded by the largest Healthcare Interpreter network in the state, and Mr. Halfen congratulated Mr. Garcia on receiving such well-deserved recognition.
GRANT WRITING & MARKETING DIRECTOR	Mr. Halfen introduced Angnette Aukee, the Hospital's new Grant Writing and Marketing Director to the District Board of Directors. Ms. Aukee was welcomed aboard by everyone present.
KITCHEN INSPECTION	Mr. Halfen also reported the Hospital's Dietary Department recently underwent yet another unannounced inspection, and once again it passed the inspection with flying colors.
CHIEF OF STAFF REPORT	Chief of Staff Charlotte Helvie, M.D. reported following careful review

CREDENTIALING

and consideration the Medical Staff Executive Committee recommends approval of the appointment of Tahoe Carson Radiologist David N. Landis M.D. to the NIH Provisional Consulting Medical Staff with requested privileges. It was moved by Doctor Clark, seconded by Ms. Hubbard, and passed to approve the appointment of Doctor Landis to the NIH Provisional Consulting Medical Staff as requested.

POLICIES AND PROCEEDURES

Doctor Helvie also reported the Medical Staff and appropriate committees recommend approval of the following hospital wide policies and procedures:

1. *Warfarin Monitoring Protocol*
2. *Warfarin Dosing*
3. *High Alert Medications: Preparation, Dispensing, Storage, Administration*

Pharmacy Director Jillene Freis R.Ph. stated that the Warfarin Monitoring Protocol policy and the High Alert Medications policy have gone back to the Medical Services Committee for additional review, therefore the Warfarin Dosing policy is the only policy ready for approval at this time. It was moved by Michael Phillips, M.D., seconded by Ms. Hubbard, and passed to approve the *Warfarin Dosing* policy as recommended.

INYO COUNTY CONFLICT OF INTEREST CODE

District Legal Counsel Douglas Buchanan reported the Districts' Conflict of Interest Code has been reviewed and is ready for final approval and submission to the County of Inyo. Following review of the updated Code it was moved by Ms. Hubbard, seconded by Doctor Clark, and passed to approve the Northern Inyo County Local Hospital District Conflict of Interest of Code as presented.

DISTRICT BYLAWS

Mr. Halfen referred to the revised Northern Inyo County District Bylaws which were presented for final review. It was noted a change may still be made to the section of the bylaws addressing cancellation of a regular meeting; however such a change may be made any time in the future after the subject has been fully researched by District Legal Counsel. It was moved by Ms. Hubbard, seconded by Doctor Clark, and passed to approve the revised Northern Inyo County Local Hospital District Bylaws as presented.

VSM & NIH AGREEMENT

Mr. Halfen called attention to a proposed agreement between VSM Medical Group and Northern Inyo Hospital which would facilitate Lara Jeanine Arndal, M.D. being employed by VMS in order to work as an employee at the NIH Women's and Family Clinic. Dr. Arndal plans to sign an employment agreement with VMS, then the Hospital will contract with VMS for her services. After review of the proposed agreement it was moved by Doctor Phillips, seconded by Ms. Hubbard, and passed to approve the agreement between Northern Inyo Hospital and VMS Medical Group as presented.

PMA OFFICE LEASE

Mr. Halfen also called attention to a proposed agreement to lease office space located at 152 Pioneer Lane, Suite C from Nickoline Hathaway M.D. and Asao Kamei, M.D.. The lease would allow NIH to have office space available in the event that a new physician is successfully recruited to this area. Following review of the proposed agreement it was moved by Doctor Phillips, seconded by Ms. Hubbard, and passed to approve the proposed office lease with Doctors Kamei and Hathaway as presented.

BIRCH STREET IMPROVEMENTS

NIH Property Manager Scott Hooker called attention to cost estimates for clean-up and improvements needed for the District's newly acquired property at 2957 Birch Street, Bishop California. The proposed work would facilitate bringing safety and security at the location up to standard, and would improve aesthetics of the property for the benefit of the neighborhood. Mr. Hooker reviewed the suggested improvements and following brief discussion it was moved by Doctor Clark, seconded by Ms. Hubbard, and passed to approve the Birch Street improvements as requested, for an approximate total cost of $118,000.

IT WIRING OF SURGERY AND PEDIATRIC CLINICS

Information Technology Department Manager Adam Taylor called attention to a proposed data wiring project for the Pioneer Medical Associates (PMA) building located at 152 Pioneer Lane, for a total cost of $34,624. The project would expand the electronic infra-structure of the building and connect the medical offices to the internet and to hospital applications. Mr. Taylor noted this is not a budgeted item; however the hospital now owns over 50 percent interest in the building and it has been determined the wiring improvements are prudent as well as in the best interest of the tenants and other owners of the building. It was moved by Ms. Hubbard, seconded by Doctor Phillips, and passed to approve the data wiring project for the PMA building as presented.

CONSTRUCTION CHANGE ORDERS

Kathy Sherry, Project Manager for Turner Construction Company called attention to the following proposed change orders for Phase II of the hospital rebuild project:

1. Change order #29; for miscellaneous structural clarification ($4,882.00)
2. Change order #30; beam relocation to coordinate with plumbing routing ($5,835.00)
3. Change order #31; adjustment to structural bracing at gridline 8 ($22,582)
4. Change order #32; additional cost related to differing site conditions encountered ($424,054.00)
5. Change order #33; cost savings returned to NIH by Turner Construction ($-313,479.00)

Ms. Sherry reviewed each correction needed and noted the overall financial impact on the total project budget would be a net increase of $143,874. Mr. Halfen reviewed the cash flow status for the project and stated at this time he does not anticipate he will have a problem funding

the rebuild. Following review of the project budget it was moved by Doctor Phillips, seconded by Ms. Hubbard, and passed to approve proposed construction change orders 29 through 33 as presented.

BOARD MEMBER REPORTS

Doctor Ungersma asked if any members of the Board of Directors wished to report on any items of interest. He then inquired as to the possibility of Northern Inyo Hospital operating a dialysis unit for area residents. Mr. Halfen responded that a dialysis center has been considered in the past however research revealed that the local population is too small to support such an endeavor. He noted, however that the hospital will conduct a needs assessment in the near future and can include the need for a dialysis unit in its inquiry into the needs of the general public.

OPPORTUNITY FOR PUBLIC COMMENT

In keeping with the Brown Act, Doctor Ungersma again asked if any members of the public wished to comment on any items listed on the agenda for this meeting, or on any items of interest. Director of Nursing Susan Batchelder commented when assessing the possibility of the Hospital operating a dialysis unit, one consideration is that there would significant difficulty providing qualified staff to operate such a center. No other public comments were heard.

CLOSED SESSION

At 6:41 p.m. Doctor Ungersma announced the meeting was being adjourned to closed session to allow the Board of Directors to:

A. Hear reports on the hospital quality assurance activities, and hear a report from the Medical Staff Executive Committee (Section 32155 of the Health and Safety Code, and Government Code Section 54962).
B. Confer with legal counsel regarding action filed by John Nesson M.D. against Northern Inyo County Local Hospital District and other Defendants (Government Code Section 54956.9(a)).
C. Confer with legal counsel regarding action filed by Stephen Johnson and Elizabeth Manahan-Johnson against Northern Inyo County Local Hospital District and other Defendants (Government Code Section 54956.9(a)).

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 7:19 p.m. the meeting returned to open session. Dr. Ungersma reported the Board took no reportable action.

OPPORTUNITY FOR PUBLIC COMMENT

Doctor Ungersma again asked if any members of the public wished to comment on any items listed on the agenda for this meeting, or on any items of interest. No comments were heard

ADJOURNMENT

The meeting was adjourned at 7:20 p.m.

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John Ungersma, M.D., Vice President

Attest: _______________________________
M.C. Hubbard, Secretary

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BUDGET VARIANCE ANALYSIS

Mar-10 PERIOD ENDING After Audit

In the month, NIH was

		-4%	under budget in IP days;
	(	0.05%)	over in IP Revenue and
	(	21.5%)	over in OP Revenue resulting in
$ 1,071,057	(	14.9%)	over in gross patient revenue from budget &
$ 1,001,587	(	23.4%)	over in net patient revenue from budget

Total Expenses were:

$ 504,568	(	12.1%)	over budget. Wages and Salaries were
$ 75,062	(	5.0%)	over budget and Employee Benefits
$ 147,389	(	16.1%)	ovder budget.
$ 10,284			of other income resulted in a net income of
$ 718,140		$ 447,301	over budget.

The following expense areas were over budget for the month:

$ 75,062	5%	Salaries and Wages
$ 147,389	16%	Employee Benefits
$ 116,530	34%	Professional Fees; registry staff & Physicians
$ 111,369	22%	Supplies
$ 1,925	2%	Interest Expense
$ 9,502	7%	Bad Debt

Other Information:

37.68%	Contractual Percentages for month
41.53%	Contractual Percentages for Year

$ 1,891,044 Year-to-date Net Revenue

Special Notes:

Radiology Professional Fee Revenue and Expense were not budgeted.
We received $566,559 from Medicare as Final Audit Settlement for FY 2007.

NORTHERN INYO HOSPITAL

Balance Sheet

March 31, 2010

	Current Month	*Prior Month*	*FYE 2009*
Current assets:			
Cash and cash equivalents	2,714,167	3,095,776	881,651
Short-term investments	16,328,704	25,962,020	29,519,296
Assets limited as to use	2,119,958	1,103,855	738,740
Plant Expansion and Replacement Cash	2,099,852	2,099,830	10,439,607
Other Investments (Partnership)	961,824	961,824	961,824
Patient receivable, less allowance for doubtful accounts $623,674	8,514,228	8,809,920	7,591,694
Other receivables (Includes GE Financing Funds)	1,123,996	1,057,835	867,584
Inventories	2,482,251	2,492,955	2,456,265
Prepaid expenses	1,221,105	1,242,714	1,057,280
Total current assets	37,566,085	46,826,730	54,513,940
Assets limited as to use:			
Internally designated for capital acquisitions	658,341	658,309	657,814
Specific purpose assets	803,612	803,522	564,033
	1,461,953	1,461,832	1,221,847
Revenue bond construction funds held by trustee	845,373	797,897	788,610
Less amounts required to meet current obligations	2,119,958	1,103,855	738,740
Net Assets limited as to use:	187,368	1,155,873	1,271,716
Long-term investments	11,751,227	1,595,933	100,000
Property and equipment, net of accumulated depreciation and amortization	44,376,390	43,565,364	35,316,271
Unamortized bond costs	664,425	667,041	687,964
Total assets	94,545,495	93,810,941	91,889,892

NORTHERN INYO HOSPITAL

Balance Sheet

March 31, 2010

Liabilities and net assets	*Current Month*	*Prior Month*	*FYE 2009*
Current liabilities:			
Current maturities of long-term debt	183,547	244,159	1,103,540
Accounts payable	1,671,469	1,680,737	1,523,288
Accrued salaries, wages and benefits	3,343,960	3,326,110	2,807,675
Accrued interest and sales tax	599,298	482,923	247,663
Deferred income	180,124	223,835	48,991
Due to third-party payors	2,678,771	2,678,771	2,940,964
Due to specific purpose funds	-	-	-
Total current liabilities	8,657,169	8,636,535	8,672,120
Long-term debt, less current maturities	38,609,004	38,609,004	38,624,386
Bond Premium	1,442,503	1,446,846	1,481,587
Total long-term debt	40,051,507	40,055,849	40,105,973
Net assets:			
Unrestricted	45,033,207	44,315,035	42,547,767
Temporarily restricted	803,612	803,522	564,033
Total net assets	45,836,819	45,118,557	43,111,799
Total liabilities and net assets	94,545,495	93,810,941	91,889,892

NORTHERN INYO HOSPITAL

Statement of Operations

As of March 31, 2010

	MTD Actual	MTD Budget	MTD Variance $	MTD Variance %	YTD Actual	YTD Budget	YTD Variance $	YTD Variance %	Prior YTD
Unrestricted revenues, gains and other support:									
In-patient service revenue:									
Routine	566,967	658,279	(91,312)	(13.9)	5,253,308	5,924,461	(671,153)	(11.3)	5,532,299
Ancillary	2,330,943	2,114,544	216,399	10.2	17,851,316	19,030,634	(1,179,318)	(6.2)	17,517,987
Total in-patient service revenue	2,897,910	2,772,823	125,087	0.05	23,104,624	24,955,095	(1,850,471)	-7.4%	23,050,285
Out-patient service revenue	5,340,814	4,394,844	945,970	21.5	43,788,803	39,553,232	4,235,571	10.7	36,992,786
Gross patient service revenue	8,238,724	7,167,667	1,071,057	14.90	66,893,428	64,508,327	2,385,101	3.7	60,043,072
Less deductions from patient service revenue:									
Patient service revenue adjustments	170,885	233,198	62,313	26.7	1,154,954	2,098,784	943,830	45.0	1,953,944
Contractual adjustments	3,345,273	2,688,599	(656,674)	(24.4)	26,307,942	24,197,366	(2,110,576)	(8.7)	22,942,055
Prior Period Adjustments	(566,559)	(41,667)	524,892	100.0	(1,424,751)	(375,000)	1,049,751	100.0	(1,635,215)
Total deductions from patient service revenue	2,949,600	2,880,130	(69,470)	(2.4)	26,038,145	25,921,150	(116,995)	(0.5)	23,260,784
Net patient service revenue	5,289,124	4,287,537	1,001,587	23%	40,855,282	38,587,177	2,268,105	6%	36,782,288
Other revenue	38,981	40,120	(1,139)	(2.8)	267,272	361,055	(93,783)	(26.0)	341,848
Transfers from Restricted Funds for Other Operating Expenses	64,666	64,666	-	-	581,994	581,992	2	0.0	589,869
Total Other revenue	103,647	104,786	(1,139)	(1.1)	849,266	943,047	(93,781)	(9.9)	931,717
Total revenue, gains and other support	5,392,771	4,392,323	1,000,448	(0.9)	41,704,548	39,530,224	2,174,324	(9.8)	37,714,005
Expenses:									
Salaries and wages	1,581,463	1,506,401	(75,062)	(5.0)	13,515,046	13,557,529	42,483	0.3	12,546,574
Employee benefits	1,065,727	918,338	(147,389)	(16.1)	9,045,006	8,264,944	(780,062)	(9.4)	7,584,007
Professional fees	455,761	339,231	(116,530)	(34.4)	3,996,452	3,053,053	(943,399)	(30.9)	3,193,909
Supplies	618,465	507,096	(111,369)	(22.0)	4,628,926	4,563,838	(65,088)	(1.4)	4,354,323
Purchased services	316,647	223,261	(93,386)	(41.8)	2,331,513	2,009,298	(322,215)	(16.0)	1,823,965
Depreciation	230,504	230,399	(105)	(0.1)	2,017,618	2,073,584	55,966	2.7	1,951,370
Interest	107,583	105,658	(1,925)	(1.8)	973,847	950,923	(22,924)	(2.4)	987,492
Bad debts	155,009	145,507	(9,502)	(6.5)	1,745,957	1,309,561	(436,396)	(33.3)	1,179,984
Other	153,754	204,455	50,701	24.8	1,765,519	1,840,048	74,529	4.1	1,797,386
Total expenses	4,684,914	4,180,346	(504,568)	(12.1)	40,019,883	37,622,778	(2,397,105)	(6.4)	35,419,010
Operating income (loss)	707,857	211,977	495,880	11.2	1,684,666	1,907,446	(222,780)	(3.4)	2,294,995
Other income:									
District tax receipts	43,711	47,650	(3,939)	(8.3)	393,400	428,850	(35,450)	(8.3)	428,850
Interest	21,060	43,338	(22,278)	(51.4)	114,249	390,045	(275,796)	(70.7)	745,337
Other	7,065	-	7,065	N/A	46,181	-	46,181	N/A	37,791
Grants and Other Non-Restricted Contributions	-	1,224	(1,224)	(100.0)	36,963	11,012	25,951	235.7	17,331
Partnership Investment Income	-	-	-	N/A	-	-	-	-	-
Net Medical Office Activity	(61,553)	(33,350)	(28,203)	(82.5)	(384,415)	(300,136)	(84,279)	(28.1)	(418)
Total other income, net	10,284	58,862	(48,578)	(83)	206,378	529,771	(323,393)	(61.0)	1,228,891
Excess (deficiency) of revenues over expenses	718,140	270,839	447,301	165	1,891,044	2,437,217	(546,173)	(22)	3,523,886

NORTHERN INYO HOSPITAL
Statement of Operations--Statistics
As of March 31, 2010

	Month Actual	Month Budget	Month Variance	Variance Percentage	YTD Actual	YTD Budget	Year Variance	Year Percentage
Operating statistics:								
Beds	25	25	N/A	N/A	25	25	N/A	N/A
Patient days	254	265	(11)	0.96	2,294	2,382	(88)	0.96
Maximum days per bed capacity	775	775	N/A	N/A	6,850	6,850	N/A	N/A
Percentage of occupancy	32.77	34.19	(1.42)	0.96	33.49	34.77	(1.28)	0.96
Average daily census	8.19	8.55	(0.35)	0.96	8.37	8.69	(0.32)	0.96
Average length of stay	2.70	3.01	(0.31)	0.90	3.08	3.01	0.07	1.02
Discharges	94	88	6	1.07	746	792	(46)	1
Admissions	98	88	10	1.11	751	787	(36)	1
Gross profit-revenue depts.	5,561,010	4,741,540	819,470	1.17	43,977,770	42,673,361	1,304,409	1.03
Percent to gross patient service revenue:								
Deductions from patient service revenue and bad debts	37.68	42.21	(4.53)	0.89	41.53	42.21	(0.68)	0.98
Salaries and employee benefits	31.88	33.81	(1.93)	0.94	33.46	33.81	(0.35)	0.99
Occupancy expenses	4.14	5.10	(0.96)	0.81	4.87	5.10	(0.23)	0.95
General service departments	5.77	5.90	(0.13)	0.98	5.82	5.90	(0.08)	0.99
Fiscal services department	5.39	5.13	0.26	1.05	5.05	5.13	(0.08)	0.98
Administrative departments	4.86	5.23	(0.37)	0.93	4.97	5.23	(0.26)	0.95
Operating income (loss)	7.23	1.41	5.82	5.13	0.99	1.41	(0.42)	0.70
Excess (deficiency) of revenues over expenses	8.72	3.78	4.94	2.31	2.83	3.78	(0.95)	0.75
Payroll statistics:								
Average hourly rate (salaries and benefits)	46.01	44.47	1.53	1.03	43.71	44.47	(0.76)	0.98
Worked hours	50,933.52	46,846.00	4,087.52	1.09	437,509.65	421,555.00	15,954.65	1.04
Paid hours	57,088.52	54,496.00	2,592.52	1.05	511,954.63	490,464.00	21,490.63	1.04
Full time equivalents (worked)	289.40	270.79	18.61	1.07	280.45	270.23	10.23	1.04
Full time equivalents (paid)	324.37	315.01	9.36	1.03	328.18	314.40	13.78	1.04

NORTHERN INYO HOSPITAL

Statements of Changes in Net Assets

As of March 31, 2010

	Month-to-date	Year-to-date
Unrestricted net assets:		
Excess (deficiency) of revenues over expenses	718,140.32	1,891,043.57
Net Assets due/to transferred from unrestricted	-	-
Interest posted twice to Bond & Interest	-	(47.40)
Net assets released from restrictions used for operations	-	593,870.00
Net assets released from restrictions used for payment of long-term debt	(64,666.00)	(581,994.00)
Contributions and interest income	32.18	527.24
Increase in unrestricted net assets	653,506.50	1,903,399.41
Temporarily restricted net assets:		
District tax allocation	-	817,828.71
Net assets released from restrictions	-	(593,870.00)
Restricted contributions	-	15,450.00
Interest income	89.44	217.94
Net Assets for Long-Term Debt due from County	64,666.00	581,994.00
Increase (decrease) in temporarily restricted net assets	64,755.44	821,620.65
Increase (decrease) in net assets	718,261.94	2,725,020.06
Net assets, beginning of period	45,118,557.24	43,111,799.12
Net assets, end of period	45,836,819.18	45,836,819.18

NORTHERN INYO HOSPITAL

Statements of Cash Flows

As of March 31, 2010

	Month-to-date	Year-to-date
Cash flows from operating activities:		
Increase (decrease) in net assets	718,261.94	2,725,020.06
Adjustments to reconcile excess of revenues over expenses to net cash provided by operating activities: (correcting fund deposit)		47.40
Depreciation	230,503.91	2,017,617.64
Provision for bad debts	155,009.02	1,745,956.87
Loss (gain) on disposal of equipment	(8,729.87)	(4,592.31)
(Increase) decrease in:		
Patient and other receivables	74,522.61	(2,924,903.67)
Other current assets	32,313.17	(189,811.57)
Plant Expansion and Replacement Cash	(21.97)	8,339,755.17
Increase (decrease) in:		
Accounts payable and accrued expenses	81,245.90	1,167,234.94
Third-party payors	-	(262,192.45)
Net cash provided (used) by operating activities	1,283,104.71	12,614,132.08
Cash flows from investing activities:		
Purchase of property and equipment	(1,050,259.71)	(11,086,466.98)
Purchase of investments	(521,977.68)	1,539,365.80
Proceeds from disposal of equipment	8,729.87	4,592.31
Net cash provided (used) in investing activities	(1,563,507.52)	(9,542,508.87)
Cash flows from financing activities:		
Long-term debt	(64,954.11)	(974,459.25)
Issuance of revenue bonds	(47,475.83)	(56,763.10)
Unamortized bond costs	2,615.43	23,538.87
Increase (decrease) in donor-restricted funds, net	(121.62)	(240,153.89)
Net cash provided by (used in) financing activities	(109,936.13)	(1,247,837.37)
Increase (decrease) in cash and cash equivalents	(390,338.94)	1,823,785.84
Cash and cash equivalents, beginning of period	3,095,776.19	881,651.41
Cash and cash equivalents, end of period	2,705,437.25	2,705,437.25

Investments as of March 31, 2010

Institution	Certificate ID	Purchase Dt	Maturity Dt	Principal	YTM	Broker
LAIF (Walker Fund)	20-14-002	02-Mar-10	01-Apr-10	$317,487	0.58%	Northern Inyo Hospital
Union Bank-Money Market	2740028807	31-Mar-10	01-Apr-10	$15,106,121	0.08%	Union Bank
Greater Bay Bancorp Sr Note	391648AT9	11-Dec-08	15-Apr-10	$101,688	3.82%	Multi-Bank Service
Bank of Waukegan	065563AR9	22-Apr-05	22-Apr-10	$99,000	4.75%	Financial Northeaster Corp.
Toyota Motor Credit Corp Note	829233PV60	11-Dec-08	28-Apr-10	$200,164	2.79%	Multi-Bank Service
American General Finance Corp Note	02635PSV6	24-Apr-08	15-May-10	$503,905	4.47%	Multi-Bank Service
Total Short Term Investments				**$16,328,365**		
Federal Home Loan Mtg Corp-MBS	313397L82	10-Nov-09	25-Oct-10	$3,988,333	0.31%	Multi-Bank Service
United States Treasure Note-FNC	912828JS0	10-Nov-09	30-Nov-10	$4,038,750	0.33%	Financial Northeaster Corp.
Worlds Foremost Bank (FNC CD)	5X42688	18-Dec-08	18-Dec-10	$100,000	4.40%	Financial Northeaster Corp.
Santander Financial Issuances LTD	802813AE5	01-Mar-10	15-Feb-11	$1,049,310	1.17%	Multi-Bank Service
National Rural Utilites Corp Bond-FNC	63743FLH7	13-Aug-09	15-Aug-11	$250,000	2.35%	Financial Northeaster Corp.
Union National Bank & Trust CO-FNC	5L27278	19-Oct-09	19-Oct-11	$250,000	2.00%	Financial Northeaster Corp.
Credit Suisse 1st	22541LAB9	02-Feb-10	15-Nov-11	$541,865	1.36%	Multi-Bank Service
HSBC Financial Corp	40429XWB8	15-Sep-09	15-Sep-12	$250,000	3.85%	Financial Northeaster Corp.
Citigroup Inc	125581FT0	10-Dec-09	01-May-13	$46,122	7.00%	Multi-Bank Service
Citigroup Inc	125588FU7	10-Dec-09	01-May-14	$66,903	7.00%	Multi-Bank Service
United States Treasure Note-FNC	912828LK4	31-Aug-09	31-Aug-14	$995,933	2.46%	Financial Northeaster Corp.
Citigroup Inc	125588FV5	10-Dec-09	01-May-15	$66,181	7.00%	Multi-Bank Service
Citigroup Inc	125581FW3	10-Dec-09	01-May-16	$107,830	7.00%	Multi-Bank Service
Total Long Term Investments				**$11,751,227**		
Grand Total Investments				**$28,079,592**		

Financial Indicators

	Target	Mar-10	Feb-10	Jan-10	Dec-10	Nov-09	Oct-09	Sep-09	Aug-09	Jul-09	Jun-09	May-09	Apr-09
Current Ratio	>1.5-2.0	4.34	5.42	5.65	6.01	5.99	6.10	5.81	6.05	6.39	6.29	6.56	7.53
Quick Ratio	>1.33-1.5	3.78	4.87	5.09	5.45	5.41	5.53	5.27	5.51	5.85	5.78	6.04	6.96
Days Cash on Hand	>75	217.46	322.93	293.20	315.81	306.58	307.60	364.93	344.81	349.84	388.66	289.03	337.98

NORTHERN INYO HOSPITAL
STATISTICS

3 MONTHS 2010	SURGERIES IP 08 / 09 / 10	SURGERIES OP 08 / 09 / 10	SURGERIES TOTAL 08 / 09 / 10	BIRTHS 08 / 09 / 10	ER ADMITS 08 / 09 / 10	ER VISITS 08 / 09 / 10	OP REFERRALS 08 / 09 / 10	ADMITS (W/NB) 08 / 09 / 10	PT DAYS (W/O NB) 08 / 09 / 10	PT DAYS (W/NB) 08 / 09 / 10	DISCH (W/NB) 08 / 09 / 10
JANUARY	33 / 46 / 26	106 / 109 / 95	139 / 155 / 121	16 / 25 / 18	48 / 48 / 47	573 / 594 / 604	3237 / 3241 / 3157	107 / 141 / 99	329 / 359 / 304	364 / 406 / 337	96 / 142 / 99
FEBRUARY	17 / 26 / 16	81 / 97 / 82	98 / 123 / 97	14 / 15 / 13	39 / 33 / 25	545 / 494 / 487	3165 / 2988 / 3066	86 / 96 / 81	241 / 245 / 209	274 / 278 / 235	96 / 100 / 83
MARCH	32 / 24 / 42	82 / 116 / 104	114 / 140 / 146	13 / 22 / 21	43 / 38 / 47	506 / 542 / 663	3285 / 3579 / 3504	108 / 124 / 120	318 / 296 / 254	349 / 338 / 301	102 / 127 / 115
APRIL	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
MAY	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
JUNE	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
JULY	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
AUGUST	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
SEPTEMBER	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
OCTOBER	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
NOVEMBER	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
DECEMBER	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
CALENDAR YEAR	82 / 96 / 83	269 / 322 / 281	351 / 418 / 364	43 / 62 / 52	130 / 119 / 119	1624 / 1630 / 1754	9687 / 9808 / 9727	301 / 361 / 300	888 / 900 / 767	987 / 1022 / 873	294 / 369 / 297
MONTHLY AVERAGE	27 / 32 / 28	90 / 107 / 94	117 / 139 / 121	14 / 21 / 17	43 / 40 / 40	541 / 543 / 585	3,229 / 3,269 / 3,242	100 / 120 / 100	296 / 300 / 256	329 / 341 / 291	98 / 123 / 99

NORTHERN INYO HOSPITAL
DEPARTMENTAL NON-EMERGENCY OUTPATIENT VISITS

3 MONTHS 2010	DIAGNOSTIC RADIOLOGY 08 / 09 / 10	MAMMOGRAPHY 08 / 09 / 10	NUCLEAR MEDICINE 08 / 09 / 10	ULTRASOUND 08 / 09 / 10	CT SCANNING 08 / 09 / 10	MRI 08 / 09 / 10	LABORATORY 08 / 09 / 10	E K G / E E G 08 / 09 / 10	PHYSICAL THERAPY 08 / 09 / 10	RESPIRATORY THERAPY 08 / 09 / 10	RURAL HEALTH CLINIC 08 / 09 / 10	TOTALS 08 / 09 / 10
JANUARY	544 / 606 / 622	193 / 434 / 330	71 / 96 / 77	205 / 206 / 198	170 / 165 / 167	89 / 470 / 658	1809 / 1635 / 1619	103 / 120 / 96	335 / 363 / 352	10 / 10 / 17	1057 / 1457 / 1220	4586 / 5562 / 5356
FEBRUARY	593 / 477 / 542	193 / 182 / 313	63 / 51 / 51	205 / 195 / 201	217 / 153 / 147	85 / 435 / 456	1744 / 1643 / 1522	113 / 116 / 114	364 / 314 / 376	11 / 10 / 15	1150 / 1374 / 1254	4738 / 4950 / 4991
MARCH	529 / 581 / 567	311 / 261 / 321	133 / 1 / 99	223 / 201 / 206	233 / 152 / 170	403 / 472 / 440	1774 / 1904 / 1795	149 / 121 / 117	346 / 428 / 449	12 / 13 / 9	1211 / 1477 / 1404	5324 / 5611 / 5577
APRIL	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
MAY	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
JUNE	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
JULY	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
AUGUST	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
SEPTEMBER	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
OCTOBER	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
NOVEMBER	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
DECEMBER	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /	/ /
CALENDAR YEAR	1666 / 1664 / 1731	697 / 877 / 964	267 / 148 / 227	633 / 602 / 605	620 / 470 / 484	577 / 1377 / 1554	5327 / 5182 / 4936	365 / 357 / 327	1045 / 1105 / 1177	33 / 33 / 41	3418 / 4308 / 3878	14648 / 16123 / 15924
MONTHLY AVERAGES	555 / 555 / 577	232 / 292 / 321	89 / 49 / 76	211 / 201 / 202	207 / 157 / 161	192 / 459 / 518	1776 / 1727 / 1645	122 / 119 / 109	348 / 368 / 392	11 / 11 / 14	1139 / 1436 / 1293	4883 / 5374 / 5308

*Radiology has changed their methodology for capturing statistics and feel these are more accurate. They are much higher than previously reported.

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2010
As of MARCH 31, 2010

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES	AMOUNT
FY 2008-09	Coagulation Analyzer	25,000
	Zeiss Opthalmic Argon Laser	42,642 *
	AMOUNT APPROVED BY THE BOARD IN PRIOR FISCAL YEARS TO BE EXPENDED IN THE CURRENT FISCAL YEAR	67,642
FY 2009-10	STAT Centrifuge	3,441 *
	QuickThaw Plasma Thawing System	5,736 *
	Blood Gas Analyzer	16,028 *
	Shredding Machine	32,178 *
	CommVault IT Data Backup	75,031
	Zumasys NetApp IT Data Storage	67,005 *
	CDW-G IT Network Switches	74,382
	Platelet Function Analyzer	9,000
	Birch Street Property	706,815 *
	Birch Street Probably Cleanup and Improvements	117,000
	PMA-IT Server Room Wiring Project	34,625
	AMOUNT APPROVED BY THE BOARD IN THE CURRENT FISCAL YEAR TO BE EXPENDED IN THE CURRENT FISCAL YEAR	1,141,241
	Amount Approved by the Board in Prior Fiscal Years to be Expended in the Current Fiscal Year	67,642
	Amount Approved by the Board in the Current Fiscal Year to be Expended in the Current Fiscal Year	1,141,241
	Year-to-Date Board-Approved Amount to be Expended	335,038
	Year-to-Date Administrator-Approved Amount	211,858 *
	Actually Expended in Current Fiscal Year	873,844 *

Northern Inyo Hospital
Monthly Report of Capital Expenditures
Fiscal Year Ending JUNE 30, 2010
As of MARCH 31, 2010

MONTH APPROVED BY BOARD	DESCRIPTION OF APPROVED CAPITAL EXPENDITURES	AMOUNT
	Year-to-Date Completed Building Project Expenditures	0 *
	TOTAL FUNDS APPROVED TO BE EXPENDED	1,420,740
	Total-to-Date Spent on Incomplete Board Approved Expenditures	130,644

Reconciling Totals:

Actually Capitalized in the Current Fiscal Year Total-to-Date	1,085,702
Plus: Lease Payments from a Previous Period	0
Less: Lease Payments Due in the Future	0
Less: Funds Expended in a Previous Period	0
Plus: Other Approved Expenditures	335,038
ACTUAL FUNDS APPROVED IN THE CURRENT FISCAL YEAR TOTAL-TO-DATE	1,420,740

Donations by Auxiliary	0
Donations by Hospice of the Owens Valley	0
+Tobacco Funds Used for Purchase	0
	0
	0

*Completed Purchase
(Note: The budgeted amount for capital expenditures for all priority requests for the fiscal year ending June 30, 2010, is $1,800,000 coming from existing hospital funds.)

**Completed in prior fiscal year

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NORTHERN INYO HOSPITAL

SECURITY REPORT

03/24/10 THRU 04/24/10

FACILITY SECURITY

Access security during this period revealed six occasions of open or unsecured exterior doors being located during those hours when doors were to be secured. Five interior doors were located during this same period.

Pioneer Medical Building was found unsecured on thirteen occasions.

On April 2nd the lights in the main parking lot failed to illuminate at darkness. A tripped breaker was located and Maintenance Personnel responded to the Hospital. Temporary lighting was set-up. It was later determined that construction activity in the main lot earlier in the day damaged an electrical line.

On April 5th an alarm was activated in the IT Offices. The area was checked and no problems were found. The alarm was reset without further problems.

On April 14th a broken sprinkler system was located near Radiology. An outside area flooded and Maintenance Staff was notified.

On April 21st a motion detector alarm was activated in the Rural Health Clinic. The building was found secure and the interior checked secure as well. The alarm was reset without further problems.

HUMAN SECURITY

On April 3rd an extremely intoxicated subject entered the Hospital looking for a family member. A phone call was made and the family member picked up the subject a provided him a ride home.

On April 5th a formal meeting was held with Mr. Charles Santa at his request. Present were Mr. Santa, Hospital Advocate, Lucy Alarid and Security Staff, Steve Day. Mr. Santa had many questions and comments, however ultimately he was again advised of his obligation to comply with the rules as set forth by the Hospital with regard to his conduct. Essentially, although he is welcome at the Hospital for legitimate medical needs, his span of freedom is limited to those areas directly adjacent to his wife if she is being treated. He access to the cafeteria is prohibited unless accompanied by his wife and coffee is his only drink of choice and in cups as provided by the Hospital. He has been in on at least two occasions since that meeting and no problems were reported.

On April 7th an Emergency Department patient became agitated and moderately disruptive. The patient was counseled by Security Staff and calmed down.

On April 9th an Emergency Department patient became loud and disruptive. Security Staff was called and stood by during treatment without any further outbursts.

On April 11th a slightly, intoxicated, subject presented in the Emergency Department for treatment. This subject was moderately uncooperative and Security Staff stood by during treatment. The subject was treated and discharged.

On April 14th and intoxicated, individual was treated in the Emergency Department. During treatment the subject decided he was going to leave after being advised he needed to be admitted. The patient was given the option of staying or going to jail. He chose the former.

Law Enforcement assistance was provided eight times during this period. Five cases were for Lab BAC's.

Two cases of suspected 5150 condition were monitored by Security Staff during this period.

Security Staff provided patient assistance on thirty-five occasions during this period.

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04/24/10

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NORTHERN INYO HOSPITAL

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March 23, 2010

Credit FAQ:

The Credit Impact Of Health Care Reform Will Take Hold Slowly

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Table Of Contents

Frequently Asked Questions

Credit FAQ:

The Credit Impact Of Health Care Reform Will Take Hold Slowly

The U.S. appears set to enter a new era with the passage of major health care reform—the Patient Protection and Affordable Care Act—which President Barack Obama signed into law today. The book hasn't closed on this controversial law yet; it will almost certainly face amendments in the short term, and some of its chief provisions, such as mandatory insurance purchases, will likely come under fire in the courts. Also, it will be months, or even years, before many of the law's chief provisions take effect.

Yet, the fact remains that the passage of this law is a landmark: The U.S. has the potential to achieve near-universal health care coverage for its citizens for the first time.

The addition of millions of new insured people to the health care system will have a direct effect on hospitals, drug companies, and medical device makers. It will also have repercussions for state and local governments and the national economy. As the law evolves, the ripple effects might change. But in the immediate aftermath of today's signing, Standard & Poor's Ratings Services is answering some questions about the new law.

Frequently Asked Questions

Will the new law help cut medical costs or the rate of growth in medical costs?

We suspect that in some instances, medical costs might rise in the short term but level off later after some of the law's key initiatives take full effect. More people with health insurance, for example, means more people with access to preventive and primary care. Insuring them will be expensive, but the payoff could come years later if we see the population's health improve and there are far fewer visits to expensive hospital emergency rooms instead of primary care physicians.

The law also ushers in a period of active pilot projects that could cut costs, such as by bundling payments for patient care into a single bill to cut down costs rather than paying several providers. That builds on the work many hospitals have already begun to standardize and computerize patient records—another initiative that will cut down on medical errors, improve productivity, and reduce costs. The law also creates an independent Medicare board to make recommendations to help curb spending if the law's current measures prove insufficient.

We believe that, however imperfect, the new law will at least let the country begin to get a handle on medical cost inflation. The Congressional Budget Office predicts that reform will shave $130 billion off the federal deficit in the first 10 years and $1.2 trillion in the following decade, while reducing Medicare growth by 1.4% annually, thus extending the solvency of Medicare funding. Although we believe that this forecast might prove overly optimistic, the cost of health care in its present form is rising at a rate we believe is unsustainable for the U.S. economy. Perhaps the new law will prompt lawmakers into taking further action to control medical cost inflation.

What are Standard & Poor's long-term expectations for the rollout of the legislation for health insurers?

We believe that health care reform will result in federal and state programs that continue to work in concert with the private sector. The migration from legislative status to law should, at the very least, enable health insurers to be in a better position to plan strategically and develop the necessary relationships with the providers of medical goods

and services to stay viable, or, in some circumstances, to pursue an exit strategy from some lines of business, either in whole or in part. That could ultimately lead to a pickup in mergers and acquisitions or joint ventures to gain scale, operational capability, and competency.

We also expect that the development of specific rules and regulations to implement the new law's provisions will play an important role in how insurers are affected. The health insurance sector will essentially be dealing with a four-year, back-end-weighted phase-in period (full implementation is scheduled for 2014), which could create some interim difficulties for insurers as they seek to reposition themselves for a reshaped market in the midst of a weak, slow-growing economy.

Although the roll-out is not expected to destabilize the existing operational infrastructure of the marketplace, the emerging new partnerships between the government and private health insurers will likely introduce some longer-term risks. Increasing budgetary pressures and economic imbalances at the federal, state, and local levels could crimp financing for public/private programs, including well-functioning state-based exchange systems. Our credit concern is that these conditions could dim health insurers' earnings prospects and compress margins, potentially weakening cash-flow strength and debt-servicing capacity. The expansion of government-sponsored insurance could also make underwriting standards, rate structure, and provider contracting more subject to the political process, which could constitute material risks that would be factored into our ratings.

How does Standard & Poor's factor the reform law into its health insurance sector outlook?

We cited health reform legislation as a factor when we updated and sustained our negative outlook for the health insurance sector in January 2010. Although we continue to believe that there is potential for moderate credit-quality erosion over the long term, we're not expecting the new law, in and of itself, to drive rating actions in 2010. The primary credit factors continue to be the sluggish economic development (as it relates to the level of payroll employment in the commercial sector) and weakened operating performance overall.

What are some of the key near-term considerations that could affect health insurers?

Two big downside concerns for us are the inclusion of minimum medical benefit ratios (the share of revenue spent on medical expenses) and the movement toward a new payment structure for Medicare Advantage. The marketplace, we believe, will begin to feel these changes in 2011.

The reform mandates that insurers writing individual and small-group policies must spend 80% of their revenues on medical costs, while insurers covering large groups must spend 85%. Based on our initial assessment, margins for a cross-section of companies—primarily for-profit, diversified health insurers—could erode moderately. But for us to fully assess the risk, we'll need to see exactly how rules and regulations to be developed in 2010 will lay out how information pertaining to these calculations will be reported (i.e., by operating company, by state, on a consolidated basis, or by some other method) and by which accounting method, such as GAAP (generally accepted accounting principles, SAP (statutory accounting principles), or another approach.

We believe that Medicare Advantage rates will likely be the same in 2011 as in 2010, as the government begins changing the payment structure. We believe the revised funding scheme is likely to result in lower margins in this segment and moderately lower penetration levels for health insurers over the next one to three years. We expect payment benchmarks to vary from 95% of Medicare spending in high-cost areas to 115% of Medicare spending in low-cost areas. Health insurers controlled about 23% of the Medicare market in 2009 after a rather strong three-year expansion.

What are the implications of health insurance reform for drug company revenues?

Over the next few years, major patent expirations on high-priced branded prescription pharmaceuticals could shrink revenues for some drug companies. Accordingly, health insurance reform could provide some welcome support, with provisions that close the gap in Medicare coverage for drug expenditures between $2,700 and $6,154, commonly referred to as the "donut hole."

This might be reminiscent of the boost in drug spending following the 2006 implementation of Medicare prescription pharmaceutical coverage for the elderly (Part D). However, the closing of the donut hole should be much more gradual, with a rather limited $250 rebate for Part D enrollees entering the gap in 2010. Thereafter, a 50% discount on all name-brand drugs in the donut hole becomes effective, with additional discounts to close the hole completely. However, that's not likely to occur for 10 years.

Although the additional 32 million beneficiaries could also help raise revenues, the full potential of the opportunity might take some time to realize. First of all, the mandatory purchase of health insurance, which we believe will spur private insurance enrollment, won't kick in until 2014. Although lower out-of-pocket costs for the newly insured could bolster drug utilization, the enrollment of more young, healthy beneficiaries who might not heavily use the benefit could offset some of the potential benefit.

Moreover, until more people have insurance, there could be a timing mismatch between the expected ramp-up in revenues from a gradual increase in enrollment and the incremental cost associated with new drug company fees under the law. (The fees begin at $2.5 billion in 2011 and subsequently rise to a total of $85 billion over 10 years.)

How might reform affect the speculative-grade for-profit hospital chains?

For-profit hospital chains, which operate less than 15% of all U.S. acute care facilities, could benefit from more patients and lower costs for uncompensated care. At the same time, however, reform provisions call for more than $150 billion in Medicare spending cuts over 10 years, and that could especially affect revenues after 2015.

Those more difficult operating conditions could also accompany an increase in private managed care efforts to shift some of their costs to providers. Indeed, managed care plans face major reductions in their Medicare Advantage reimbursement as well as operating restrictions that could cut into profits. If hospitals need more staff to treat patients, they might encounter a tighter labor supply and have to pay higher salaries.

The ongoing reimbursement risk that for-profit hospitals face, and the aggressive capital structures under which they operate, contribute to the predominance of speculative-grade ratings in the sector. Still, the outlooks on HCA Inc. (B+/Positive/--) and HealthSouth Corp. (B/Positive/--) in 2009 benefited from financing that reduced our liquidity concerns stemming from large upcoming debt maturities. An IPO contributed to our upgrade of Select Medical Corp. (B/Stable/--) late last year. Notwithstanding these cases of credit improvement, the failure of hospital chains to prepare operationally and financially for the changes that are likely coming could weaken credit quality as reform efforts take hold. The good news is that these challenges might not intensify for a few years.

How might the law affect not-for-profit hospitals, especially with regard to Medicaid and Medicare reimbursements?

The Patient Protection and Affordability Act and related Reconciliation Act of 2010 do little to change our view that credit quality for these hospitals in 2010 will stabilize, though in our recent outlook, we discussed longer-term cost and revenue pressures that remain despite some improvement in 2009. The new legislation will alter the landscape over time, especially after 2014, when insurance becomes mandatory.

Many of these newly insured people will get their coverage through insurance exchanges that are projected to become operational in 2014, even though some smaller initiatives will increase the number of insured before then. To the extent that the uninsured are already receiving services at a not-for-profit hospital, the provider can now expect to benefit, as insured revenues will rise and the aggregate cost of treating those without insurance declines. It follows that while all hospitals should see some benefit as uninsured levels decline, hospitals treating a greater percentage of uninsured people will likely be the greatest beneficiaries--although they will have to demonstrate an ability to retain these patients, as competition for the newly insured will likely intensify.

This benefit, however, is offset directly by potential reductions in Medicare's annual update factor, in reductions to disproportionate share revenues, and indirectly, by Medicare Advantage insurers that we believe are likely to pass on their funding reductions to all providers, including hospitals. Although the benefits of increased insurance availability are more likely to be skewed to hospitals with high charity care and self-pay burdens, the Medicare funding reductions are more broad based and will affect most hospitals significantly.

How much not-for-profit hospitals benefit from this new law could well depend on the balance between revenue lost, largely from Medicare, versus revenue gained from the newly insured. Much will also depend on the level of reimbursement provided by the newly insured population, how well it covers the cost of care, and the level of disproportionate funding that is lost.

Another issue that could significantly affect hospitals is the potential for a surge in demand as the newly insured people seek out services that they previously deferred. Although this is generally likely to be positive for hospitals, it raises issues of staffing and space, which they will have to address. And finally, the law has generated numerous pilot projects that aim to change how care is reimbursed and provided. For example, there is clear movement toward bundled payments, which is one payment for one episode of care and includes numerous parties that are now paid separately. Many hospital administrators have indicated they are already preparing for bundled payments though, although it remains to be seen how this will ultimately affect hospital financial performance. The pilot projects also provide incentives for more efficient care, which could lower patient volume. Over time, this could lower overall health care costs but reduce hospital revenues.

Are device fees a concern for the makers of medical products?

We believe that, even with the imposition of medical device fees, the manufacturers of high-margin technological devices are well-positioned for the foreseeable future. The increasing needs of an aging population already bode well for the demand for new procedures and technologies. Reform legislation could strengthen the ability of patients to receive care by virtue of growth in Medicaid and mandated private insurance coverage.

The Congressional Budget Office projects that Medicaid enrollment will grow by more than 40% over this decade, versus 16% growth in the private sector. Accordingly, even as health insurance coverage broadens, there could be a greater proportional increase in less-profitable Medicaid business. At the same time, government budgetary pressures could discourage more expensive and profitable medical treatment. In such a scenario, we believe that more aggressive negotiations with hospital customers feeling the pinch of tighter third-party reimbursement could indirectly squeeze margins for medical device companies. Moreover, regulatory shifts, such as a more demanding new product-approval process, add to the potential for variability in revenues and earnings.

There will now be a 2.3% excise tax on medical devices, scheduled to take effect in 2013. That tax is forecast to raise $20 billion over 10 years. But to the extent that these fees cannot be offset by higher prices, costs savings, or increased revenues from a larger base of insured people, medical device makers could, in coming years, see some

adverse consequences.

How will health care reform affect U.S. states, especially with regard to Medicaid reimbursement?

The new law is not expected to have immediate credit implications for U.S. states, though there are many aspects of the legislation that will affect states down the road. The impact will likely vary in each state, depending on the level of insured residents in a state and the nature of its Medicaid program. Each state determines its own eligibility rules, roster of services, and reimbursement levels, subject to federal minimums, and there is wide variation among states, which we expect will affect the future costs associated with expansion. The new law aims to extend insurance coverage to 32 million currently uninsured individuals by 2019, and we expect a large share of them will be covered by Medicaid.

Since its creation in 1965, states have shared Medicaid costs with the federal government. Those costs, however, have historically risen faster than the rate of inflation and remain one of the biggest components of state spending. Although the new law outlines federal reimbursement for low-income Medicaid recipients initially, there will also be a phased-in state cost. Moreover, the uninsured rate varies significantly by state. Because Medicaid caseloads tend to rise when the economy is weak and state revenues are falling, managing this program during economic cycles has consistently been a challenge for the states. It is clear that the new legislation will alter the health care landscape over time, and we will review the fiscal and economic implications on a state-by-state basis as details emerge.

by Robert McNatt

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Draft revision

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Warfarin Monitoring Protocol	
Scope: Hospital-wide	Department:
Source: Pharmacy	Effective Date:

[changes are in Arial type in italics]

PURPOSE:

Warfarin drug and food interactions frequently lead to destabilization of International Normalization Ratios (INR) in patients taking warfarin. Hospitalization often requires the temporary use of medications and the temporary use of therapeutic diets. Warfarin dosage requires adjustment in response to changes in INR. Warfarin dosage adjustment can be overlooked. The purpose of this policy is to provide a protocol by which pharmacists can order an INR and inform the physician of the need for dose adjustment, or, failing to contact the physician before the next dose, of holding a dose.

POLICY:

1. *An initial INR will be ordered within 24 hours of admission for patients who have been on Warfarin Therapy prior to admission and who are to be continued on the therapy in the hospital.*

2. An INR will be ordered at least every 3 days to monitor warfarin dosage unless the physician specifically orders a different frequency of INR testing.

3. Pharmacists shall note a patient's most recent INR prior to dispensing warfarin any time.

4. Nurses shall note a patient's most recent INR prior to obtaining warfarin from an automated dispensing machine.

5. A pharmacist may order an INR on the physicians' order sheet with the notation "per Warfarin Monitoring Protocol," the date and time, and the pharmacists signature, if:

    a. a patient's most recent INR is 3 or more days old
    b. if a patient is on a medication known to interact with warfarin drug activity
    c. if a patient is starting warfarin therapy

6. If a patient's most recent INR is 3 or more days old, a nurse, intending to remove a warfarin dose from an automated dispensing machine, shall hold the dose until the patient's physician is reached for an INR order, or until a pharmacist is reached to write an INR order under this protocol. *All efforts to coordinate blood draws to avoid extra draws will be made by pharmacists under this protocol.* The warfarin dose shall be held until the INR result is known.

7. If INR Point of Care testing is instituted in the hospital for INRs, the pharmacist shall use that means for determining INR rather than ordering a blood draw and laboratory run test.

8. If the INR is under the therapeutic range, the dose shall be given and the physician informed of the INR.

9. If the INR is over the therapeutic range, the dose shall be held and the physician informed of the INR.

Committee Approval	**Date**
Pharmacy and Therapeutics Committee	4/20/2010
Policy and Procedures Committee	12/17/2009
Medical Services/ICU Committee	
Peri/Peds Committee	
Surgery/Tissue Committee	
Medical Executive Committee	
Administration	
Board of Directors	

Revised:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Annual Clinic Evaluation RHC**	
Scope: Single Unit	Department: **Rural Health Clinic**
Source: Aspel, Tracy	Effective Date: 8/2001

PURPOSE:

The Annual Clinic Evaluation serves several purposes. It is essential to evaluate the clinic program to look for areas that should be improved. It is also important to assess the RHC's impact on members of the community. Since the RHC was developed to meet the needs of a medically underserved population, we need to determine if we are meeting that goal.

POLICY:

A review of the Rural Health Clinic's functioning will be performed annually. This review will look at patient satisfaction, patient services utilized and needed, as well as financial cost reports. This review will be performed by a committee, which includes the Medical Director, Clinic Nurse Manager, at least one clinic Nurse Practitioner, a Community Member at large, and the RHC Case Manager.

PROCEDURE:

1. The responsibility for compilation of the information rests with the Nurse Clinic Manager.

2. The Evaluation will include review of the following:

   A. The utilization of RHC services including number of patients served.

      1. Type of provider (Nurse Practitioner or MD).

      2. Type of specialty of provider.

   B. The hours of operation of the clinic.

      1. Number of patient contacts per hour, broken down for each individual provider.

      2. Number of patient contacts by day of the week.

   C. Patient satisfaction questionnaire with emphasis on ability to be treated on an urgent basis, as well as scheduled basis. The information needs to be provided both in Spanish and English.

   D. A representative sample of clinical records will be reviewed (See Performance Improvement Plan.)

   E. The NIH Medical Services/ICU Committee will review and update the department policies and procedures that require committee input.

   F. The Medical Director will report on the review of Standardized Procedures that has been performed with each Mid-Level Provider on staff at RHC. He will report on any changes

to the Standardized Procedures and additions of Mid-level Provider names to the Standardized Procedures. Standardized Procedures will be reviewed and approved after collaborative input from Physicians and Nurse Practitioners at the Interdisciplinary Committee.

3. The information obtained will be shared with the Medical Services Committee, Medical Executive Committee, and the RHC staff.

4. The Nurse Clinic Manager and Medical Director at the direction of the Medical Services Committee will implement corrective Actions based on the findings.

DOCUMENTATION:

The Clinic Nurse Manager will maintain records of the results of the Annual Clinic Evaluation for 7 years. Results of corrective actions taken will also be maintained to demonstrate efforts towards improvement.

Committee approval needed: Yes; Medical Services Committee
Responsibility for review and maintenance: Nurse Clinic Manager
Index listings: Annual Clinic Evaluation; RHC Review;
Initiated: 8/01
Revised: 3/21/08, 10/28/2009

NORTHERN INYO HOSPITAL
STANDARDIZED PROCEDURE

GENERAL POLICY FOR RURAL HEALTH CLINIC NURSE PRACTITIONER

I. Definition: "Nurse Practitioner" (NP) means a registered nurse who possesses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards.

II. Development and Review

A. All standardized procedures are developed collaboratively and approved by the NIH Interdisciplinary Practice Committee (IDPC) and must conform to all 11 steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.
B. All standardized procedures will be kept in a manual that includes dated and signed approval sheets of the persons covered by the standardized procedures.
C. All standardized procedures are to be reviewed every 3 years at minimum by the NP(s), Clinic Nurse Manager, Medical Director and then by the IDPC. Standardized procedures will be updated by the Nurse Practitioner(s), Nurse Clinic Manager, or Medical Director as practice changes.
D. All changes or additions to the standardized procedures are to be approved by the IDPC. All standardized procedures approved by the IDPC will be sent to the Medical Staff Executive Committee and, if so approved, to the NIH Board of Directors.

III. Setting of Practice: Northern Inyo Hospital Rural Health Clinic (NIH RHC)

IV. Scope of Practice

A. The NP may perform the following functions within his/her specialty area and consistent with their experience and credentialing: assessment, management, and treatment of episodic illness, chronic illness, contraception, and the common nursing functions of health promotion, and general evaluation of health status (including but not limited to ordering laboratory procedures, x-rays, and physical therapies as well as recommending diets, and referring to specialty services when indicated).
B. Standardized procedure functions, such as managing medication regimens, are to be performed at NIH RHC. Consulting Medical Director Physician, or his/her relief will be available to the NP(s) in person or by phone.
C. Physician consultation is to be obtained under the following circumstances:

    1. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
    2. Acute decompensation of patient situation.
    3. Problem which is not resolving as anticipated.
    4. History, physical, or lab finding inconsistent with the clinical picture.
    5. Upon request of patient, nurse, or supervising physician.

D. Medical Records: Medical record entries by the NP shall include, for all problems addressed: the patients' statement of symptoms, the physical findings, results of special studies, the NP's assessment and management plan including further studies ordered, medication or procedures, information given patient and the names of any physicians consulted.

V. Qualifications and Evaluations

A. Each nurse performing standardized procedure functions must have a current California registered nursing license, be a graduate of an approved Nurse Practitioner program, and have current certification as a Nurse Practitioner by the California Board of Registered Nursing.

B. Evaluation of NP's competence in performance of standardized procedure functions will be done in the following manner:

1. Initial: at 3 months, 6 months, and 12 months by the clinic nurse manager, through feedback from the NIH RHC Medical Director, other physicians and colleagues, and review of charting completed during performance period being evaluated.
2. Routine: annually after the first year by the NIH RHC Nurse Manager through feedback from the physicians, colleagues and charting review.
3. Follow-up: areas requiring increased proficiency, as determined by the initial or routine evaluation, will be reevaluated by the NIH RHC Nurse Manager and NIH RHC Medical Director at appropriate intervals until acceptable skill level is achieved.

The scope of supervision for the performance of the functions referred to in this area shall include chart review as per RHC chart review protocols.

C. Further requirements shall be regular continuing education in primary care, including reading of appropriate journals and new text books, attending conferences in primary care sponsored by hospitals, professional societies, and teaching institutions equaling 15 hours a year, minimum.

1. A record of continuing education must be submitted to the Clinic Nurse Manager annually at the time of the NP's evaluation.
2. Continuing education information will remain on file in the NP's personnel folder along with written evaluations.

VI. Protocols

A. The standardized procedure protocols developed for the use by the nurse practitioners are designed to describe the steps of medical care for given patient situations. They are to be used in the following circumstances: health promotion exams, contraception, routine gynecological problems, trauma, infectious disease contacts, management of acute/episodic or chronic conditions, and furnishing of medications.

Approval: This standardized procedure has been approved for use at Northern Inyo Hospital by:

James Richardson MD
Chairman, Interdisciplinary Practice Committee — Date 4/26/10

Administrator — Date 4-26-10

Chief of Staff — Date

President, Board of Directors — Date

Registered Nurses authorized to perform this standardized procedure and date of authorization:

1. ______________________ ______________
2. ______________________ ______________
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NORTHERN INYO HOSPITAL – RURAL HEALTH CLINIC
STANDARDIZED PROCEDURE

Subject: ADULT HEALTH MAINTENANCE (Specific chronic diseases – protocols i.e. HTN, DM.)

Scope: FNPs

I. POLICY - Will meet all General Policy Standardized Procedure guidelines.

A. Function: management of adult health maintenance.

B. Circumstances:

1. Patient population: adult patients
2. Setting: Medical Clinic
3. Supervision: Physicians indicated in general standardized procedure statement.

II. PROTOCOL

A. Definition: health maintenance, health promotion and prevention activities which promote the physical, psychosocial and developmental well-being of adults.

Includes health assessment, and disease prevention through physical exam, diagnostic testing, immunizations, developmental screening, and health education.

B. Data Base

1. Subjective: obtain complete histories on all first time patients; interval histories on subsequent visits.

2. Objective.

   a. At each visit obtain vital signs, height, weight.
   b. Perform complete physical exam.
   c. Perform appropriate psychosocial assessment.
   d. Laboratory/diagnostic testing as needed.

C. Plan

1. Diagnosis

   a. Health maintenance
   b. Acute illness
   c. Current assessment of chronic illness

2. Therapeutic regimen

    a. Diet as appropriate for age/nutritional status
    b. Medications

        i. Vitamins/mineral supplements
        ii. Immunizations as indicated
        iii. Hormonal replacement as indicated
        iv. Medications appropriate to address acute and chronic health problems.

    c. Activity/exercise as appropriate for age/health status
    d. Health education related to age/health status, preventive health behaviors.
    e. Interventions appropriate to address acute and chronic health problems.

3. Consultation/referral

    a. Physician consult to be obtained under the circumstances:

        i. Unexplained history, physical laboratory/diagnostic finding.
        ii. Emergency conditions requiring medical intervention.
        iii. Upon request of patient/family.

    b. Refer to specialist or other community resource indicated.

4. Follow-up

    a. According to adult health maintenance schedule sooner as indicated.

5. Record keeping

    a. Appropriate documentation to be maintained patient's chart.
    b. Allergic reaction to vaccine/medication.

D. Contraindications to immunization

1. Live virus vaccines contraindicated (consult with physician first):

    a. Patient with disorder of immune system
    b. Household member of patient with disorder of immune system
    c. Patient who received immune globulin in last 3 months
    d. During pregnancy
    e. PPD should not be administered for 3 months following MMR

E. Management of anaphylactic reactions to immunizations

1. Mild anaphylaxis involving skin (immediate):

    a. Pruritus, flush, urticaria, angioedema
    b. Emergency treatment

i. Maintain patient airway
ii. Administer 1:1000 (aqueous) Epinephrine SQ or IM 0.01 ml/kg. Repeat dose every 15-20 minutes.
Usual dose: infants 0.05-0.10 ml, children 0.10-0.30 ml.
Consult with physician.

2. Systemic – in addition to skin rash, rhinitis, redness, tearing of eyes, bronchospasm, laryngeal spasm, shock with cardiovascular collapse.

   a. Treatment:

      i. Maintain patient airway, administer CPR if necessary.
      ii. Administer Epinephrine as outlined above.
      iii. Refer to M. D. Call Code Blue if indicated
      iv. Report adverse reaction to local health department/manufacturer of vaccine.

APPROVAL: This standardized procedure has been approved for use at Northern Inyo Hospital by:

[signature] MD	4/26/10
Chairman, Interdisciplinary Practice Committee	Date
[signature]	4-26-10
Administrator	Date
Chief of Staff	Date
President, Board of Directors	Date

Registered Nurses authorized to perform this standardized procedure and date of authorization:

1. ______________________ ______________
2. ______________________ ______________
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NORTHERN INYO HOSPITAL-RURAL HEALTH CLINIC

STANDARDIZED PROCEDURE

OBSTETRIC CARE

Scope: Nurse Practitioner

I. POLICY

A. Function: Management of Obstetric Care

B. Circumstances:
   1. Patient population: pregnant patients of the Rural Health Clinic.
   2. Setting: Rural Health Clinic.
   3. Supervision: Rural Health Clinic physician as indicated in the General Standardized Procedure statement.
   4. Specialized education to provide OB care will consist of one of the following:
      a. Certification as a Nurse Practitioner with a specialty which includes OB training
      b. Education by the physician provider of OB care in clinic both by didactic proctoring and attending at least 2 hours of continuing education in the field of obstetrics

II. PROTOCOL

A. Definition: This standardized procedure establishes guidelines for antepartum care and postpartum care of pregnant patients presenting at the Rural Health Clinic for Obstetric care.

Prenatal visits may include but are not limited to documentation of gestational age, maternal uterine growth and weight gain, urinalysis by dipstick, blood pressure monitoring, patient teaching, fetal heart rate, fetal activity, identification of high risk conditions (see list), and referral to community resources or the supervising physician as necessary.

The NPs shall consult with the supervising physician on any prenatal female with a potential or obvious high-risk condition.

B. Data Base: Data shall include but not be limited to:
   1. Subjective:
      a. Relevant health history
      b. Family medical/genetic history
      c. Medications and sensitivities
      d. Self-care practices-sexual, nutritional, exercise, use of drugs, alcohol and tobacco
      e. Current issues and problems with pregnancy-nausea, vomiting, edema, abdominal pain, vaginal discharge/bleeding, urinary symptoms
      f. Assess for HIV risk factors

   2. Objective:
      a. Physical examination as soon as possible after determination of pregnancy
      b. Laboratory and diagnostic tests appropriate to the gestational age.

c. Measurement of fundal height and fetal heart tones appropriate to presenting gestational age.

3. Assessment: Maternal and fetal diagnosis consistent with subjective and objective findings. Notation of risk factors for possible referral or consultation.

4. Plan:
   a. Plan of care initiated based on objective findings and assessment. Treatment regimens to include, but not limited to: monitoring diet, exercise, employment, medication, psycho/social issues, baby and child safety and common complaints in pregnancy.
   b. Medications shall be ordered as appropriate according to Drugs in Pregnancy and Lactation.

C. Patient Education:
   1. Provide client with information on course of pregnancy, utilizing the Pregnancy handout created by Dr. Arndal.
   2. Provide counseling and approximate schedule of follow-up prenatal visits (see schedule C).

D. Consultation and/or Referral: Provide consultation and referral as indicated in General Policy Statement. Additional reference text resource for management guidelines: Management Guidelines for Nurse Practitioners Working with Women, 2nd edition, 2004 Chapters 12-13 (Antepartum and Postpartum Care)

POTENTIAL HIGH RISK CONDITIONS

Anemia: Hct 30%/Hgb 10 gm/dl unresponsive to iron replacement.
Abnormal QUAD screen
Drug/Alcohol abuse
Diabetes Mellitus or history of gestational diabetes
Habitual spontaneous abortions
Hemoglobinopathies
Rh isoimmunization or positive antibody screen
Multiple gestation
Maternal cardiac disease
Maternal hypertensive disease
Maternal hepatic disease
Maternal cancer
Maternal collagen vascular disease
Maternal renal disease
Maternal seizure disorder
Other maternal Gyn, endocrine, GI, neuromuscular, infectious, or pulmonary disease.
Previous pre-term labor or pre-term delivery
Pregnancy induced hypertension
Post maturity 41 weeks gestation
Positive HIV, Herpes, Hep B, Hep C
Psychiatric illness
Premature rupture of membranes

Bleeding at any time during pregnancy
Maternal age over 35 years or under 16 years
Fetal malpresentation after 36 weeks gestation
Maternal/paternal or family history of congenital anomalies
Grand multiparity ≥ 6
Late presentation for prenatal care ($\geq$ 16 weeks)

Source: The Journal of Family Practice 28(i)

SCHEDULE

Prenatal Visit Schedule:
Every 4 weeks up to 28 weeks
Every 2 weeks from 28-36 weeks
Weekly from 36 weeks to delivery

Estimated Schedule of Care

Initial visit:
Labs, Studies, Referrals
Schedule or perform complete physical examination to include Pap smear, Chlamydia and Gc

Prenatal Lab Panel:	CBC	Rubella
	Type and Rh	HepBsAg
	RPR	PPD
	UA & Pregnancy test	
	HIV	
	Cystic Fibrosis Screen optional	

QUAD Screen at 12-18 weeks
1 hour GTT – 50 grams glucola at 20-28 weeks gestation
U/S @ 15-24 weeks
Group B Strep perineal culture @ 36 weeks

Education
Outline prenatal care
Diet, psychosocial, exercise
Risks
Prenatal vitamins

12-18 weeks:	QUAD Screen	Review diet, exercise, habits
15-24 weeks:	Ultrasound	OB Ultrasound for size dates, AFI, Anatomy
24-28 weeks:	1-hour GTT Hct/Hgb Rhogam @ 28 weeks if Negative	Discuss scheduling prenatal classes Discuss BTL/Family Planning
32 weeks:	BTL consent signed	Discuss labor precautions Breast Feeding options Circumcision options

34-36 weeks:	Begin Fetal Activity Studies	Review procedure for fetal activity studies
36 weeks:	GBS Swab	Discuss episiotomy, vacuum, forceps, C-Section
38 weeks:		Review labor precautions
39-41 weeks:	Vaginal exam NST by 41 weeks	Postpartum: car seat, WCC, Discuss induction if indicated
Post-dates:	NST/CST after 41 weeks (2x/week) NST for decreased fetal movement	

APPROVAL: This standardized procedure has been approved for use at Northern Inyo Hospital by:

Chairman, Interdisciplinary Practice Committee	Date
Administrator	Date
Chief of Staff	Date
President, Board of Directors	Date

Registered Nurses authorized to perform this standardized procedure and date of authorization:

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NORTHERN INYO HOSPITAL
STANDARDIZED PROCEDURE
PRE-EMPLOYMENT PHYSICAL EXAMS

I. Policy:
   A. As described in the General Policy.
   B. Covers only those registered nurse practitioners as identified in the General Policy.

II. Protocol:
   A. Purpose: The purpose of the pre-employment physical is to attempt to determine if the employee is capable of performing the physical requirements of their job and is free of infectious disease. It is also to help screen for potential health problems that may arise for any employee. The purpose is not to replace the comprehensive care that employees receive through their own health care providers.
   B. Data Base:
      1. Subjective: The NP will obtain a complete medical history:
         a) Acute health problems.
         b) Chronic health problems.
         c) Current medications.
         d) Allergy history.
         e) Immunization status.
         f) Review of systems.
      2. Objective: The NP will perform a physical exam, utilizing the NIH Employee Health physical exam form, which includes, but is not limited to, the following:
         a) Head, eyes, ears, nose, and throat
         b) Skin
         c) Lymphatic system
         d) Pulmonary and cardiac systems
         e) Abdominal
         f) Musculoskeletal
         g) Neurologic
         h) Psychological
      3. Interpretation of the following test results:
         a) Urinalysis
         b) Complete blood count
         c) Electrocardiogram, when applicable.
         d) Chest x-ray, when applicable.
   C. Evaluation:
      1. Establish accurate diagnoses and a general level of health wellness.
      2. Identify any conditions that effect or limit the employee's abilities to perform their job functions.
   D. Plan:
      1. Appropriate health education and preventive measures for work-related health and safety.
      2. Provide immunizations per NIH's policies and CDC Guidelines
      3. Identify any disabilities that may restrict or limit his/her work as defined in the specific job description.
   E. Categorize the employee as:
      1. Qualified for hire.
      2. Qualified with a disability. Able to fulfill the job requirements with or without reasonable accommodation.
      3. Deferred - Further data must be obtained prior to making a final determination of the employee's capabilities to fulfill their job requirements.

4. Reject Recommendation - Medical findings indicate a condition that cannot be reasonably accommodated and which prohibits meeting the job requirements. This recommendation is done in conjunction with the primary supervising physician, the department head, the director of nurses, the director of personnel, and the prospective employee.

F. Physician consultation:
   1. Any unexplained or major physical, laboratory, radiographic, or historical finding. (e.g. transmissible infection in the employee with potential to infect co-workers or patients. This includes, but is not limited to, active hepatitis or tuberculosis).
   2. Emergency situations.
   3. Any health condition that requires significant accommodation or which may endanger the employee, co-workers, or patients.
   4. Any employee desiring physician examination or consultation.

III. Record Keeping:
   A. All physicals will be recorded on the physical exam record.
   B. The physical exam record will be kept in the employee's health file.

IV. Validation of Competency:
   A. If the NP has been previously proctored or is an employee of the Rural Health Clinic (RHC), the scope of supervision for the performance of the functions referred to in this area shall include review and signing of:
      1. Two completed physical exams for each nurse practitioner.
      2. Review of all exams where a medical consultation was requested.
   B. If the NP has not been previously proctored and is not an employee of the RHC, the NP will perform the pre-employment physical exams with the supervising physician in the room- "direct supervision"- until such time that the supervising physician documents competency as satisfactory. This period of direct observation will include no less than 4 physical exams.
   C. The documentation of competency will be done in writing and will address all the NP skills listed under the protocol section.
   D. Competency reviews will then be done as described in the General Policy.

Approval: This standardized procedure has been approved for use at Northern Inyo Hospital by:

Asma Richardson MD	4/26/10
Chairman, Interdisciplinary Practice Committee	Date
[signature]	4-26-10
Administrator	Date
Chief of Staff	Date
President, Board of Directors	Date

Registered Nurses authorized to perform this standardized procedure and date of authorization:

1. ______________________________ ____________________
Date

2. ______________________________ ____________________
Date

3. ______________________________ ____________________
Date

4. ______________________________ ____________________
Date

5. ______________________________ ____________________
Date

6. ______________________________ ____________________
Date

7. ______________________________ ____________________
Date

NORTHERN INYO HOSPITAL

STANDARDIZED PROCEDURE

Medical Screening Examination for the Obstetrical Patient Performed by Registered Nurse

I. POLICY

A. Procedure to be performed

Standardized procedure for medical screening examination for the obstetrical patient performed by a registered nurse (RN) who is determined qualified by the Hospital's Medical Staff Bylaws, Rules and Regulations and approved by the Hospital's Governing Board, in compliance with the provisions of the Emergency Medical Treatment Act (EMTALA) 42 U.S.C., Section 1395, Tag A406.

B. Responsible Party

1. A physician on the hospital medical staff available for consultation and to certify false labor.

2. A medical screening examination may be performed by a RN certified to perform medical screening examinations following this standardized procedure.

3. The RN must successfully complete a didactic module and a competency validation. Documentation is to be kept in the employee's competency file.

C. Conditions for Physician Consultation and Orders

1. All pregnant women presenting to the obstetrical department for care will receive a Medical Screening Examination and Assessment of Labor when requested without discrimination and regardless of their ability to pay.

2. Following examination and assessment of the patient, the RN will communicate with the physician by telephone to apprise him/her of the findings. Based thereon, the physician will either concur with the assessment of the RN, or will present to the hospital to further evaluate the patient him/herself.

3. If the RN determines that a woman is in false labor; a physician must certify the diagnosis. How the physician certifies (telephone consultation, or actually examines the patient) the diagnosis of false labor is determined by the hospital and its medical staff. If telephone consultation is the means utilized to satisfy this requirement, documentation within the patient charts must be in accordance with the hospital Conditions of Participation (CoP) at 42 CFR §482.24(c)(1).

4. A physician must be notified immediately if:

   a. Delivery is imminent. Preparations should be made for immediate delivery.

b. Complications or abnormal assessments arise during the performance of this procedure. Such problems include:

(1) fever, signs of infection;
(2) excessive vaginal bleeding;
(3) elevated blood pressure;
(4) abnormal reflexes;
(5) non-vertex presentation;
(6) hyperstimulation of the uterus;
(7) no uterine activity;
(8) tetanic contraction;
(9) abnormal FHR (non-reassuring); and
(10) premature gestation with ruptured membranes.

c. Contraindications to performing this procedure are present
(1) patient refusal

D. Review Process

1. Quality improvement monitoring of this standardized procedure is ongoing.

2. Quarterly (or more frequently as indicated), an audit of the Medical Screening Examination will be completed by the Nursing Manager, the Department of Obstetrics, Administration, and Interdisciplinary Practice Committee as appropriate.

3. Quality indicators developed and applied to all obstetrical patients:

a. Births occurring outside the hospital, following a Medical Screening Exam by a RN; and
b. Maternal or neonatal complications occurring following a Medical Screening Exam performed by a RN.

II. PROTOCOL

A. Purpose/Definition

To allow designated RN's to perform Medical Screening Examinations on obstetric patients presenting to the obstetrical department.

B. Database (Patient Selection Criteria)

1. Patient must be an obstetric patient.
2. Patient must give consent.
3. Patient must have absence of complications as listed under Section I (C)(4).

C. Treatment Plan

1. Initiation
a. Confirm appropriate patient selection under Section II (B).
b. Validate patient obstetrical status.

2. Preparation
    a. Explain procedure to patient/family.
3. Equipment
    a. See Procedure, Section III (C).
4. Process
    a. See Procedure, Section III.
5. Follow-up
    a. Provide patient education and any ordered follow-up care.

III. PROCEDURE

A. Purpose

To outline the methodology for the medical screening examination of the obstetric patient by the RN.

B. Supportive Data

1. Only Northern Inyo Hospital certified RN's or physicians may perform this standardized procedure.

C. Equipment

1. Sterile gloves
2. Lubricant
3. Amniotest if appropriate
4. Electronic Fetal Monitor
5. BP cuff
6. Thermometer
7. Reflex hammer
8. Slides/microscope for ferning

D. Content

Action	Key Points
1. Validate appropriate patient selection criteria	Ensure compliance with standardized procedure.
2. Explain procedure to patient.	Allay anxiety
3. If delivery is imminent, CALL THE PHYSICIAN and prepare for immediate delivery.	

Action	Key Points
4. If delivery is not imminent, continue assessment which will include but is not limited to: a. gravida, parity, EDC, maternal age, chief compliant; b. prenatal preparation, determination of physician/patient relationship; c. partner support needs; d. obstetric history; risk factors; e. labor status: (1) vital signs (2) fetal monitoring (3) frequency of contractions (4) presentation (5) status of membranes f. any other associated information.	To establish baseline for labor process.
5. Continue examination to assess maternal hydration, labor progress, and fetal wellbeing.	

Maternal Hydration

a. If temperature is elevated:
   (1) Assess for bladder distention:
      a) Encourage to void
      b) Check urine for protein, color, amount and odor
      c) If unable to void, continue to assess bladder and include this information with report to physician when total assessment is completed.
   (2) Suspect infection – CALL ATTENDING PHYSICIAN.
   (3) Assess for other abnormal findings such as elevated blood pressure or excessive bleeding. If present – CALL ATTENDING PHYSICIAN.
   (4) Determine proteinuria and check reflexes. If abnormal – CALL ATTENDING PHYSICIAN.

b. If hydration status and temperature are normal:

   (1) Encourage to void; and
   (2) Include this information with report to physician when total assessment is completed.

Assessment of Labor Progress

Action	Key Points
a. Abdominal palpation (1) Assess uterine contraction pattern noting: (a) Frequency; (b) Duration; (c) Intensity; and (d) Resting tone. (2) If normal, include this information with report to physician when total assessment is completed.	To establish baseline assessment of uterine activity.
(3) Potential complications may include but are not limited to: (a) Hypotonia; and (b) Tetanic contraction. (4) If potential complications are present – CALL ATTENING PHYSICIAN.	Tetanic contractions decrease adequate fetal oxygenation.
b. Assess position of presenting part.	Perform Leopold's Maneuvers.
c. Vaginal examination: (1) Determine the membrane status: (a) Intact or ruptured (b) Color, odor, or amount. Normal appearing amniotic fluid is clear to pale straw in color. A green, brown, or black color indicates passage of meconium and possible fetal distress. (c) Include this information with report to physician when total assessment is completed. (d) NO DIGITAL EXAM IF PRETERM OR IF KNOWN PLACENTA PREVIA	Follow Nitrazine procedure
(2) Determine descent of presenting part (a) If normal, include this information with report to physician when total assessment is completed. (b) If abnormal, CALL ATTENDING PHYSICIAN	
(3) Determine the state of the cervix: (a) Effacement; (b) Dilation; (c) Station;	

Action	**Key Points**
(d) If normal, include this information with report to physician when total assessment is completed; and	
(e) If abnormal, CALL ATTENDING PHYSICIAN	
(4) Assess bleeding:	
(a) CALL ATTENDING PHYSICIAN if abnormal due to:	
(i) Suspected bleeding is greater than normal "bloody show"; and	
(ii) Vaginal exam only at discretion of MD.	
(b) If normal, include this information with report to physician when total assessment is completed.	
d. Assessment of fetal wellbeing	
(1) Identify fetal heart rate pattern with application of a Doppler or an electronic fetal monitor	See Fetal Heart Rate Monitoring procedure
(2) Abnormal patterns (non-reassuring) may include but are not limited to:	• ACOG states normal fetal heart rate baseline is110-160 bmp.
(a) Baseline outside normal range with recurrent late or variable decelerations;	• Late decelerations indicate uteroplacental insufficiency
(b) Prolonged decelerations; (c) Absence of long-term variability; (d) Sinusoidal pattern; (e) Severe bradycardia; and (f) If abnormal, CALL ATTENDING PHYSICIAN	• Variable decelerations indicate umbilical cord compression. • A prolonged deceleration lasts longer than 2 minutes. • Average long-term variability indicates an intact central nervous system.
(3) Normal patterns (reassuring) (a) Consistent baseline rate of 110-160 beats per minute (b) Average long-term variability	
(c) Periodic accelerations (d) Early decelerations (e) Include this information with report to physician when total assessment is completed	Accelerations indicate an intact central nervous system. Early decelerations indicate head compression.

Action	**Key Points**

6. At the completion of the medical screening examination, the RN will report to the patient's physician, by phone or in person, the findings of the examination and any other pertinent information before any further procedures are performed. Regardless of the assessment, any patient meeting the following criteria will be examined, in person, by a physician prior to discharge home:
    a. No prenatal care;
    b. Maternal temperature >100.6(F), of uncertain etiology;
    c. Patient not alert and/or patient not oriented to person, time and place;
    d. Active vaginal bleeding;
    e. Rupture of membranes with meconium;
    f. FHR abnormalities; and
    g. Major maternal trauma.
7. In regards to a patient who is determined to not be in labor but needs additional evaluation to rule out an emergency condition: This patient will be seen in the Emergency Department and be provided with a medical screening examination to rule out other medical conditions prior to being discharged home. Prior to transfer back to the Emergency Department, the L&D RN will report to the patient's physician, or the on-call obstetrician, the findings of the labor examination and any other pertinent information. This RN will also call report to the Emergency Department RN and/or the Emergency Department Attending Physician to inform them of the patient's impending return to the Emergency Department.

E. Documentation
1. On Obstetrical Log, document:
    a. Date and time of arrival;
    b. Physician;
    c. Admitting RN;
    d. Name of patient;
    e. Medical record number;
    f. Account number;
    g. Room number;

h. Patient status (observation/inpatient)
i. Procedure (NST, Labor check, Ferning)
j. Other procedures;
k. Comments;
l. Disposition (transported to other facility, home);
m. Date and time of discharge; and
n. Discharge RN.

2. On Obstetrical Assessment Record, document:
   a. Attending Practioner;
   b. Pediatrician (if other than Attending Practioner);
   c. Gravida, parity;
   d. LMP;
   e. EDC;
   f. Age;
   g. Date and time of arrival;
   h. Name and telephone number of next of kin;
   i. Reasons for admission;
   j. Prenatal care and education;
   k. Allergies;
   l. Contraction status;
   m. Membrane status;
   n. Presence of bleeding;
   o. Other medical history;
   p. Plan for anesthesia;
   q. Current medications;
   r. Cervical examination;
   s. Fetal evaluation;
   t. Physical assessment;
   u. Height and weight; and other vital signs;
   v. Deep tendon reflexes;
   w. Notification of physician;
   x. Narrative notes;
   y. Discharge instructions;
   z. Date and time of discharge;
   aa. Disposition;
   bb. Patient signature; and
   cc. RN signature.

REQUIREMENTS FOR MEDICAL SCREENING EXAMINATION FOR THE OBSTETRICAL PATIENT

I. Minimal Education/Training

Selected RNs will have:

A. Successfully completed the hospital didactic module for performing Medical Screening Examination of the Obstetric Patient.

II. Expertise

Selected RNs will demonstrate:

A. Experience in direct patient care with laboring patients as a RN.
B. Successful completion of annual antepartum and intrapartum competency validation.
C. Current California Registered Nurse (RN) license.
D. Completion of electronic fetal monitoring program every two years.

III. Initial Evaluation

A. Successfully complete the Northern Inyo Hospital module post-test with 100% accuracy.

B. Successfully complete at least two (2) different obstetric patient medical screening examinations under the observation of the physician preceptor or a qualified nurse preceptor.
   1. A qualified "nurse preceptor" is a RN who may validate the competency of another RN to perform this procedure. A nurse preceptor must have completed at least five (5) obstetric patient medical screening examinations.

   Determined competency must be documented on the Medical Screening Examination of Obstetric Patient Competency Validation Tool.

IV. Ongoing Evaluation

A. Annual competency validation to be performed.

B. Review/evaluation of Quality Improvement Data on all patients where a RN performed a medical screening examination.

MEDICAL SCREENING EXAMINATION FOR THE OBSTETRICAL PATIENT EDUCATIONAL COMPONENT

OBJECTIVES

Upon completion of this class/module, the RN will be able to:

1. Describe systemic changes occurring in the woman's body during pregnancy;
2. List the forces affecting labor;
3. Identify the possible causes of the onset of labor;
4. List the techniques used for assessing uterine activity;
5. Differentiate between the labor and false labor, using information gathered by history and physical examination;
6. Define fetal lie, attitude, presentation, presenting part, position and station;
7. Recognize the signs and symptoms of labor;
8. Accurately record documentation of nursing care; and
9. Describe patient education.

OUTLINE

A. Anatomy and Physiology
B. Maternal-Fetal surveillance during pregnancy
C. Overview of labor
D. Maternal Status and Assessment
E. Fetal Status and Assessment
F. Fetal Membrane Status and Assessment
G. Labor Status
H. Priority setting and decision making
I. Patient Education
J. Documentation and Communication

Reviewed/Revised 11/12/07

PATIENT CARE SERVICES DIVISION

NAME/TITLE: ____DATE: ________________

COMPETENCY: Medical Screening Examination for the Obstetrical Patient Performed by the Registered Nurse

*Evaluation Method Codes: O=Observation; M=Module; T=Test; RD=Return Demonstration; C-Computer

Measurement of Competency	Meets Requirements Date	Needs Additional Assistance	*Evaluation Methods/ Comments
1. Successfully completes module and post-test with 100% accuracy.			
2. Describes patient selection criteria and instances of physician notification.			
a. Imminent delivery			
b. Fever, signs of infection			
c. Excessive vaginal bleeding			
d. Elevated blood pressure			
e. Abnormal deep tendon reflexes			
f. Non-vertex presentation			
g. Uterine hyperstimulation			
h. Lack of uterine activity			
i. Tetanic contraction			
j. Non-reassuring fetal heart rate			
k. Premature gestation			
l. Ruptured membranes regardless of gestational age.			
3. Explains procedure to patient			
4. Assembles equipment			
5. Performs assessment in systematic format			
a. Chief complaint			
b. Obstetric history			
c. Labor status and progress			
d. Maternal hydration			
e. Fetal wellbeing			
6. Communicates findings of examination and any other pertinent information to physician.			
7. Documents appropriately on the Birthing Center Log Book and on the Obstetrical Assessment Record.			

____

Employee Signature   Instructors Signature

MEDICAL SCREENING EXAMINATION FOR THE OBSTETRICAL PATIENT

PERFORMED BY REGISTERED NURSE

QUALITY IMPROVEMENT DATA

MEDICAL RECORD #________________________________

AGE: ________________________

C.C.: ________________________

DATE: ________________________

1. Patient Selection
   - ❑ Meets criteria
   - ❑ Does not meet criteria. Describe: ____________________________
2. Maternal Assessment
   - ❑ All systems WNL
   - ❑ Presence of complications
3. Fetal Assessment
   - ❑ Reassuring FHR
   - ❑ Non-reassuring tracing

   Describe: ____
4. Documentation
   - ❑ Log Book ❑ Medical Record
5. Physician Contacted:
   - ❑ Yes Who: __________________________
   - ❑ No Why not: __________________________
6. Outcome
   - ❑ Birth Outside of Hospital
   - ❑ Maternal complications Describe: ____________________________
   - ❑ Neonatal complications Describe: ____________________________

NOT A PART OF PERMANENT MEDICAL RECORD

Approval: This standardized procedure has been approved for use at Northern Inyo Hospital by:

James Richardson MD
Chairman, Interdisciplinary Practice Committee

Date 4/26/10

Chief of Staff

Date

Administrator

Date 4-21-10

President, Hospital District Board of Directors

Date

Registered Nurses authorized to perform this standardized procedure and date of authorization:

Name of R.N.	Date of Authorization	Change/Date

The Joint Commission
Findings

Chapter: Emergency Management

Program: Critical Access Hospital Accreditation

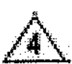
Standard: EM.02.02.13

Standard Text: During disasters, the critical access hospital may grant disaster privileges to volunteer licensed independent practitioners.
Note: A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization's capabilities and requires outside assistance to sustain patient care, safety, or security functions.

Primary Priority Focus Area: Credentialed Practitioners

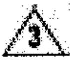
Element(s) of Performance:

2. The medical staff identifies, in its bylaws, those individuals responsible for granting disaster privileges to volunteer licensed independent practitioners.



Scoring Category : A
Score : Insufficient Compliance

5. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the critical access hospital obtains his or her valid government-issued photo identification (for example, a driver's license or passport) and at least one of the following:
- A current picture identification card from a health care organization that clearly identifies professional designation
- A current license to practice
- Primary source verification of licensure
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group.
- Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
- Confirmation by a licensed independent practitioner currently privileged by the critical access hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster



Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in the Emergency Management session at Northern Inyo Hospital site.
During the Emergency Management session, it was noted that the Medical Staff bylaws did not contain information related as to who has the authority to grant disaster privileges.

EP 5
Observed in the Emergency Management session at Northern Inyo Hospital site.
During the Emergency Management session, it was noted that the recently approved policy, Credentialing Health Care Practitioners in the event of a disaster, did not contain information related to obtaining the volunteer's valid government-issued photo-identification.

Chapter: Environment of Care

NORTHERN INYO HOSPITAL

MEDICAL STAFF
POLICY & PROCEDURE

CREDENTIALING HEALTH CARE PRACTITIONERS
IN THE EVENT OF A DISASTER

POLICY:

In the event of a disaster or emergency where the Hospital's emergency management plan has been activated and the Hospital is unable to handle the immediate patient care needs, the Chief Executive Officer or the Chief of Staff or their designee(s) may grant Disaster Privileges to individuals presenting themselves as health care practitioners seeking to volunteer their services, after the process outlined below has been followed.

PROCEDURE:

1. All Hospital departments and supervisory personnel (including Disaster Team Leaders) shall be instructed to direct all volunteering health care practitioners ("HCPs") to the Medical Staff Office (or to the Acting Administrator in the Disaster Command Center if the Medical Staff Office is not accessible).

2. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the volunteering HCP shall be required to produce a valid government-issued photo ID card with a signature (e.g., driver's license or passport) <u>and</u> at least one of the following:
   a. a current license to practice medicine issued by a state, federal, or regulatory agency; or
   b. identification indicating that the individual is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group; or
   c. identification indicating that the individual has been granted authority, by a federal, state or municipal entity, to render patient care, treatment, or services in disaster circumstances; or
   d. signed statement by a current Hospital or Medical Staff Member with personal knowledge regarding the practitioner's identity and ability to act as a licensed independent practitioner during a disaster.

   If possible, copies of these documents should be made (and/or notation of the current hospital or medical staff member with personal knowledge). If it is not possible to make copies, the identification information (including full name, address, license number, issuing agency, etc.) shall be recorded.

3. The volunteering HCP shall be requested to indicate his/her malpractice carrier and the name of the hospital(s) where he/she currently holds privileges. If possible, verification of licensure, insurance, and hospital affiliations shall be made by telephone or electronic query. A query to the NPDB and OIG shall also be submitted, unless technologically not possible. In the event this information cannot be verified, emergency approval of Disaster Privileges may still be granted pending verification.

4. The Request for Disaster Privileges form shall be completed (as indicated on the attached form).

5. The available information shall be reviewed by the individual(s) authorized to grant emergency approval of Disaster Privileges. The on-site responsible Medical Staff member (i.e., in accordance with facility disaster plan, e.g., ER physician) shall interview the volunteer to determine the appropriate scope of assigned responsibilities, and make a recommendation based on the available information to the Chief Executive Officer or Chief of Staff or their designee(s), who are authorized to grant Disaster Privileges.

6. The volunteer HCP shall be partnered with a member of the Medical Staff or Allied Health staff of similar specialty. Partnering information shall be recorded with the other information regarding the volunteer HCP.

7. The volunteer HCP shall be issued a temporary identification badge indicating his/her name, status as an approved volunteer HCP, and notation of his/her partner.

8. Any such Disaster Privileges may be terminated at any time, with or without cause or reason, and any such termination shall not give rise to any rights of review, hearing, appeal or other grievance mechanism. Disaster Privileges shall be terminated immediately if any information is received that suggests the volunteer HCP is not capable of rendering services as approved.

9. As soon as the status of the emergency situation is such that routine credentials verification procedures are possible, the Medical Staff Office shall initiate such procedure in the manner set forth in the Medical Staff Bylaws.

NORTHERN INYO HOSPITAL
REQUEST FOR DISASTER PRIVILEGES

Name: ______________________________ Specialty: ____________________

Date of Birth: ____________________ SSN: ________________________ Sex: M F

Office Address: ____

Office Telephone: ____________________ Other Telephone: ____________________

Hospital(s) Where You Hold Privileges: ____

Malpractice Insurance Carrier: ____

Medical Staff Member References (name & contact info for each):

1. ____

2. ____

3. ____

Signature: ______________________________ Date: ____________________

****

VERIFICATIONS

	Photo ID	Type:	State/Country:	Expiration:
	Medical License	Number:	Issued By:	Expiration:
	DMAT, MRC, ESAR-VHP, Other	Number:	Issued By:	Expiration
	Affirmation of Identity	By:	Capacity:	
	Other			

Hospital Affiliation(s): ____

NPDB query submitted: ________ Received: ________ Findings: ____________________

OIG query submitted: ________ Received: ________ Findings: ____________________

DISASTER PRIVILEGES APPROVAL

Partner Assignment ____

Scope of Disaster Privileges Responsibilities: ____________________________

____

____

Approved by (check one): ___ CEO ___ Chief of Staff ___ Designee

Signature:______________________________ Date: __________________

Print Name: ____________________________

EP 8
Observed in Medical staff credentials tracer at Northern Inyo Hospital site.
Review of Credentialed provider's files found that the request letter for professional recommendation, to those individuals named by the applicant provider, did not require or allow for each of the required 6 elements to be addressed by the respondent. While the letter sent to the named references contained the language required by this standard, it was written in a way that the response would not allow for each individual item to be addressed by the person commenting on the qualifications and personal knowledge of the applicant. It is necessary to design a letter that will state each of the 6 elements in such a way that the person responding may or may not choose to address each one individually.

Chapter: Medical Staff
Program: Critical Access Hospital Accreditation
Standard: MS.08.01.03 (ESC 60 days)
Standard Text: Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.
Primary Priority Focus Area: Credentialed Practitioners
Element(s) of Performance:

2. The process for the ongoing professional practice evaluation includes the following: The type of data to be collected is determined by individual departments and approved by the medical staff. (4)

Scoring Category : A
Score : Insufficient Compliance

Observation(s):

EP 2
Observed in medical staff credentialing tracer at Northern Inyo Hospital site.
It was noted that the medical staff has not yet adopted or put into practice an ongoing professional practice evaluation methodology that meets the intent of this standard.

Chapter: Medication Management
Program: Critical Access Hospital Accreditation
Standard: MM.04.01.01 (ESC 45 days)
Standard Text: Medication orders are clear and accurate.
Primary Priority Focus Area: Medication Management
Element(s) of Performance:

13. The critical access hospital implements its policies for medication orders. (3)

Scoring Category : C
Score : Partial Compliance

Observation(s):

Northern Inyo Hospital
MEDICAL STAFF
PEER REVIEW POLICY & PROCEDURE

I. INTRODUCTION

Medical Staff members and committees participate in peer review activities in accordance with this policy as well as the Medical Staff Bylaws and Medical Staff Rules and Regulations, and as required by licensure regulations, accreditation standards and conditions of participation in federally funded programs. "Peer review" includes all evaluation activities involving Members of the Medical Staff or other individuals holding privileges ("Practitioners"), including quality/performance improvement, utilization review, focused professional practice evaluation (including monitoring, proctoring, and other focused review and evaluation), data collection and evaluation, ongoing professional practice evaluation, and medical record review. The Medical Staff's peer review process also includes activities described in the Hospital's performance improvement plan and utilization review plan. Results of the peer review activities are utilized to assess a Practitioner's professional practice and behavior as part of the credentialing, privileging and corrective action processes. The peer review process includes an assessment for proficiency in the six areas of general competency: patient care, medical and clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice, as further described in Exhibit A to this policy.

II. PEER REVIEW ACTIVITIES

All complaints or reports regarding a Practitioner's practice or behavior shall be documented in writing and sent to the Medical Staff Services office for evaluation by the Chief of Staff, who shall determine how the complaint/report will be handled within the peer review process. To the extent possible, documentation should include the name(s) of individual(s) involved; date, time and place of event/incident; detailed factual description of event/incident; immediate effects/consequences of the event/incident; any action taken to intervene/remedy the event/incident/ and names of any witnesses.

A. Quality Data Collection shall be carried out on an on-going basis in a manner so as to preserve the protection from discovery of peer review information. Each clinical service shall annually approve quality measures to be monitored for all service members. Such quality measures shall be subject to approval by the Medical Executive Committee. Information received in the Medical Staff Services Office from the various sources shall be routed to the appropriate Medical Staff Officer, Service Chief or Committee. As directed by the applicable Officer, Committee or Chief, support staff may (1) enter data into the quality database for tracking and trending purposes; (2) screen medical records against approved criteria; and (3) refer those not meeting criteria to the applicable Committee for initial medical record review.

Note: Information received regarding practitioner behavior (e.g., disruptive, harassment, sexual harassment) shall be evaluated and processed in accordance with the Medical

Staff's Policy and Procedure on Disruptive Behavior, OR the Medical Staff Bylaws, Rules and Regulations.

B. <u>Privilege volume data collection</u> shall be carried out on an on-going basis with the assistance of the hospital's various departments and health information systems in order that Practitioners' volume of activity can be reviewed and evaluated.

C. <u>Individual Case Review</u> is initiated in the following circumstances:

1. Routine medical record review based on approved screening criteria;

   Examples of criteria include operative/invasive procedure review, outcomes of operative/invasive procedures, blood usage, pharmaceutical usage, morbidity and mortality data.

   (Criteria shall be designed to collect information related to the six areas of general competency as described in Exhibit A to this policy.)

2. Medical record review in response to reported deviations from expected care;

3. Statistical analysis showing:

   a. important single events, levels of performance, or patterns or trends varying significantly from expected;
   b. performance varying significantly from other organizations;
   c. performance varying significantly from recognized standards;

4. Variances from recognized utilization practices (e.g., length of stay, use of consultants, appropriateness of admission);

5. Risk management concerns involving quality of care;

6. Complaints from patients, family or staff relating to quality of care;

7. Notices from regulatory bodies, accreditation agencies or third party payors involving quality of care;

8. An appropriate Medical Staff Officer, Service Chief or Committee determines a need.

D. <u>On-Going Professional Practice Evaluation</u> is the Practitioner-specific review, at established intervals, of the results of peer review activities relating to each Practitioner's clinical practice, behavior, and compliance with bylaws, rules, regulations and policies, using multiple sources of information including data collection and evaluation activities which allows the organization to identify practice or behavior trends that impact on

quality patient care and patient safety and to take steps to improve performance on a timely basis. On an every 8 months basis, data shall be aggregated by Practitioner. Such aggregation activity may be distributed throughout the year in order that each Practitioner is reviewed at the required frequency, but not all Practitioners must be reviewed at the same time.

1. The report of aggregated Practitioner quality data shall be reviewed to ensure that information regarding the applicable Practitioners is being collected. In the event that a Practitioner does not have any data, the appropriate Service Chief or Committee will be notified and a source or mechanism to ensure data collection will be implemented. The reports of those Practitioners with data will be evaluated by the appropriate Service Chief or Committee for determination of whether (a) the Practitioner is performing well/within the desired expectation and no action is needed; or (b) one or more issues exist requiring focused review.

2. Concurrent with the quality data report, a report of volume by privilege shall be generated for each applicable Practitioner. If it is determined that a Practitioner is not performing a particular privilege, a letter will be sent to the Practitioner noting non-performance of the privilege, and indicating that continued failure to perform the privilege could result in automatic termination of the privilege OR imposition of proctoring on the privilege based on the recommendation of the appropriate Service Chief or Committee, subject to MEC and GB approval. The Service Chief (or MEC and GB) may also recommend to continue the privilege despite the lack of activity, because the hospital's mission is to be able to provide such service.

E. Focused Professional Practice Evaluation includes monitoring, proctoring and focused review activities. These activities are intended to evaluate the privilege-specific competence of a Practitioner granted new/initial privileges, where activity is insufficient to evaluate competence at time of privilege renewal, or when questions arise regarding a Practitioner's ability to provide quality care.

1. Monitoring. Monitoring shall consist of the on-going scrutiny of a Practitioner's practice without limitations or obligations on the monitored Practitioner. Examples include, but are not limited to, retrospective chart review, concurrent chart review with no limitations or obligations placed on Practitioner, and concurrent observation with no limitations or obligations placed on Practitioner. The appropriate Service Chief or Committee may initiate such monitoring. The Medical Executive Committee shall be informed of the initiation and status of such monitoring activities.

2. Proctoring. Proctoring is when a Practitioner is obligated to arrange for another Practitioner to be present during a patient care episode or obtain mandatory consultation and approval of care plan by another Practitioner and, except in the case of an emergency, when the Practitioner may not proceed with the specific patient care unless the proctor is present or has approved the care plan. In the

case of newly or initially granted privileges, all Practitioners shall be subject to such proctoring requirements as set forth the in the Medical Staff Bylaws and Medical Staff Rules and Regulations. In addition, in cases where a Practitioner has insufficient activity in a particular privilege to evaluate competence at time of renewal, the proctoring process may be utilized. The provisions of the Bylaws and Rules and Regulations shall be followed with regard to the methods of proctoring, duration of proctoring, criteria for conclusion of proctoring, process for conclusion of proctoring, etc.

3. Focused Review. In cases where, based on the evaluation of a Practitioner's current clinical competence, compliance with standards, or ability to perform requested privileges, questions arise regarding a Practitioner's ability to provide quality care, focused review may be initiated.

   a. Circumstances which may give rise to focused evaluation activities include, but are not limited to: provision of inappropriate care, including a single egregious incident or a clinical practice trend; mortality/morbidity complication rates at variance with local or national standards; failure to comply with hospital or Medical Staff policies, procedures, rules, regulations or bylaws; action by a licensing agency or other governmental entity; a significant pattern of malpractice claims; and a significant number or dollar amount of malpractice settlements, judgments or arbitration awards.

   b. Focused evaluation activities may be conducted utilizing those data source/collection mechanisms determined appropriate by the Service Chief or Committee to address the identified issues.

   c. The Service Chief or Committee shall determine the duration of such focused professional practice evaluation activities, and the criteria for conclusion. The Medical Executive Committee shall be informed of the initiation and status of focused evaluation activities.

4. External Review. External peer review is encouraged and is initiated and conducted in accordance with the Medical Staff's Policy on Use of External Peer Review Consultants.

III. GENERAL RULES SURROUNDING PEER REVIEW ACTIVITIES:

A. Participants in the Peer Review Process:

1. Peer. Within the context of this policy, a "peer" is one with similar clinical competence and scope of responsibility, and to the extent possible, in the same or related specialty, with the experience to render technically sound judgment of the clinical circumstances under review.

2. Reviewer(s). The Service Chief shall appoint individuals or sub-committees for the purpose of carrying out peer review activities. The appointed reviewer(s) shall not be personally involved in the care of the patient, and to the extent possible should not be a member of the same practice group or have other personal or professional conflicts.

3. Affected Practitioner. A Practitioner whose practice is being reviewed shall participate in the peer review process at the earliest reasonable time to afford the affected Practitioner with an opportunity to provide additional information or obtain education regarding the particular circumstances. This participation may include, but is not limited to, written response to a written inquiry, or attendance at a meeting for case discussion, as determined by the Service Chief or Committee Chairperson. In cases where the peer review process advances to the investigation for corrective action stage, the process will comply with the provisions of the Medical Staff Bylaws.

4. Support Staff. Employees of the Hospital (including Medical Staff Services personnel, quality/performance improvement personnel, or others) may be designated to assist the Medical Staff with its peer review activities. Employees acting in such role shall be under the direction and supervision of the Medical Staff, and shall comply with all Medical Staff bylaws, rules, regulations, policies and procedures, including the confidentiality requirements with regard to peer review materials.

B. Data Sources/Collection: Sources of data may differ by specialty. The Service Chief or Committee shall further define data sources.

1. Medical records are a key source of data for peer review activities, including internal concurrent and retrospective review, as well external reviews.

2. Information from throughout the facility which pertains to the practice or conduct of Practitioners shall be forwarded to the Medical Staff for use in its peer review activities. Examples of sources of such data include patient complaints, patient compliments, incident reports, occurrence reports, letters of intent, summons and complaints, and licensing/regulatory/accreditation notices.

3. Data collection may also occur through direct observation, monitoring of diagnostic and treatment techniques (e.g., proctoring), simulation, or discussions with other individuals involved in the care of each patient (e.g., consulting physicians, surgical assistants, nurses, and administrative personnel).

C. Medical Record Review Process. Initial medical record review will be performed by Service Chiefs or Committee members as assigned in accordance with the Medical Staff's approved indicators.

1. Medical record review results will be rated according to the following system:

[SAMPLE:]

Review Outcome:
☐ 1: Practice acceptable, outcome expected, within standard of care. (Trend Only.)
☐ 2: Practice not routine/unexpected outcome, but within standard of care. (Trend Only.)
☐ 3: Practice unexpected, deviation from standard of care. (Practitioner required to provide written response or attend meeting.)
☐ 4. Practice unacceptable/questioned, significant deviation from standard of care. (Automatic referral to Chair with specific issues/questions.)

2. Review Timelines. Peer review of a particular matter shall be conducted as soon as reasonably possible, based on when the matter is discovered and the complexity of the matter to be reviewed. In general, initial review of those circumstances identified herein should be carried out within thirty (30) days of discovery. The affected Practitioner shall participate prior to final resolution, as further described in Section III.A.3 ("Participants in the Peer Review Process: Affected Practitioner") of this policy. Completion of the peer review process of a particular circumstance should occur within ninety (90) days of discovery, unless unusual events intercede, including, but not limited to, focused review. Delays in review shall be reported to the Medical Executive Committee by the Service Chief or Committee Chair. Expedited reviews are appropriate in the event there may be an imminent threat to the health or safety of an individual.

3. Reporting Findings. The findings of peer review activities are reported through the applicable Service Chief or Committee Chair to the Medical Executive Committee within forty-five (45) days of review completion.

4. Action. Consistent with the provisions of the Medical Staff Bylaws, the Service Chief or Committee/Chair may take action or make recommendations for action, including implementation of monitoring, proctoring and focused evaluation activities. Any recommendations for corrective action which may give rise to hearing rights shall be processed in accordance with the Medical Staff Bylaws.

D. Documentation. All peer review activities (including data collection and review/evaluation activities) are recorded and maintained in a peer review database which includes electronic and paper files. Peer review evaluations, findings, conclusions and subsequent recommended actions are documented and include minority opinions and views of the individual under review. Documentation may be in the form of peer review worksheets, minutes, Practitioner profiles, and correspondence or database records. The periodic reports of peer review activities shall be placed in the Practitioner's credential file.

E. Confidentiality. All peer review documentation will be maintained in accordance with the Medical Staff Bylaws in order to protect their confidentiality and to qualify for protection under Evidence Code Section 1157.

F. Resources. As appropriate, conclusions are supported by reference to literature, relevant clinical practice guidelines, Hospital or Medical Staff policies or other resource material.

G. Use of Results. The results of peer review activities are considered in Practitioner-specific credentialing and privileging decisions (including whether to maintain existing privileges, revise existing privileges, or revoke a privilege prior to or at time of renewal) and are compared to aggregate information when appropriate. The results of all peer review activities are also considered when evaluating and modifying the performance improvement plan, and relevant information is integrated into the hospital's performance improvement activities to the extent possible while preserving confidentiality standards.

H. Tracking. Peer review conclusions are tracked over time, and actions based on peer review conclusions are monitored for effectiveness. Peer review data are compiled and analyzed to identify trends and opportunities for improvement. In the event a trend or question/concern involving quality patient care or patient safety is identified, the appropriate Service Chief or Committee shall initiate such further review and/or action as appropriate and in accordance with the Bylaws. The Chief of Staff will report aggregate peer review data to the Medical Executive Committee and the Governing Board.

Exhibit A
To
Medical Staff Peer Review Policy

Six Areas of General Competency

1. **Patient Care**
Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

   Sample data sources: patient/family complaints, patient/family compliments, patient satisfaction surveys, letters of intent, summons and complaint, results of core measures and other reviews, outcomes review, morbidity and mortality rates

2. **Medical/Clinical Knowledge**
Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, and the application of their knowledge to patient care and the education of others.

   Sample data sources (in addition to credentialing data of peer references, department chair recommendation, CME participation, board certification status, teaching activities): peer review demonstrating compliance with (or deviation from) standard of care

3. **Practice-based Learning & Improvement**
Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.

   Sample data sources: peer review demonstrating compliance with policies and procedures, standard of care, and established benchmarks

4. **Interpersonal & Communication Skills**
Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

   Sample data sources (in additional to credentialing data of peer references and department chair recommendation): patient satisfaction surveys, patient/family complaints, patient/family compliments, staff complaints, staff compliments

5. **Professionalism**
Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity and a responsible attitude toward their patients, their profession, and society.

Sample data sources (in addition to credentialing data of peer references and department chair recommendation): reports of disruptive behavior, patient satisfaction survey, patient/family complaints, patient/family compliments, staff complaints, staff compliments.

6. **Systems-based Practice**

Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

Sample data sources: utilization of resources (e.g., blood, consultants), length of stay, appropriateness of admission, compliance with policies and procedures

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BETA HEALTHCARE GROUP

1443 Danville Boulevard
Alamo, CA 94507-1911
Tel 925-838-6070 Fax 925-838-6088
www.betahg.com

April 12, 2010

John Halfen
Chief Executive Officer
Northern Inyo Hospital
150 Pioneer Lane
Bishop, CA 93514-2599

RE: Northern Inyo Hospital
BETA Healthcare Group Risk Management Authority July 1, 2010 Rates and Dividends

Dear Mr. Halfen:

With the approval of the BETA Council, BETA Healthcare Group Risk Management Authority (BETA) recently finalized rates and dividends for the upcoming renewal of the Healthcare Entity Liability (HCL), Directors and Officers/Employment Practices Liability (D&O/EPL), and Automobile Coverage Contracts.

I am pleased to announce that for the third consecutive year BETA will be decreasing HCL base rates, and the D&O/EPL and Automobile base rates will remain unchanged for the July 1, 2010 renewal. This year's base rate reduction for the primary $3 million liability limits for HCL coverage will be 5%. "Base" rate changes are passed along to all members irrespective of a facility's claims experience or other underwriting factors that may impact an individual member's rates. It should be emphasized; however, that experience rating will continue to play an important role in determining an individual member's renewal pricing and could result in a total rate change that is greater or less than the 5% HCL base rate decrease. For HCL members with limits above $3 million, BETA purchases reinsurance at rates that are determined by our reinsurers. Reinsurance rates will be finalized by the end of April, and we are hopeful that these rates will remain unchanged for the 2010 renewal. Since the actual cost of reinsurance is passed through to our members, changes in reinsurance rates may impact renewal contributions.

In addition to the positive news regarding base rates, the BETA Council approved a $6 million HCL dividend credit for 2009 that will be available to eligible members on July 1, 2010. Eligible members will also receive the remaining dividend from the previous year of approximately $1.3 million, which brings the total dividend for this year's renewal to $7.3 million. This renewal marks the 18th consecutive year that BETA has returned dividends to its members. Similar to past years, dividends will be applied to the monthly HCL invoices and will reduce the contributions otherwise due.

Lastly, for members that purchase D&O/EPL coverage through BETA, we have made one change to the D&O Coverage Contract that will be summarized in a separate letter. This year there will not be any changes to the HCL or Automobile Coverage Contracts.

We look forward to working with you and your staff on the upcoming renewal. If we can be of any assistance throughout the process, please let us know how we can help.

Sincerely,

R. Corey Grove, J.D., CPCU
Vice President, Underwriting
and Client Services

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NORTHERN
INYO HOSPITAL
Northern Inyo County Local Hospital District

150 Pioneer Lane
Bishop, California 93514
(760) 873-5811 voice
(760) 873-2633 fax

To: Board of Directors

From: Pharmacy and Nursing Departments

Date: May 19, 2010

Re: Request for Omnicell-based Bar Code Administration and Electronic Medication Administration Record

Background:

Bar Code Medication Administration (BCMA) is a proven method for reduction of medication administration errors. Research published this month in the New England Journal of Medicine (*Effect of Bar-Code Technology on the Safety of Medication Administration*, Volume 362:1698-1707 May 6, 2010 Number 18) showed the following:

- 57% less likely to receive the wrong drug;
- 42% less likely to receive the wrong dose;
- 61% less likely to receive a drug when none had been prescribed; and
- 27% less likely to receive a drug at the wrong time.

Our own estimate of preventable error reduction at NIH based upon our reported medication errors is similar.

The Pharmacy and Therapeutics Committee at NIH has endorsed the immediate implementation of BCMA.

Why Omnicell SafetyMed Bar code add on:

- The Bar Coding and electronic Medication Administration Record use the existing interface between the Pharmacy System and the Omnicell Dispensing system. No imposition of a new interface and build of new databases would be necessary.
- The system would not require new hardware except bar code readers that would be used with existing nursing laptops.
- Competing systems require the replacement of the pharmacy system as well as the nursing administration system.

Request:

SafetyMed Add on for Omnicell Cost:

Product and Licenses:	$28,720
20 ea Bar Code Readers:	$ 2,000

4 additional Laptops:	$ 3,580
Conversion to Virtual Server	$ 6,425
Personnel costs are "soft costs" (not add-on).	
Total Capital Costs:	**$40,725**
Yearly Maintenance and Service Fees:	**$12,600**

Implementation time is approximately 60 days.

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NORTHERN INYO HOSPITAL
2011 Budget
As of January 31, 2010

	2010 YTD Actual	2010 Projected	2011 bud	Dept Requests	
Unrestricted revenues, gains and other support:					
In-patient service revenue:					
Routine	4,211,107	7,219,040			
Ancillary	14,106,825	24,183,129			
Total in-patient service revenue	18,317,932	31,402,169			
Out-patient service revenue	34,107,495	58,469,992			
Gross patient service revenue	52,425,428	89,872,162	96,163,213	96,163,213	7.00%
Less Radiology Professional Fee Revenue		**-3,092,556**	**-3,309,035**	**-3,309,035**	without Radiology Pro fee Revenue
Less deductions from patient service revenue:		**86,779,606**	**92,854,178**	**92,854,178**	92,854,178.00
Patient service revenue adjustments	1,012,533	1,735,771			
Contractual adjustments	20,073,335	34,411,431			
Prior Period Adjustments	-392,906	-673,554			**38.92%**
Total deductions from patient service revenue	20,692,961	35,473,648	36,136,892	36,136,892	adj for profee reductions
Net patient service revenue	31,732,467	51,305,958	56,717,286	56,717,286	
Other revenue	208,033	356,627			
Transfers from Restricted Funds for Other Operating Expenses	452,662	775,992			
Total Other revenue	**660,695**	**1,132,619**	**1,332,755**	**1,332,755**	
Total revenue, gains and other support	**32,393,161**	**52,438,577**	**58,050,041**	**58,050,041**	
Expenses:					
Salaries and wages	10,518,941	18,032,470	18,898,029	19,593,202	4.8 (1% COLA and 3.8% for steps)
Employee benefits	7,070,162	12,120,278	11,716,778	12,130,661	62.00%
Professional fees	3,127,439	5,361,323	5,629,390	4,349,693	5.00%
Less Radiology Professional Fees		-1,237,608	-1,299,488	0	
Supplies	3,592,905	6,159,266	6,590,415	6,762,426	7.00%
Purchased services	1,807,984	3,099,401	3,347,354	3,054,678	8.00%
Depreciation	1,557,516	2,670,028	3,500,000	3,500,000	plug-estimate
Interest	758,458	1,300,214	1,249,253	1,249,253	plug-actual

Bad debts	1,454,230	2,492,966	2,630,079	2,630,079	5.50%
Other	1,427,050	2,446,371	2,568,690	2,577,627	5.00%
Total expenses	31,314,686	52,444,711	54,830,499	55,847,619	
Operating income (loss)	1,078,475	-6,134	3,219,542	2,202,421	
Other income:					
District tax receipts	305,978	524,533		839,878	
Interest	112,946	193,621			
Other	34,043	58,359			
Grants and Other Non-Restricted Contributions	36,963	63,364			
Partnership Investment Income	0	0			
Net Medical Office Activity	-331,059	-567,529		-640,394	
Total other income, net	158,870	272,348	272,348	199,484	
Excess (deficiency) of revenues over expenses	1,237,345	266,215	3,491,890	2,401,905	

NORTHERN INYO HOSPITAL

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Sending Protected Health Information by Fax**	
Scope: **HOSPITAL WIDE**	Department:
Source: Compliance Officer	Effective Date:

PURPOSE:
Sending Protected Health Information (PHI) by fax is a common practice at NIH. Both Federal and State Law require that health facilities 'prevent the unlawful or unauthorized access to, and use or disclosure of, patients' medical information" [H&SC 1280.15] Failures in prevention that result in Faxes going to persons not authorized to receive them must be reported to the State within 5 days of discovery, must result in a change in process in the facility to prevent such an occurrence and must result in "appropriate personnel actions, including discipline of any employees, volunteers, or members of the medical or allied health staff who were responsible for the breach."[42 U.S.C. Section 17939] This policy sets forth the requirements for Faxing PHI at NIH in compliance with Federal and State Law.

POLICY:

1. PHI may only be Faxed by NIH personnel who have been trained in this policy.

2. Prior to Faxing PHI, NIH personnel must either:
   a. Verify the Fax number as being accurate and correct for the intended recipient, or
   b. Utilize a preprogrammed Fax number by accessing the number memory of the Fax machine or faxing program
3. The person who preprograms Fax numbers into a Fax machine or into a computer system is required to verify the numbers in accordance with this policy, or to utilize numbers that have been previously verified. Persons using previously verified numbers must view the documentation of the verification.

4. Verification of a Fax number must be done through one of the following means:
   a. Contacting the intended recipient (or the recipient's office personnel) and reading back the number to that individual
   b. Sending a test fax asking for the recipient to send a verification fax back

5. NIH personnel performing Fax verification must document
   a. who verified the recipients fax number for the recipient,
   b. which NIH person performed the verification,
   c. the date and time of verification

FAXING TO AN UNINTENDED RECIPIENT

6. NIH personnel who send Faxes of PHI in accordance with this policy, but through human error still send a Fax to an unintended recipient must report the mistake to the Compliance Officer via phone or via email as soon as the mistake is recognized. Self reporting will exempt the employee from disciplinary action unless a pattern of such errors is evident. Note: The report to the State requires that the violator be named in the report.

7. NIH personnel who are notified by an unintended recipient that they received a Fax containing PHI must report to the Compliance Officer by phone or email, as soon as possible, but not later than the end of their shift. The employee who receives this notification from the unintended recipient must report the following:
   a. The name and telephone number of the unintended recipient
   b. The time and date of the notification by the unintended recipient

c. A description of the PHI that was received including the patients name and the general type of PHI (doctors' orders, test results, etc)

d. The disposition of the PHI (e.g.: the recipient will send the document(s) back to us, the recipient will deliver the document(s)s to the hospital, the recipient will shred the document(s))

8. If the unintended recipient is a hospital, medical or dental practice or facility, NIH employees receiving notification from those offices may instruct the offices to shred the documents or send them to the NIH Compliance Officer.

9. If the unintended recipient is other than a hospital, medical or dental practice or facility, then the NIH employee must ask the recipient to send the documents to the Compliance Officer at NIH. Shredding is not to be recommended.

Committee Approval	**Date**
Compliance Committee	4-23-2010
Administration	
Board of Directors	

Revised:
Reviewed:
Supercedes:

Responsibility for review and maintenance: Compliance Officer
Index Listings: Fax, Faxing, PHI
Initiated: 4-9-2010
Revised/Reviewed:

END