

# Board Meetings

## April 17, 2024 Regular Board of Directors Meeting

### Agenda

<b>April 17, 2024 Agenda</b> .....	<b>2</b>
<b>Election Filing Window Update</b>	
<b>County of Inyo-Candidate Calendar</b> .....	<b>5</b>
<b>Results of Board Self-Assessment</b>	
<b>2024 Summary Results</b> .....	<b>6</b>
<b>CEO Report</b>	
<b>S&amp;P Global Rating Report 2024</b> .....	<b>35</b>
<b>CEO - Director Reports</b> .....	<b>44</b>
<b>Financial &amp; Statistical Reports</b>	
<b>Financial Update February 2024</b> .....	<b>48</b>
<b>Financial Statements February 2024</b> .....	<b>58</b>
<b>KPIs FYE 2024</b> .....	<b>61</b>
<b>Narrative February 2024</b> .....	<b>62</b>
<b>Chief of Staff Report</b>	
<b>MEC Board Report</b> .....	<b>65</b>
<b>Policies &amp; Procedures</b> .....	<b>66</b>
<b>Consent Agenda</b>	
<b>March 20, 2024 Regular Board Meeting Minutes</b> .....	<b>98</b>
<b>March 21, 2024 Special Board Meeting Minutes</b> .....	<b>103</b>
<b>CHRO Board Report</b> .....	<b>105</b>
<b>CEO Credit Card Statements</b> .....	<b>109</b>
<b>Medical Staff Department Policy - Hospital Medicine</b> .....	<b>112</b>



**AGENDA**  
**NORTHERN INYO HEALTHCARE DISTRICT**  
**BOARD OF DIRECTORS REGULAR MEETING**

**April 17, 2024 at 5:30 p.m.**

Northern Inyo Healthcare District invites you to join this meeting:

**TO CONNECT VIA ZOOM:** *(A link is also available on the NIHD Website)*  
<https://zoom.us/j/213497015?pwd=TDIIWXRuWjE4T1Y2YVFWbnF2aGk5UT09>  
Meeting ID: 213 497 015  
Password: 608092

**PHONE CONNECTION:**  
888 475 4499 US Toll-free  
877 853 5257 US Toll-free  
Meeting ID: 213 497 015

The Board is again meeting in person at 2957 Birch Street Bishop, CA 93514. Members of the public will be allowed to attend in person or via zoom. Public comments can be made in person or via zoom.

---

1. Call to Order (at 5:30 pm).
2. ***Public Comment:*** The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are **limited to three (3) minutes per speaker**, with a total time limit of thirty (30) minutes for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. New Business:
  - A. Election filing window update, Patty Dickson (*Information item*)
  - B. Results of Board Self-Assessment
  - C. Chief Executive Officer Report (*Board will receive this report*)
    - a. Standard & Poor's Global Rating Report 2024

- b. Directors' Reports
  - c. Patient Appointment reminder software update
  - d. Nurses' Week (May 6-12) & Hospital week (May 12-18) celebration
  - e. California Hospital Association (CHA)– Advocacy
- D. Chief Financial Officer Report
- a. Financial & Statistical Reports (*Board will consider the approval of these reports*)
  - b. CFO Report
  - c. Billings & Collections - Progress
  - d. Budget
- E. Chief of Staff Report, Sierra Bourne MD:
- a. Policies (*Board will consider the approval of these Policies and Procedures*)
    - 1. Cleaning the Pharmacy Sterile IV Preparation Area (Clean Room)
    - 2. Interim Guidance for Environmental Infection Control for Patients with Probable/Suspected Viral Hemorrhagic Fever (VHF)
    - 3. Triage of Patients Suspected of Viral Hemorrhagic Fever (VHF)
    - 4. Standardized Protocol – Minor Surgical Policy for the Physician Assistant
    - 5. Procedural Sedation
    - 6. Nursing Management of the Infant and Pediatric Security System
  - b. Medical Executive Committee Report (*Board will receive this report*)

---

4. **Consent Agenda** - *All matters listed under the consent agenda are considered routine and will be enacted by one motion unless any member of the Board wishes to remove an item for discussion.*

- A. Approval of minutes of the March 20, 2024 Regular Board Meeting
- B. Approval of minutes of the March 21, 2024 Special Board Meeting
- C. Chief Human Resources Officer (CHRO) Report
- D. CEO Credit Card Statements
- E. Approval of Policies and Procedures
  - a. Medical Staff Department Policy – Hospital Medicine

---

F. General Information from Board Members (*Board will provide this information*)

G. **Closed Session:**

- a. Chief of Staff Report – Protected by Evidence Code § 1157; Health & Safety Code § 32155

- b. Public Employee Evaluation (Government Code § 54957(b)(1)) Title: Chief Executive Officer

H. Adjournment

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

# Candidate Calendar



Clerk-Recorder/Elections Office

County of Inyo

Danielle M Sexton

Clerk-Recorder, Registrar of Voters

Dates	Responsible Agency / Applies to:	Event
Filing period: 7/15/24 - 8/09/24 (E-113 - E-88)	Candidates	<b>Declaration of Candidacy/Nomination</b> <b>Period Opens</b> <i>(Nomination Petition and/or Declaration of Candidacy)</i> <i>First day candidates may pick up documents in the Elections Office</i>
Filing period: 7/15/24 - 8/09/24 (E-113 - E-88)	Candidates (optional)	<b>Code of Fair Campaign Practices</b> <i>Each candidate has the option to submit a Fair Campaign Practices form to agree to a fair campaign. There is no requirement to submit this form, but is suggested to do so.</i>
Filing period: 7/15/24 - 8/09/24 (E-113 - E-88)	Candidates (optional)	<b>Candidate's Statement of Qualifications Period</b> <i>Each candidate has the option to submit their written qualifications to be published in the local voter guide. The Statement must be direct qualifications and not a platform for the candidate's opinion. The portion of the publication is paid by the candidate. There is no requirement to submit a statement. State Legislative candidates must agree to voluntarily limit their campaign expenditures. (Govt. Code § 85601 (b))</i>
Filing period: 7/15/24 - 8/09/24 (E-113 - E-88)	Candidates	<b>Declaration of Candidacy/Nomination</b> <b>Period Closes</b> <i>(Filing period is extended until E-83 if incumbent does not file. EC 10510, 10516)</i> <i>Deadline to file all required Declaration/Nomination documents with the Elections Official. Fax is not acceptable. EC §§ 8020, 10224, 10407, 10510, 10603(b)</i>
Filing period: 8/10/24 - 8/20/24 (E-87 - E-77)	Candidates	<b>Public review period of Candidate Statement of Qualifications</b> <i>ELEC §§9190, 9295, 9380, 9509, 13313</i>
Filing period: 8/10/24 - 8/14/24 (E-87 - E-83)	Candidates - other than incumbents	<b>Candidate Filing Extension Period</b> <i>If the incumbent fails to file by E-88 deadline for their office, any other candidate may file for said office. Incumbents of an office may not file beyond the E-88 deadline. There is no extension period if there is no incumbent to be elected.</i> <i>EC § 10516</i>
09/26/24 - 10/15/24 (E-40 - E-21)	Elections Official	<b>County Voter Information Guides mailed</b> <i>Sample Ballots, Measure information, and other details included in Guide</i> <i>ELEC §§9094(c), 13303-13304</i>

## FPPC - Fair Political Practices Commission Filing Schedule

Please visit FPPC for additional information, including Forms, form instructions, and due dates. You may also find links to their filing Schedule for this election on our website: <https://elections.inyocounty.us/voting/election-calendar/>

[Home-https://www.fppc.ca.gov/](https://www.fppc.ca.gov/)

[Campaign Rules-https://www.fppc.ca.gov/learn/campaign-rules.html](https://www.fppc.ca.gov/learn/campaign-rules.html)

[State & Local Filing Schedules-https://www.fppc.ca.gov/learn/campaign-rules/where-and-when-to-file-campaign-statements/when-to-file-campaign-statements-state-local-filing-schedules.html](https://www.fppc.ca.gov/learn/campaign-rules/where-and-when-to-file-campaign-statements/when-to-file-campaign-statements-state-local-filing-schedules.html)

## California Secretary of State (SOS) - Statewide Election Dates

Additional information from the Secretary of State for this election can be found on:

[Key Dates and Deadlines from SOS - https://www.sos.ca.gov/elections/upcoming-elections/presidential-primary-election-march-5-2024/key-dates-deadlines](https://www.sos.ca.gov/elections/upcoming-elections/presidential-primary-election-march-5-2024/key-dates-deadlines)



# SUMMARY RESULTS

## Northern Inyo Healthcare District 2024 Governance Self-Assessment

Provided as a Member Service By



**ACHD**  
ASSOCIATION OF CALIFORNIA  
HEALTHCARE DISTRICTS

# Self-Assessment Overview

In March 2024 the Northern Inyo Healthcare District Board of Directors assessed the board's overall leadership performance. The board also identified issues and priorities for the future.

Board members assessed the board's overall performance in ten leadership areas, including:

- Mission, values and vision;
- Strategic direction;
- Leadership structure and processes;
- Quality and patient safety;
- Community relationships;
- Relationship with the CEO;
- Relationships with the medical staff;
- Financial leadership;
- Community health; and
- Organizational ethics.

Board members rated 167 total criteria in these ten areas.

## How the Self-Assessment Was Conducted

The governance self-assessment was conducted using an online survey. All five Northern Inyo Healthcare District board members completed the self-assessment.

Respondents rated a variety of statements in the ten areas above, using a scale ranging from "Level 5 (Strongly Agree)" to "Level 1 (Completely Disagree)." "Not Sure" and "Not Applicable" choices were also available for each statement.

Mean scores for each statement were calculated using a five point scale (Level 5 - Level 1). No points were assigned to "Not Sure" and "Not Applicable" ratings.

Finally, board members provided insights about their priorities for the board in the next year; defined the board's strengths and weaknesses; identified key issues that should occupy the board's time and attention in the next year; provided insights about the most significant trends the board must be able to understand and deal with in the next year; and identified critical factors that must be addressed for the organization to successfully achieve its goals.

## Rating Methodology

The following rating scale was used to evaluate overall board performance:

- **Level 5:** I *strongly agree* with this statement. We always practice this as a part of our governance. Our performance in this area is *outstanding*.
- **Level 4:** I *generally agree* with this statement. We usually practice this as a part of our governance, but not always. We perform *well* in this area.
- **Level 3:** I *somewhat agree* with this statement. We often practice this in our governance, but we are not consistent. We perform *fairly well* in this area.
- **Level 2:** I *somewhat disagree* with this statement. We inconsistently practice this as a part of our governance. We *do not perform well* in this area.
- **Level 1:** I *disagree* with this statement. We never practice this as a part of our governance. We perform *very poorly* in this area.
- **N/S:** Not sure. I do not have enough information to make a determination about our performance in this area.
- **N/A:** Not applicable.

## Reviewing This Report

Board member ratings of board self-assessment criteria are depicted throughout this report in graphs.

The criteria in each graph are displayed in order from highest to lowest mean score. The mean score for each individual rating criterion appears to the right of the graph.

To facilitate the identification of areas that may require governance and/or management attention, each graph includes the number of Level 5 - Level 1 responses to each statement in the color-coded bars. Responses are grouped and color coded, with "Level 5" appearing in dark green, "Level 4" in light green, "Level 3" in yellow, "Level 2" in orange, and "Level 1" in red. "Not Sure" responses appear in gray, and "Not Applicable" responses appear in white.

Longer lists of criteria have been separated into higher and lower rated sections for ease of display and analysis.

Board member responses to all open-ended questions appear throughout the report, where applicable, and on pages 28-29.

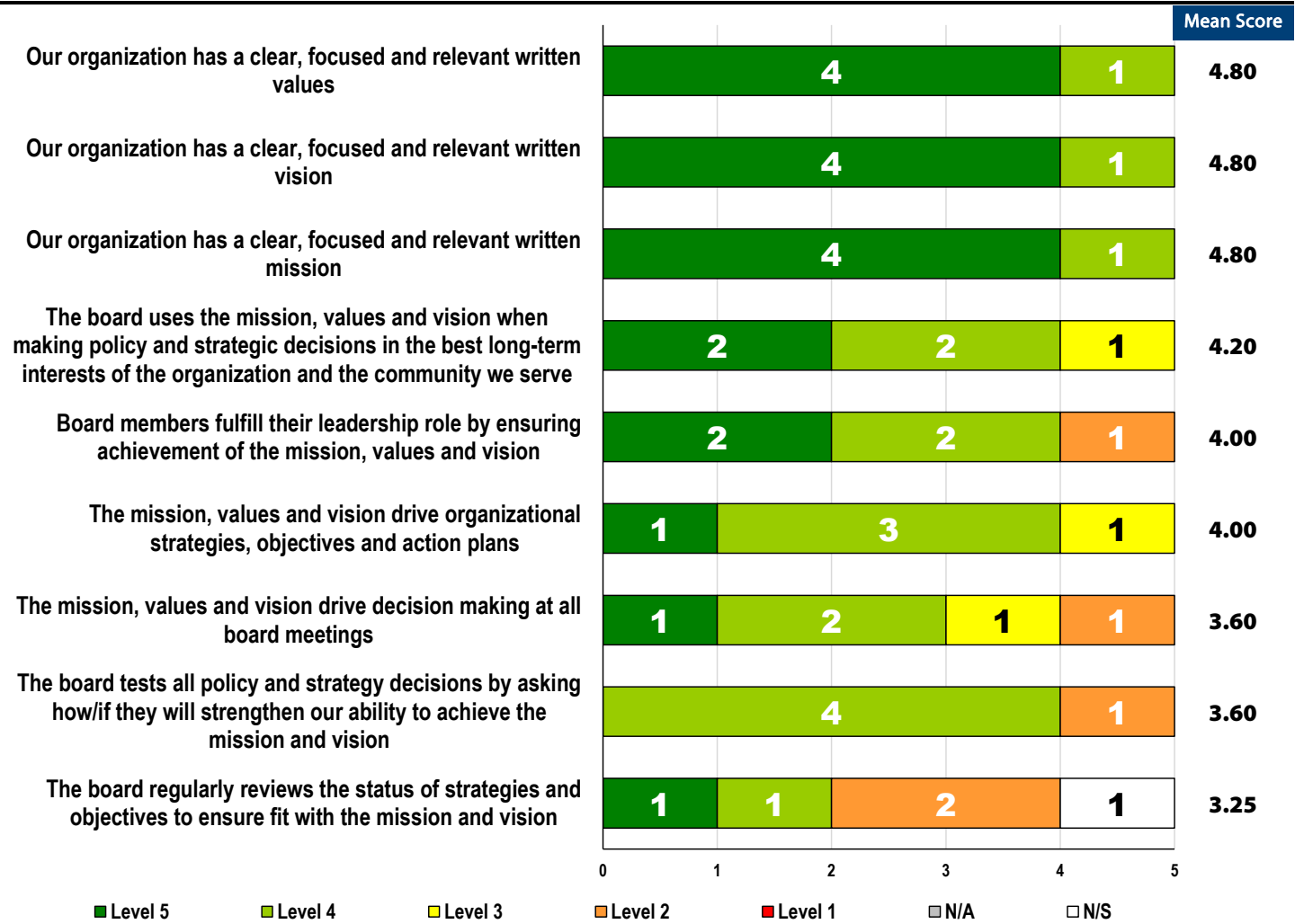
# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Mission, Values and Vision

#### Mission, Values and Vision

(sorted by highest to lowest mean score)



#### Suggestions for Governance Improvement

Board members provided the following suggestions for governance improvement in this section:

- Under our current leadership, I am confident that we will be measuring our achievement goals in the future.
- More accountability with industry standards presented. Then presentations by CEO as to how to achieve those benchmarks that get us operating at a profit in two years.
- More public awareness and reviewing of all three.
- Having a retreat.



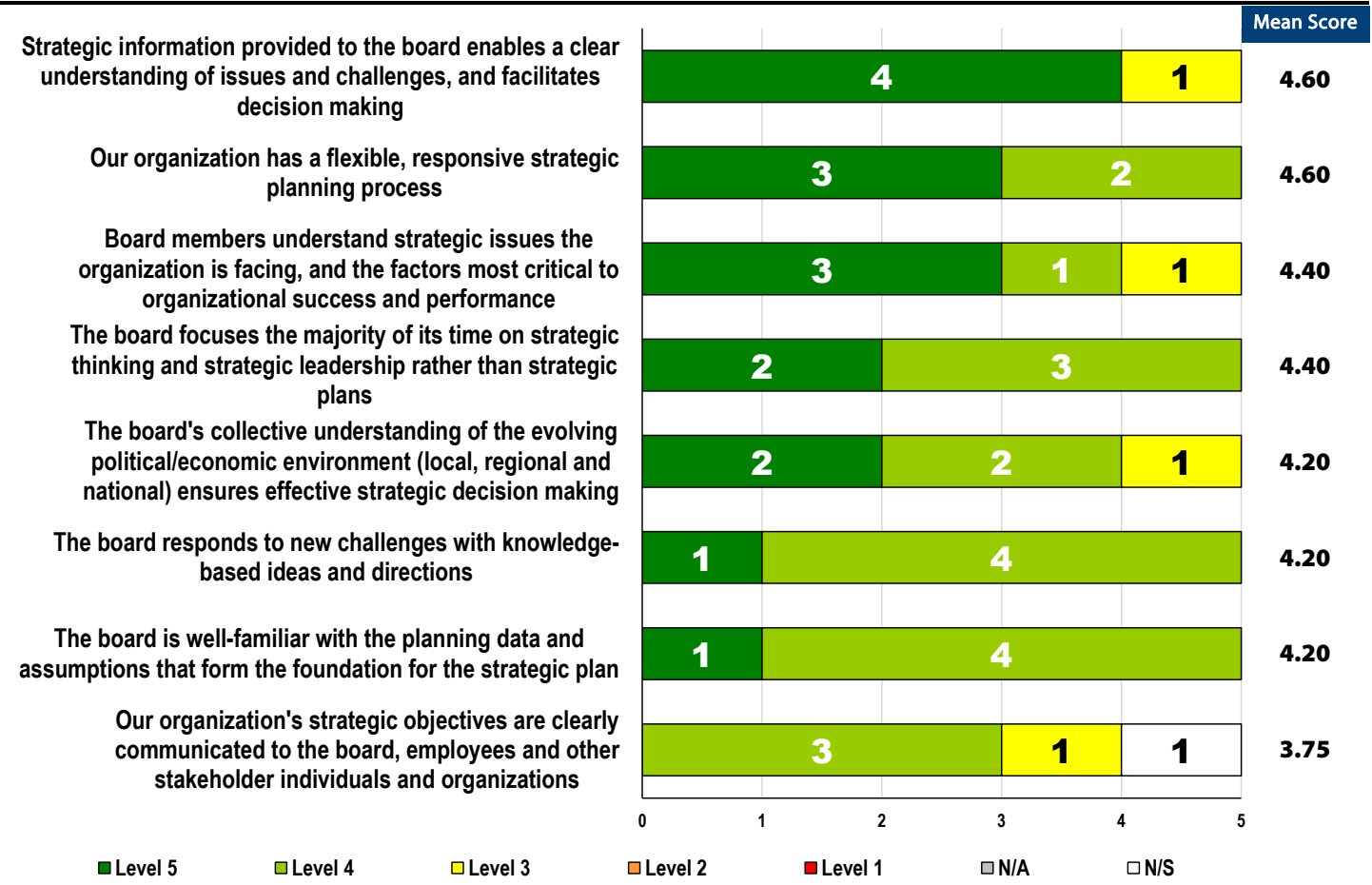
# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Strategic Direction

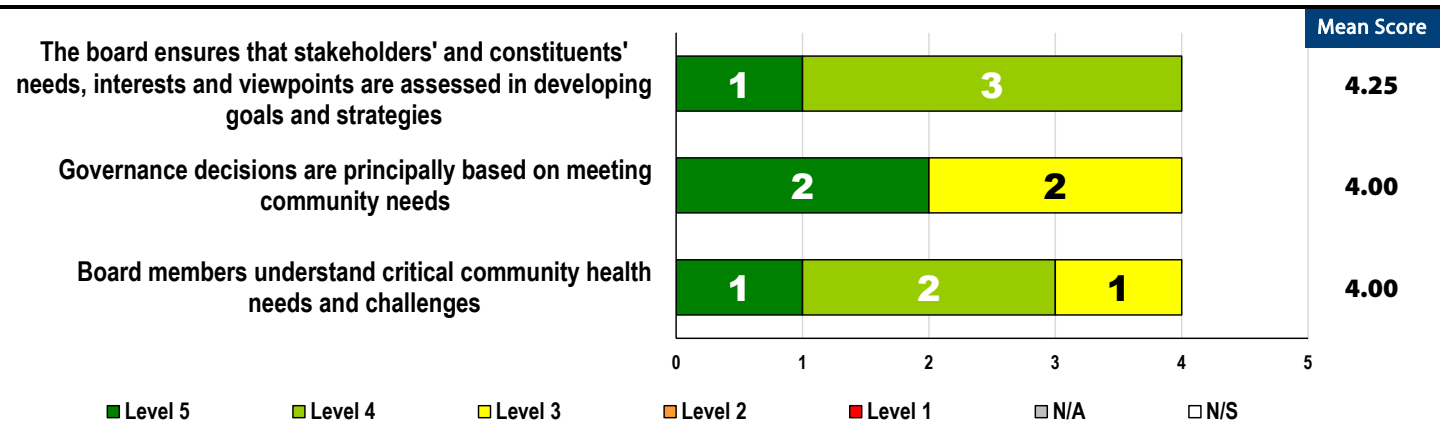
#### The Strategic Planning Process

(sorted by highest to lowest mean score)



#### Community and Stakeholder Perspectives

(sorted by highest to lowest mean score)

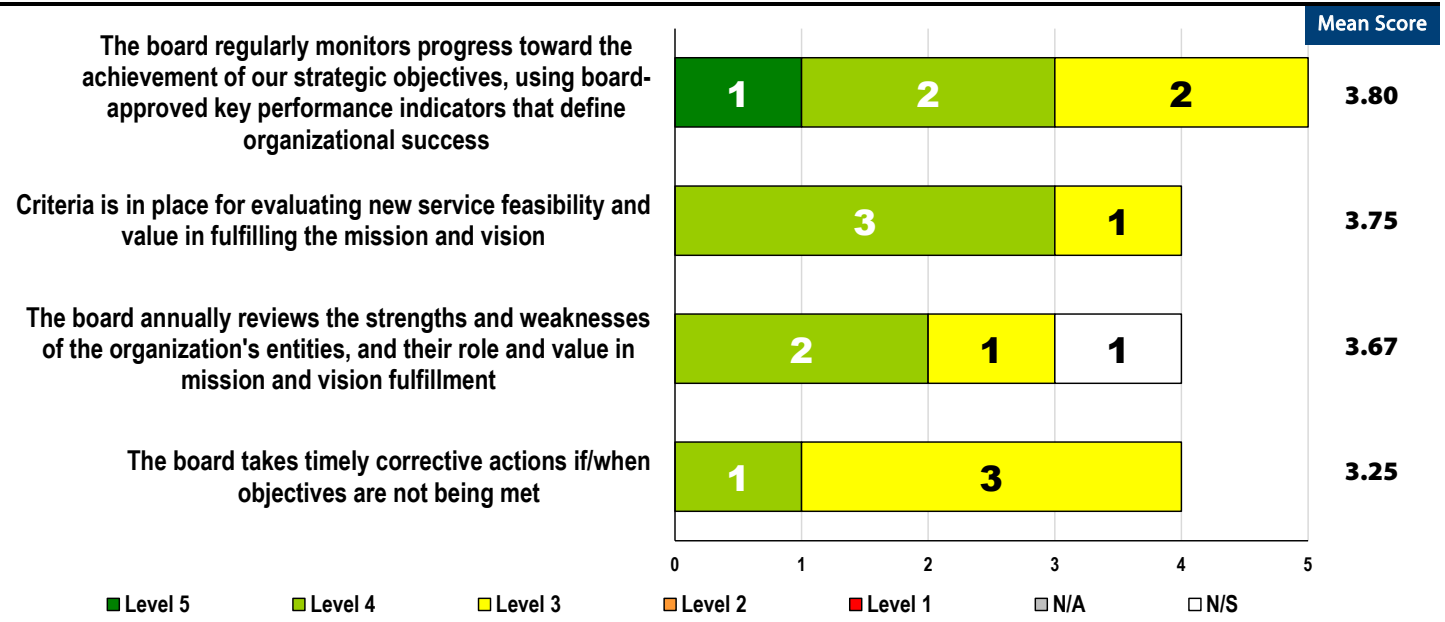


# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Monitoring Progress

(sorted by highest to lowest mean score)



### Suggestions for Governance Improvement

Board members provided the following suggestions for governance improvement in this section:

- Under current CEO leadership, these areas have been continuing to improve, and we have made great progress!
- We need more facts comparing us to industry standards. We need to know how far above the industry standards we must operate to stay in business the next two years. I want more accountability with each department and to know they understand what benchmarks they need to hit in order for the organization not to go bankrupt.
- Clear goals and monthly reporting.
- Review quarterly.

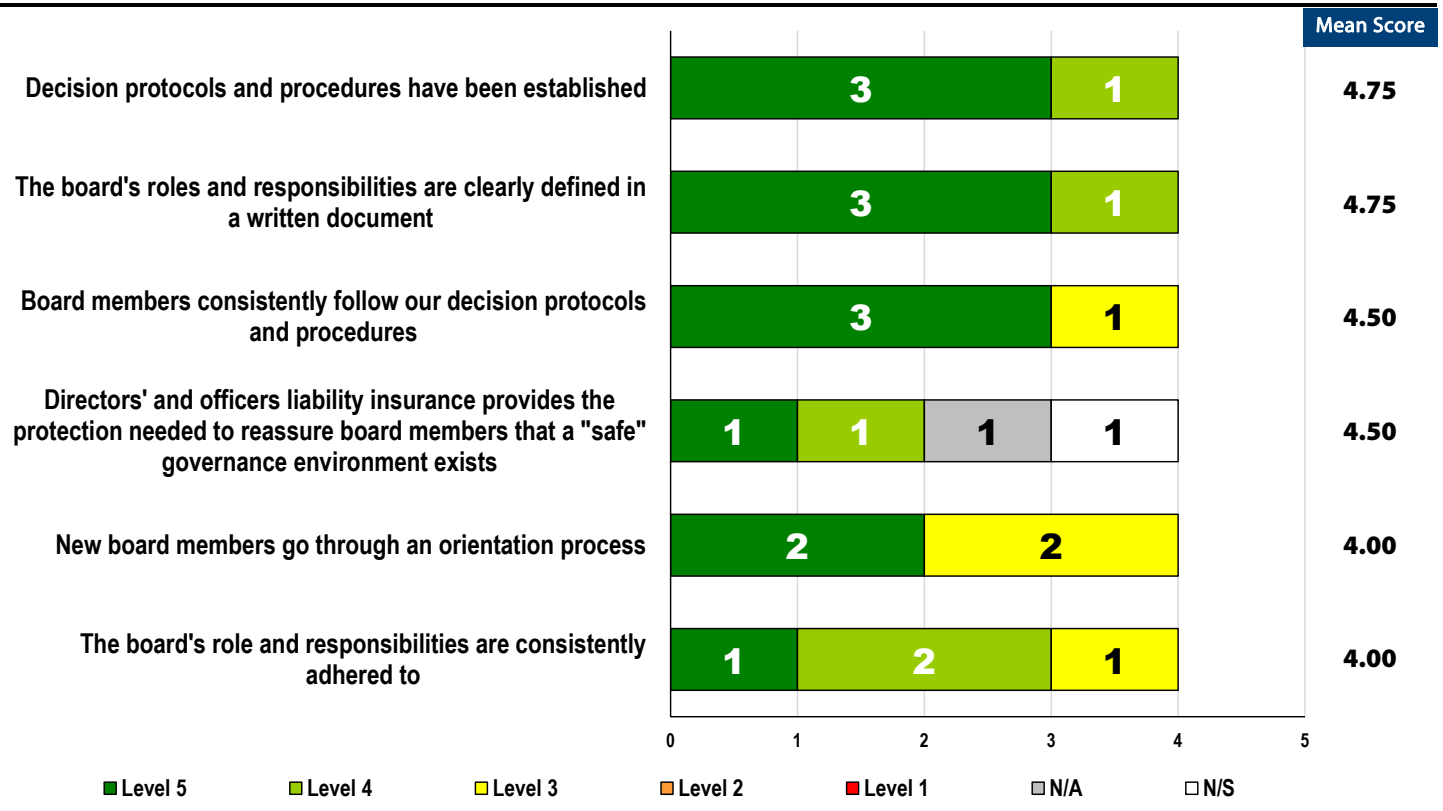
# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Leadership Structure and Processes

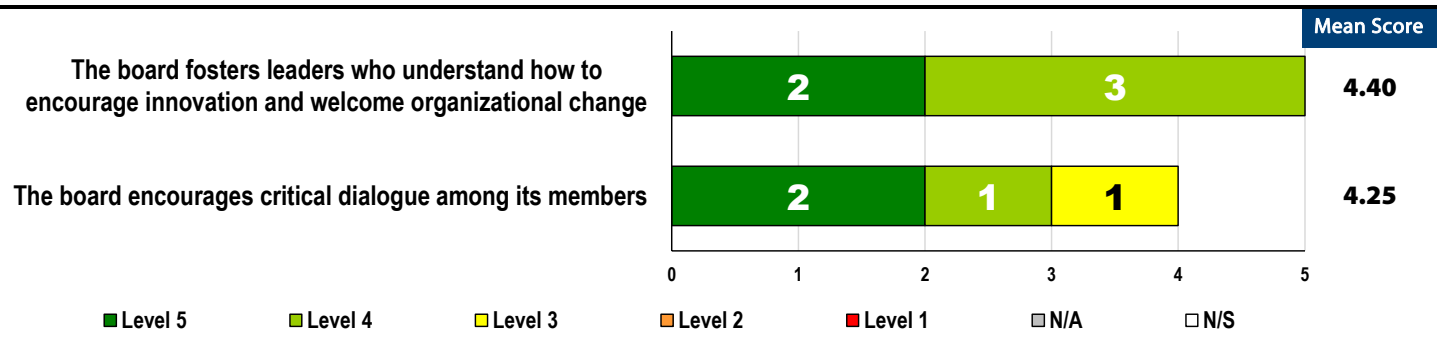
#### Board Roles and Responsibilities

(sorted by highest to lowest mean score)



#### Board Structure and Composition

(sorted by highest to lowest mean score)

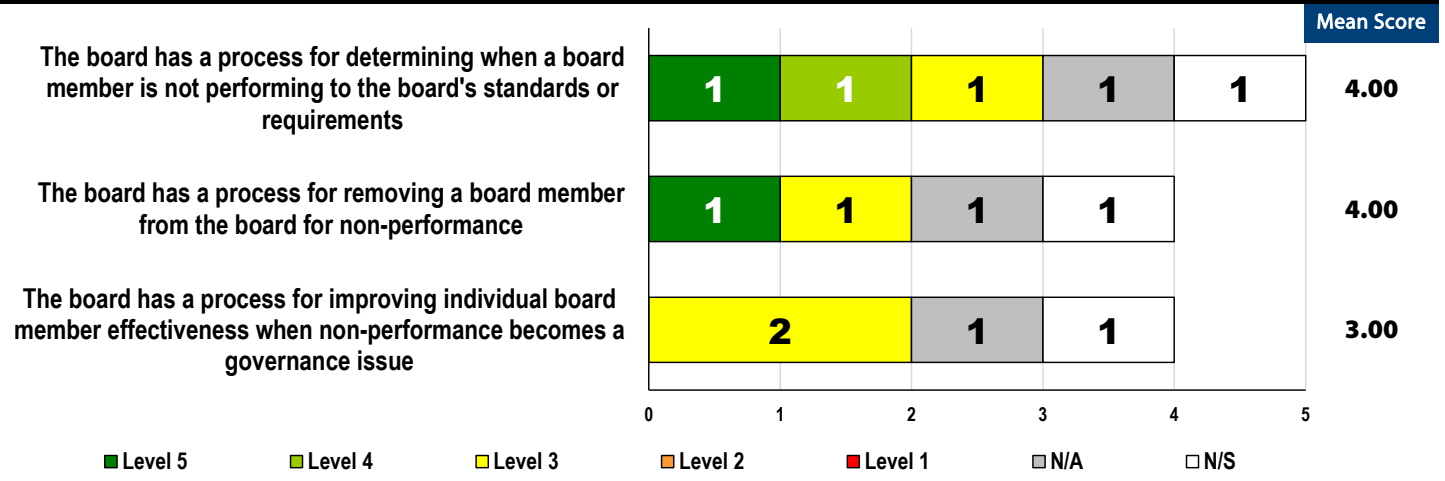


# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

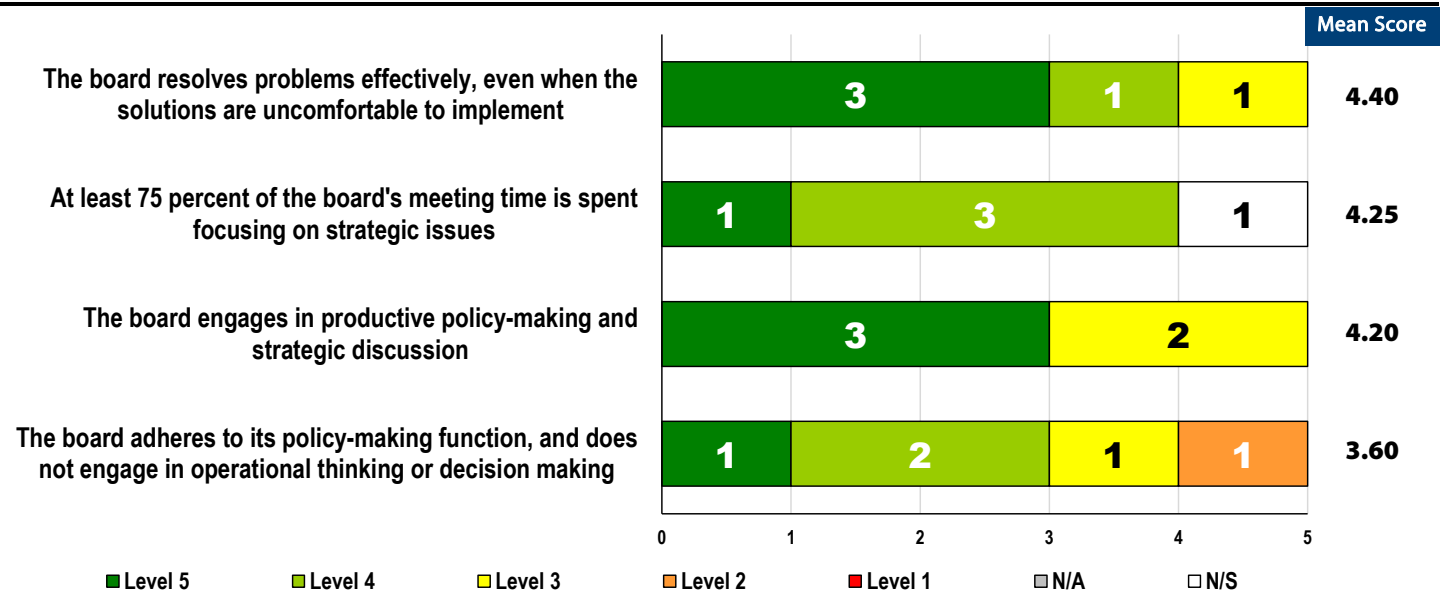
### Board Member Performance

(sorted by highest to lowest mean score)



### Strategic Focus

(sorted by highest to lowest mean score)



# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Board Meetings

(sorted by highest to lowest mean score)

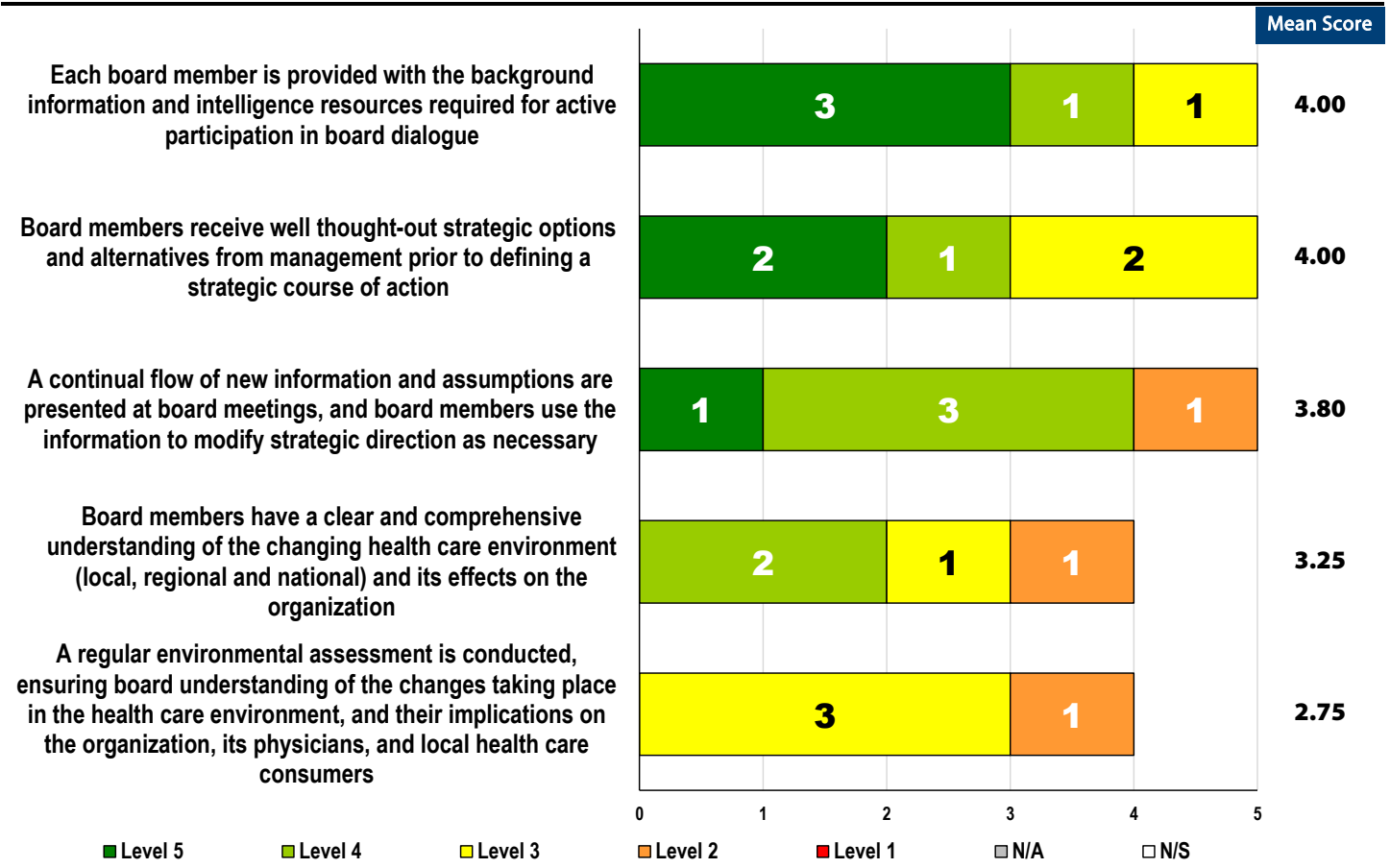


# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

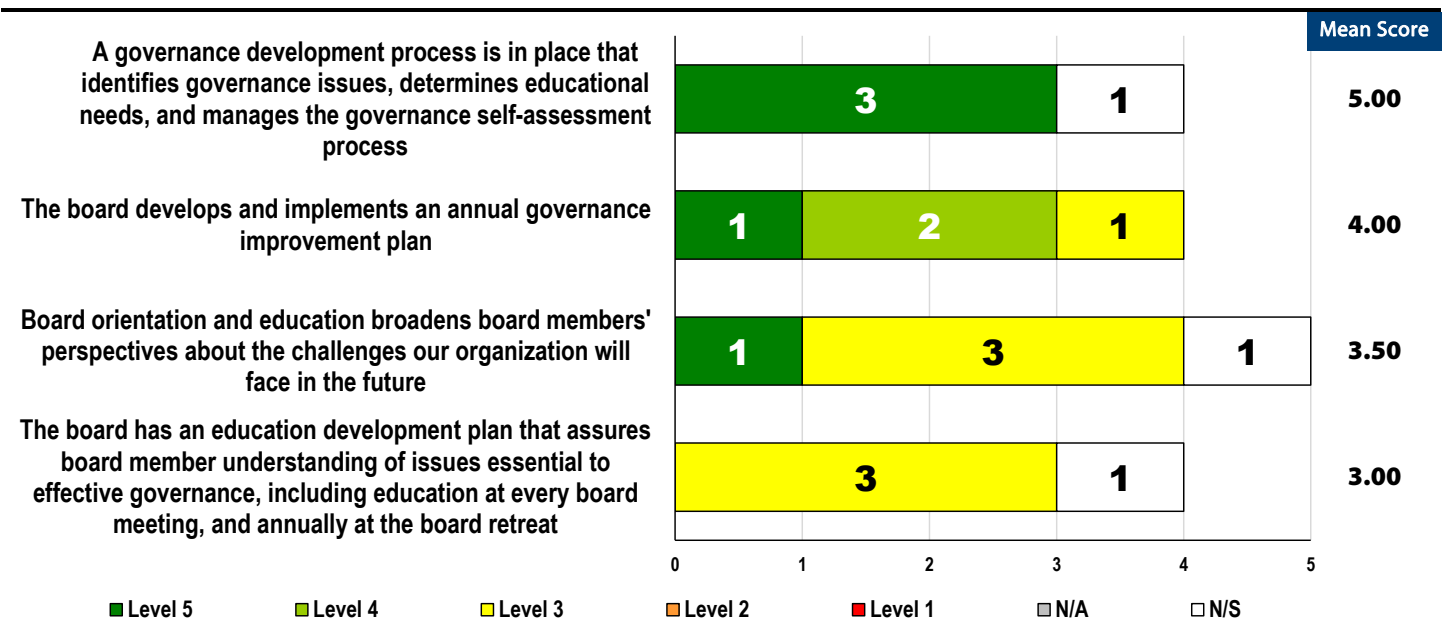
### Board Member Knowledge

(sorted by highest to lowest mean score)



### Governance Development

(sorted by highest to lowest mean score)

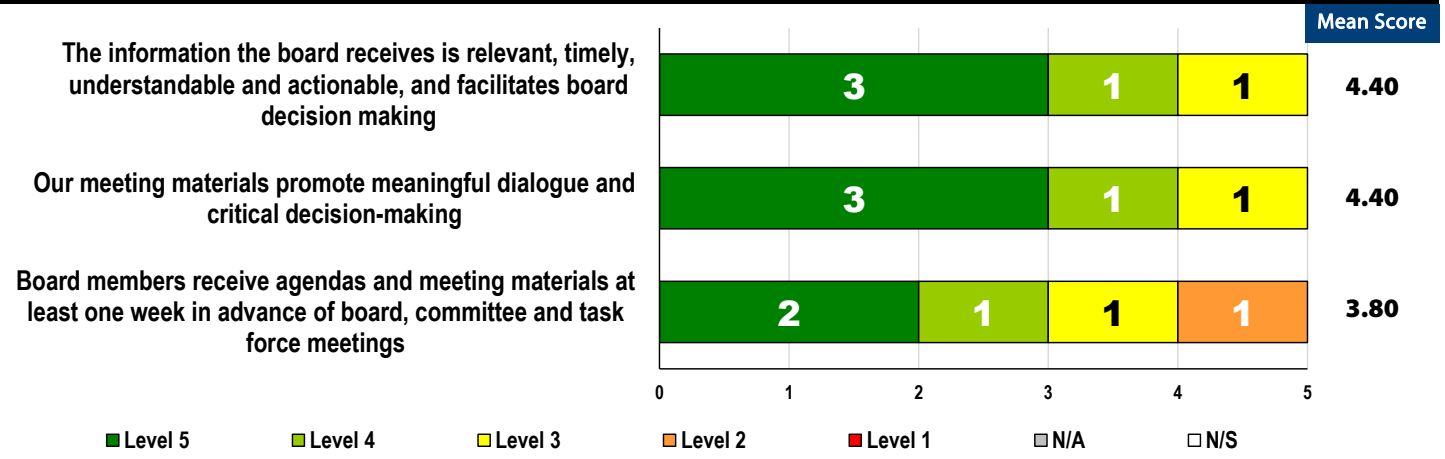


# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

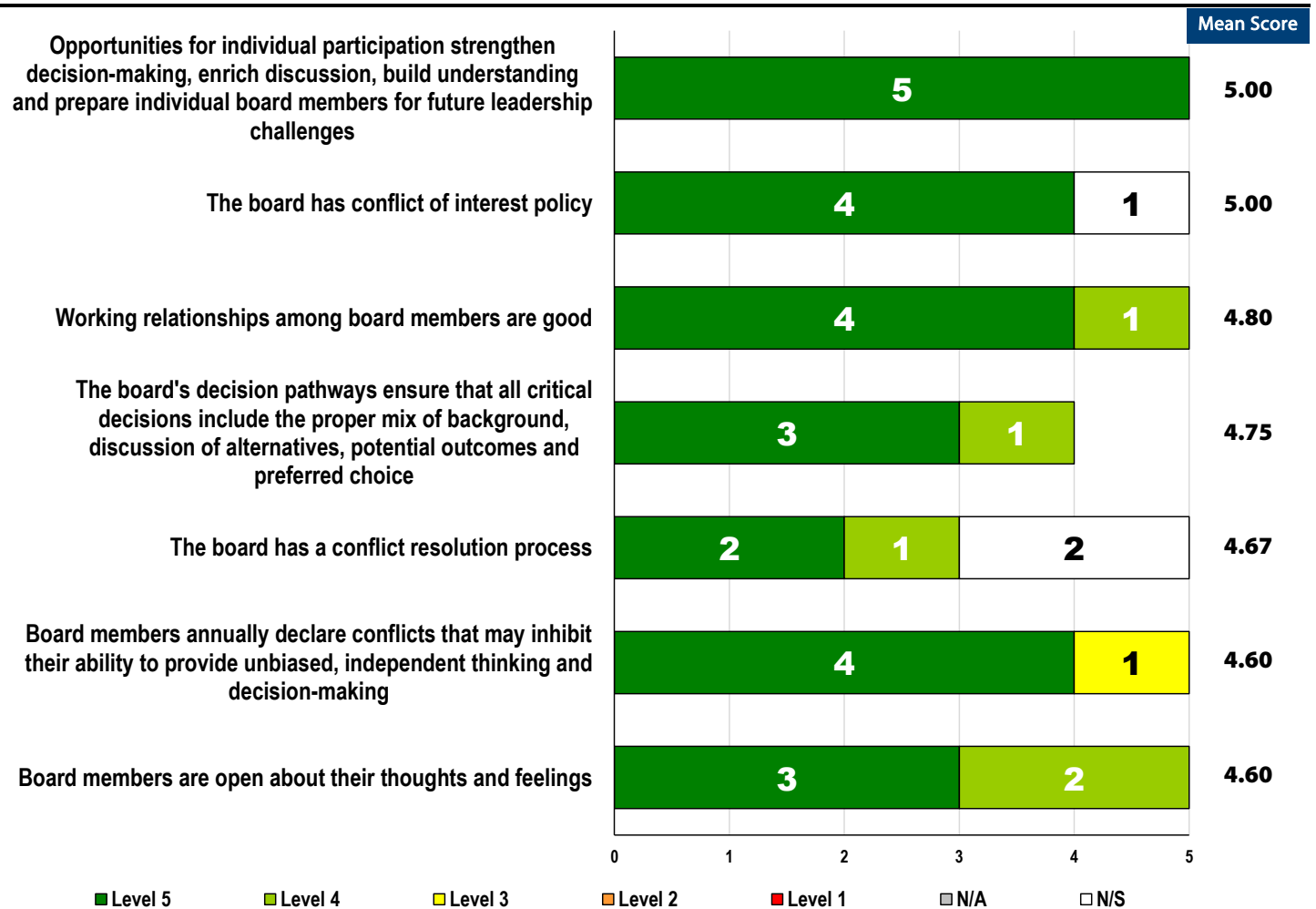
### Meeting Materials

(sorted by highest to lowest mean score)



### Board Relationships and Communication: Higher-Rated

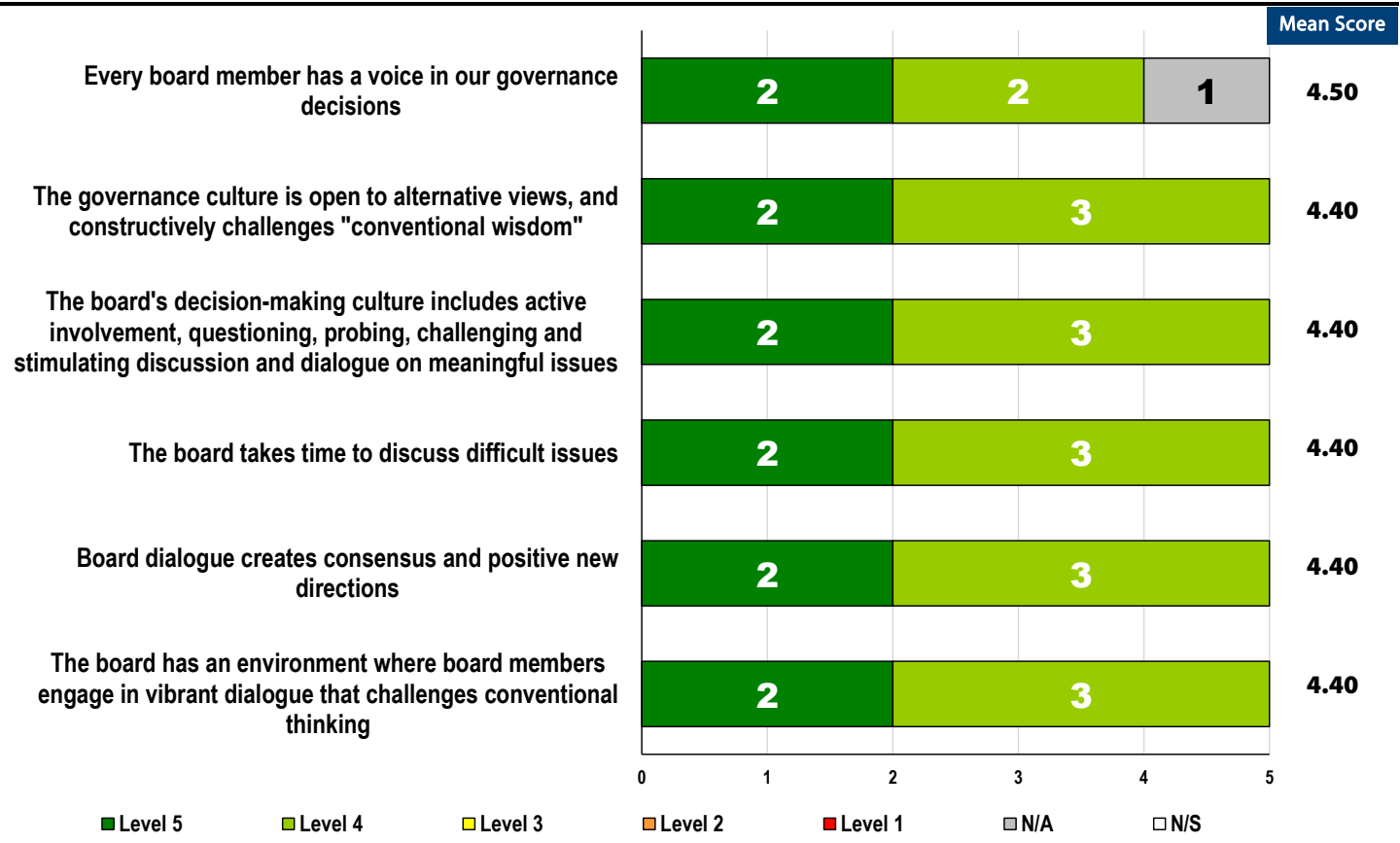
(sorted by highest to lowest mean score)



# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Board Relationships and Communication: Lower Rated (sorted by highest to lowest mean score)



### Suggestions for Governance Improvement

Board members provided the following suggestions for governance improvement in this section:

- The current Board members work well together in these areas.
- Again, having a retreat.

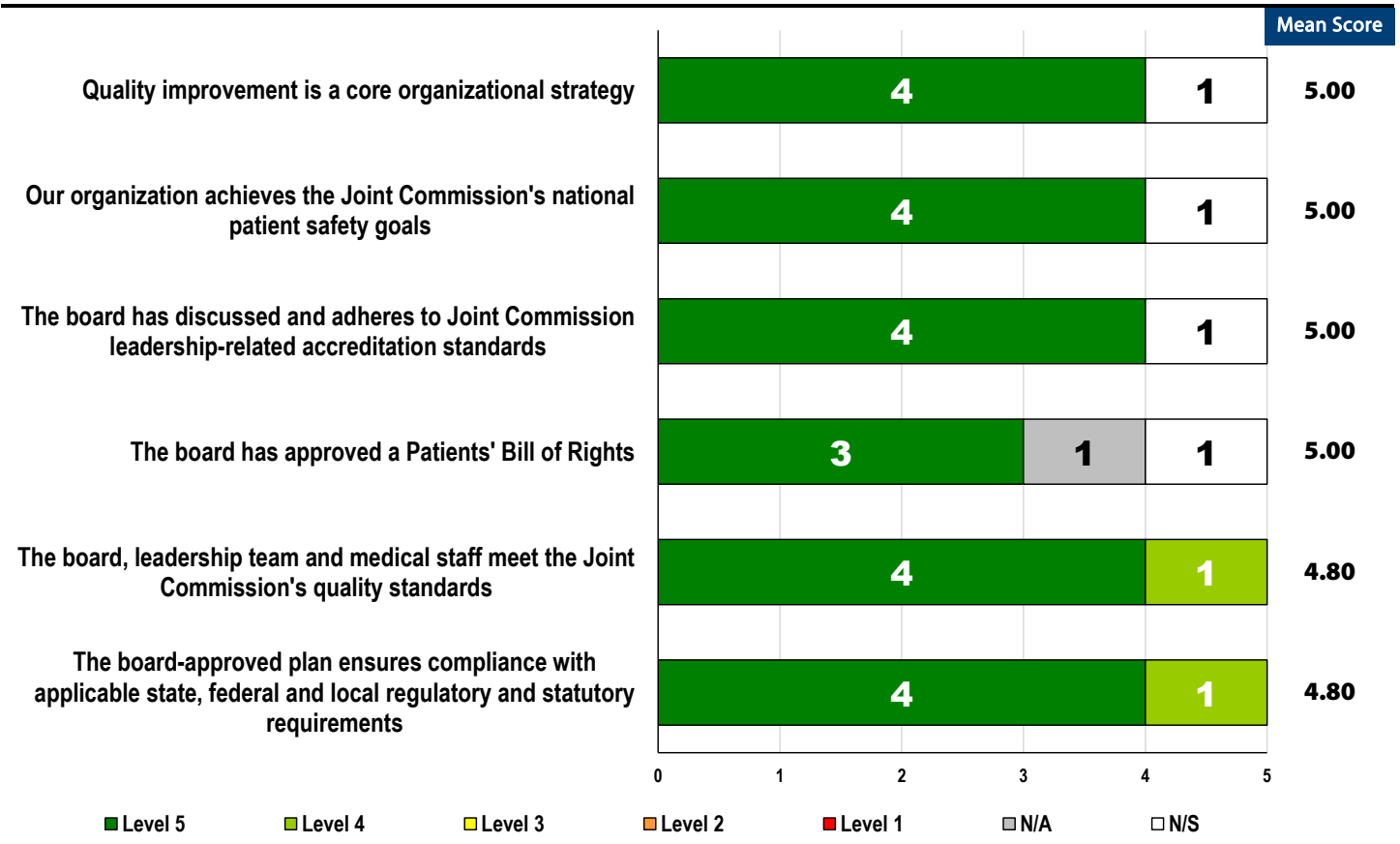


# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Quality and Patient Safety

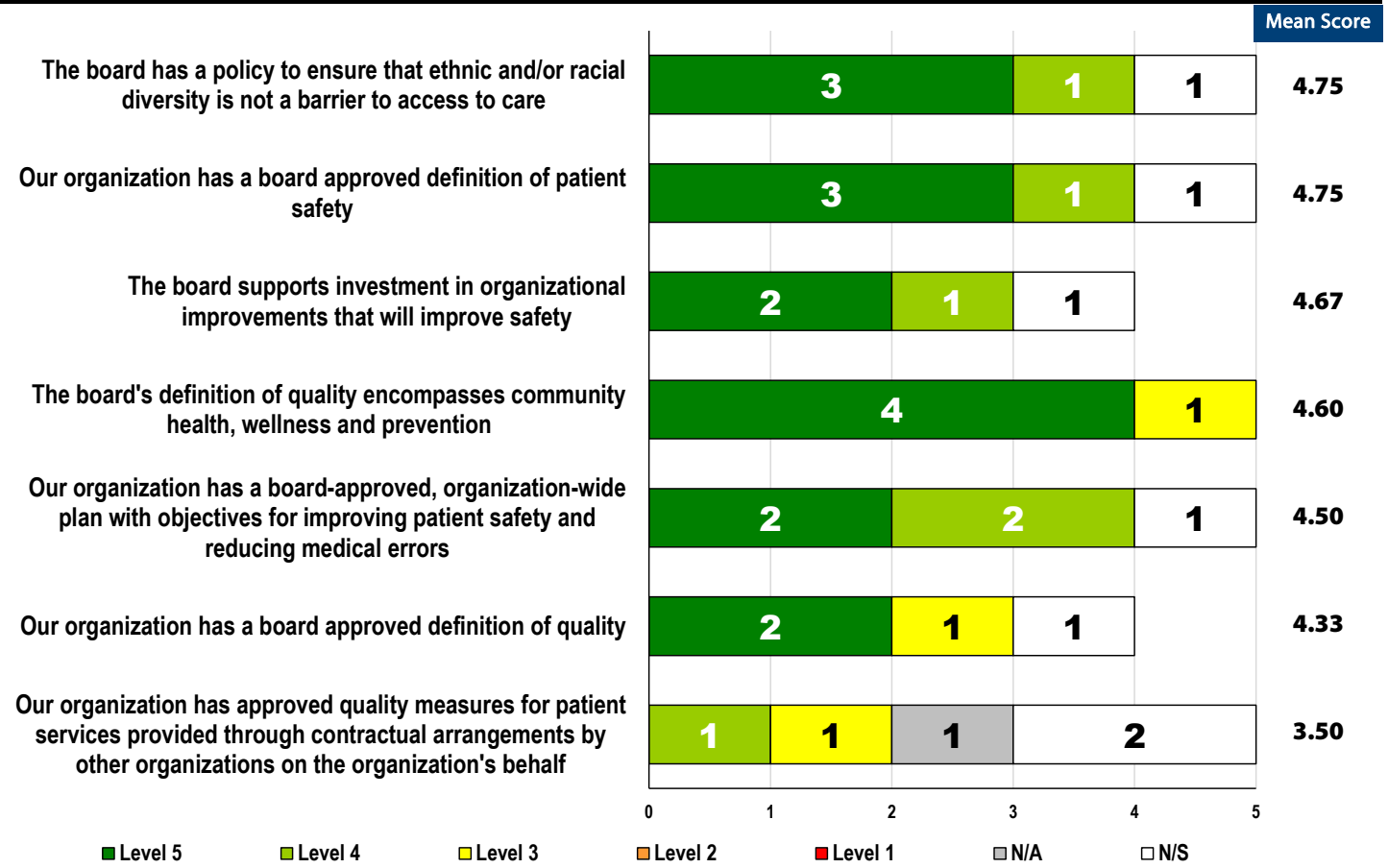
**Defining and Understanding Quality and Patient Safety Issues: Higher-Rated**  
*(sorted by highest to lowest mean score)*



# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Defining and Understanding Quality and Patient Safety Issues: Lower-Rated (sorted by highest to lowest mean score)

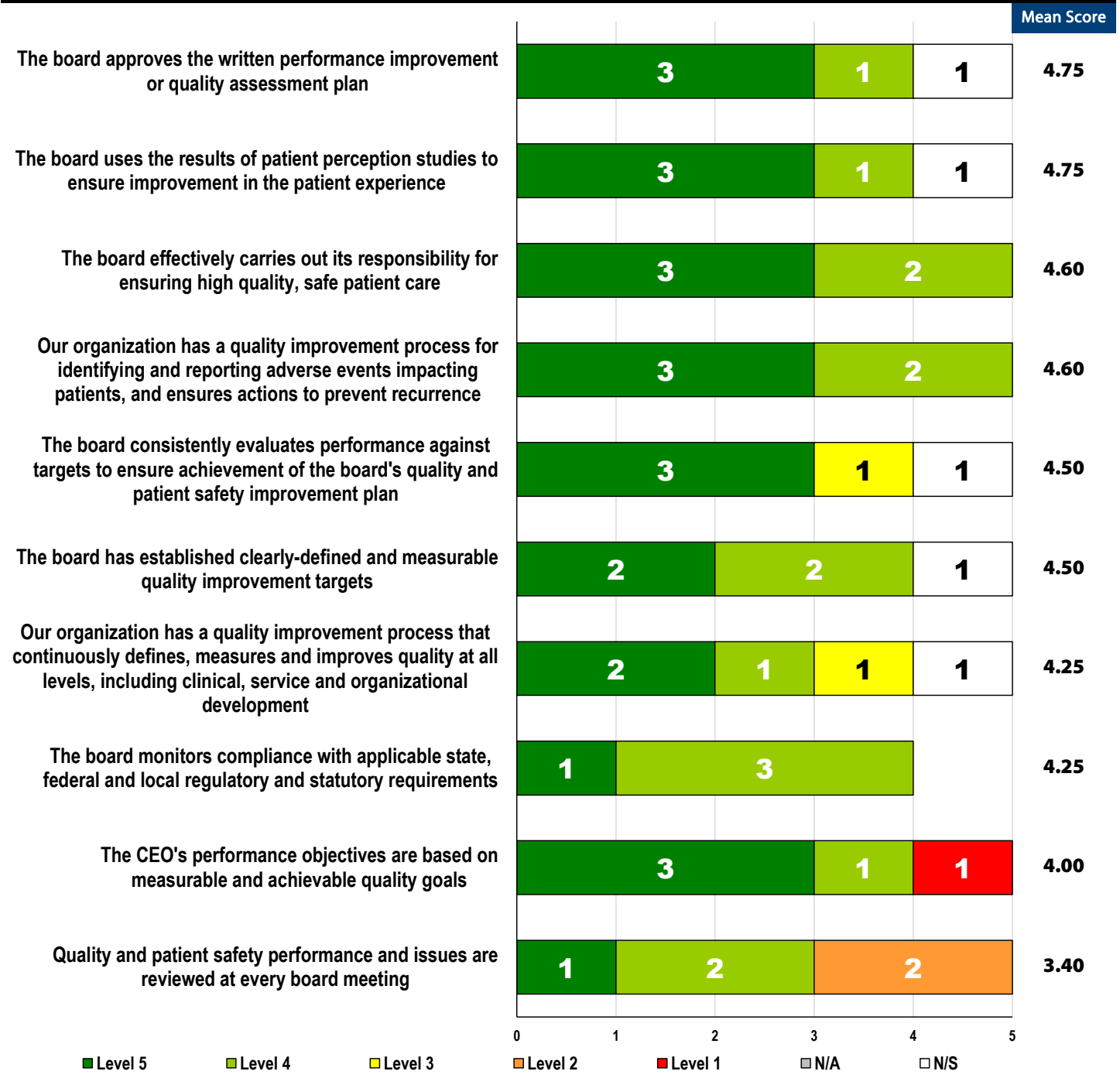


# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Monitoring Quality and Patient Safety

(sorted by highest to lowest mean score)

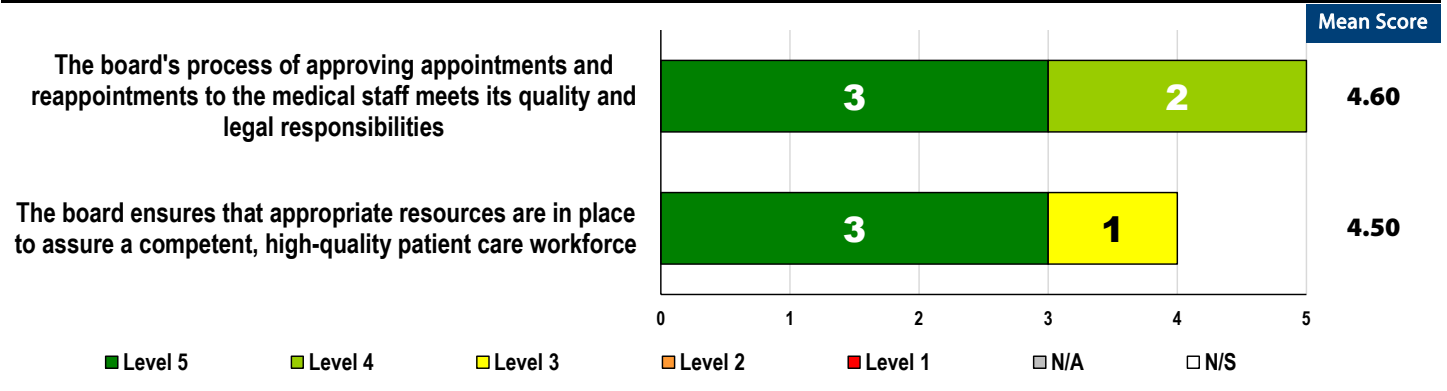


# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Ensuring a Workforce that Provides High Quality and Safe Care

(sorted by highest to lowest mean score)



### Suggestions for Governance Improvement

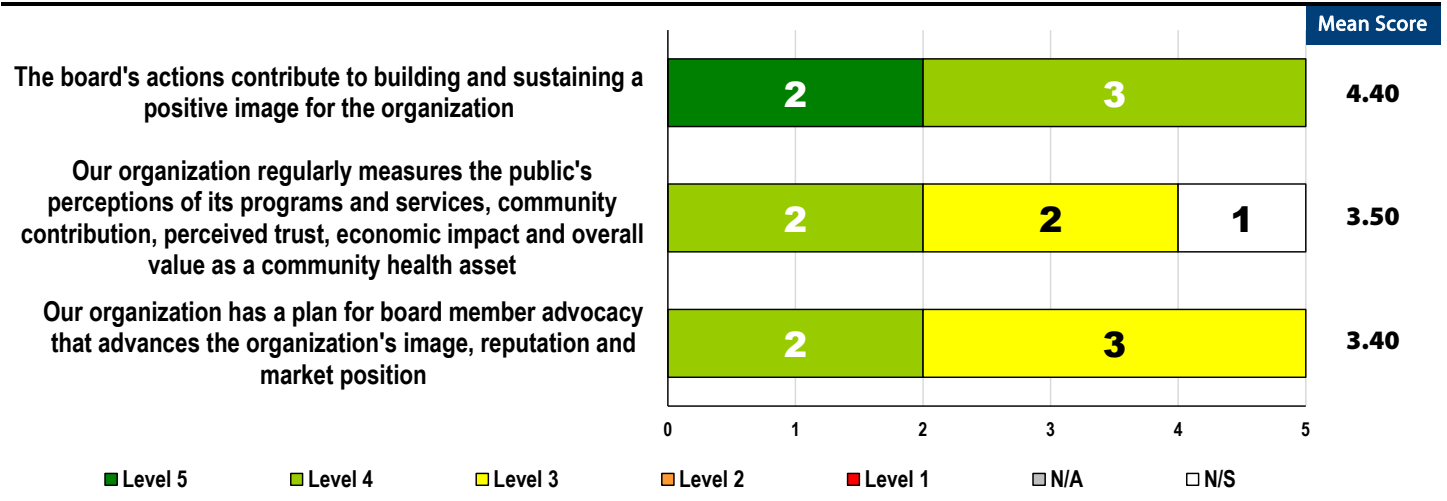
No comments or suggestions for governance improvement were provided in this section.

# SUMMARY RESULTS

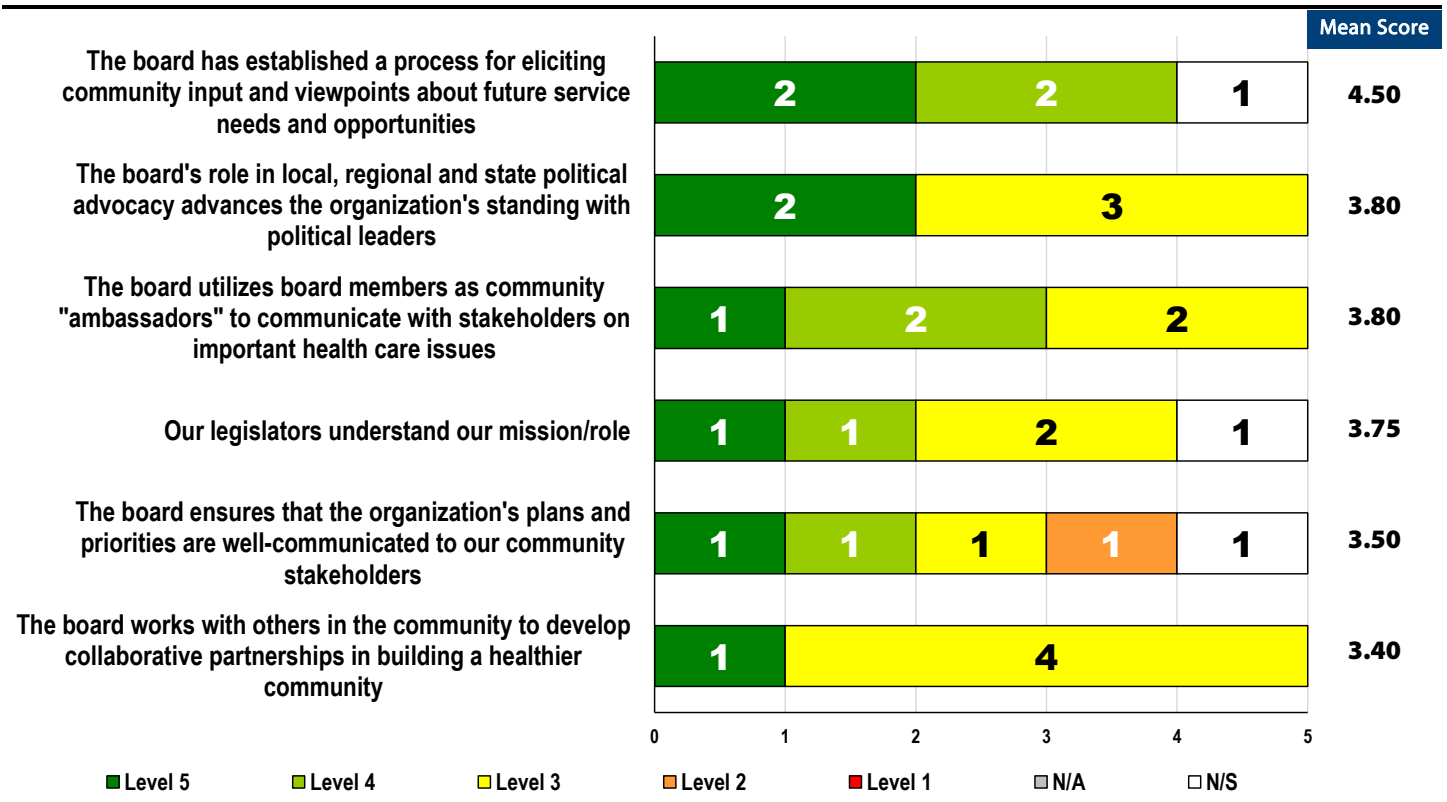
## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Community Relationships

#### Ensuring Public Trust and Confidence (sorted by highest to lowest mean score)



#### Ensuring Community Communication and Feedback (sorted by highest to lowest mean score)



# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Suggestions for Governance Improvement

Board members provided the following suggestions for governance improvement in this section:

- Much better marketing.
- Each Board member getting involved in some organization.

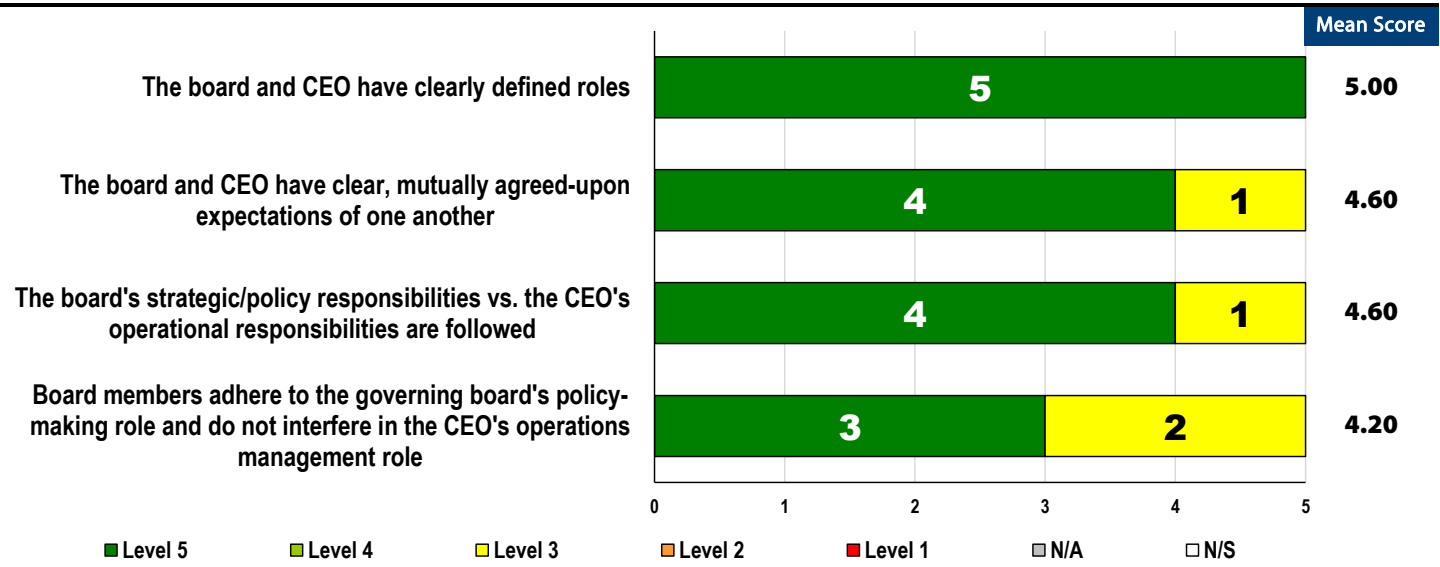
# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Relationship with the CEO

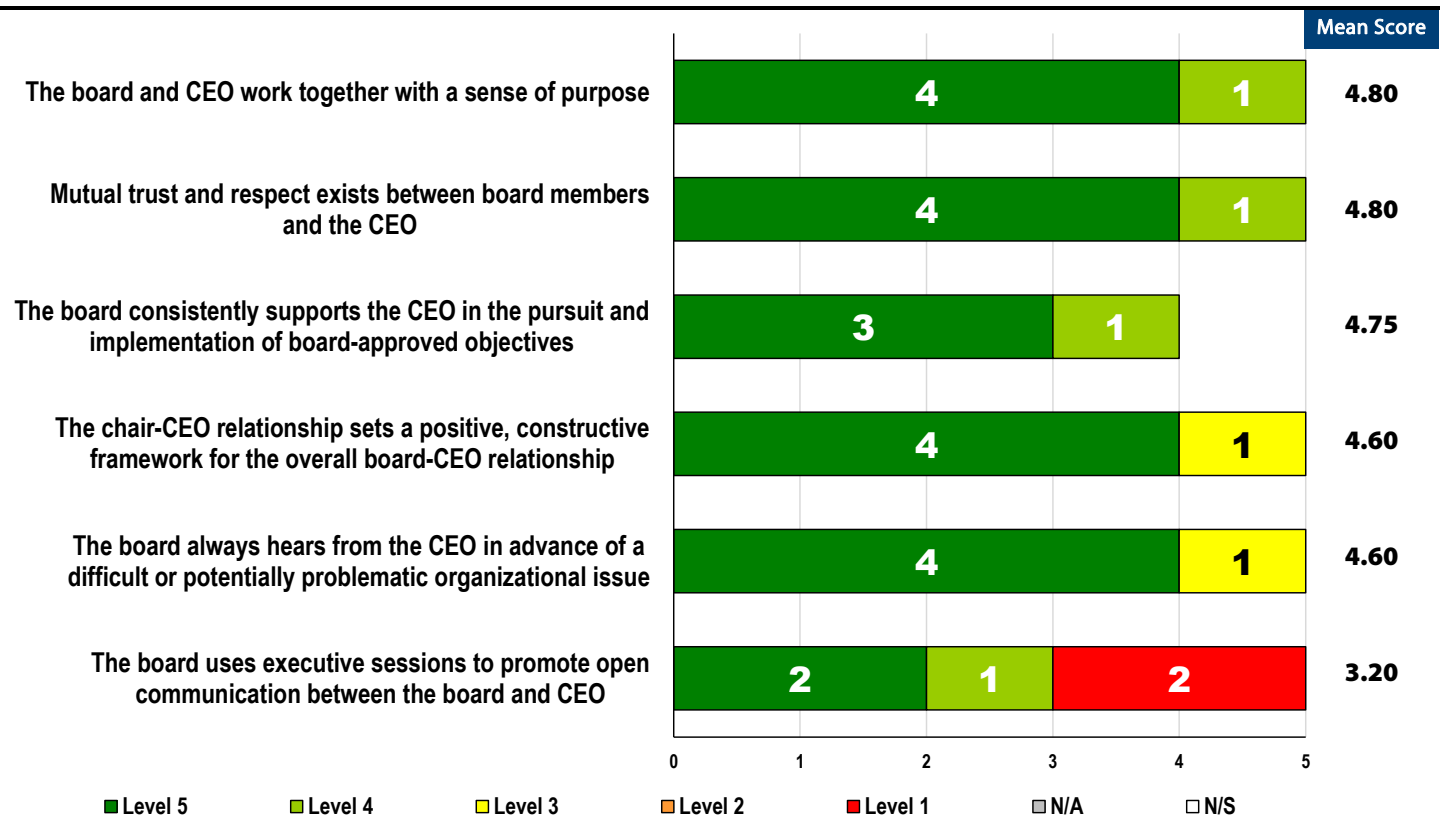
#### Board and CEO Roles

(sorted by highest to lowest mean score)



#### Communication, Support and Shared Goals

(sorted by highest to lowest mean score)

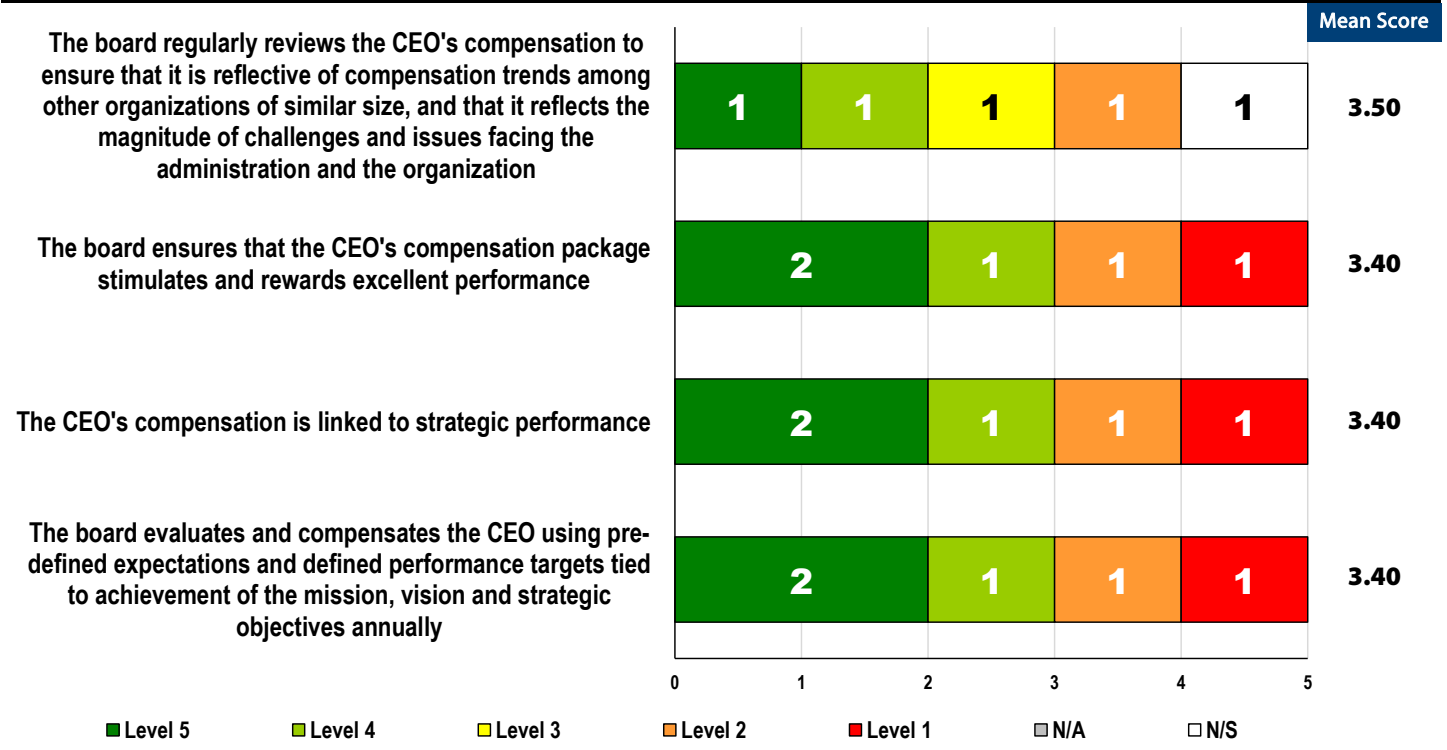


# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### CEO Evaluation

(sorted by highest to lowest mean score)



### Suggestions for Governance Improvement

Board members provided the following suggestions for governance improvement in this section:

- Having that conversation in a closed session would be helpful.
- Not sure HR regularly checks his compensation with other hospital districts of our size.



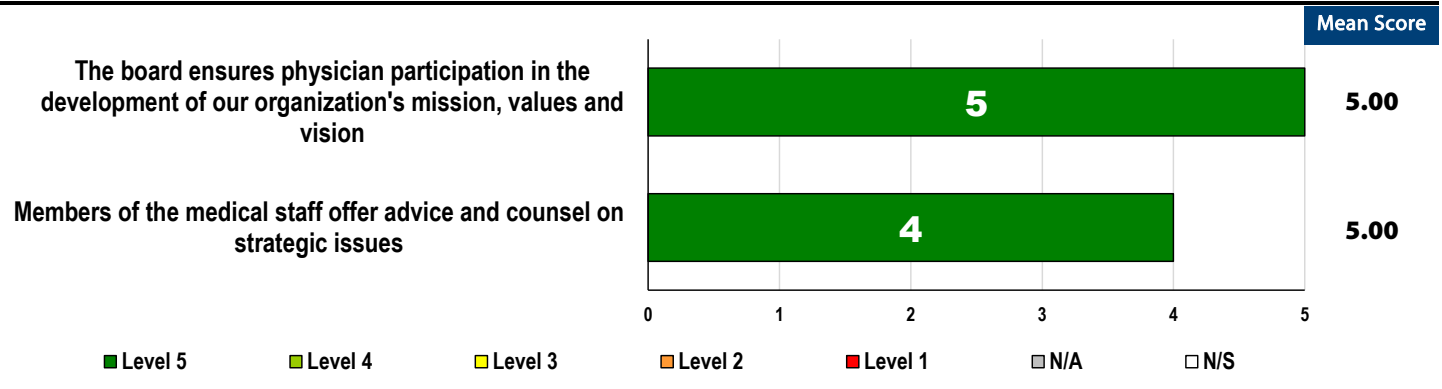
# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Relationships with the Medical Staff

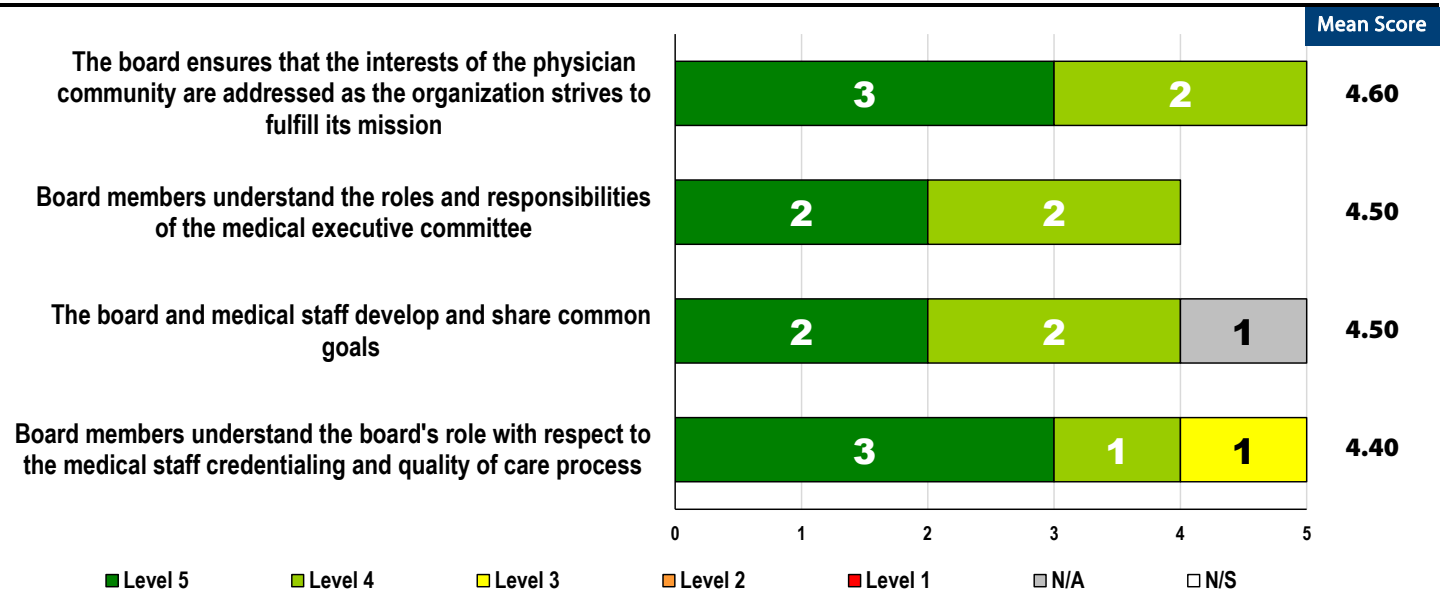
#### Physician Involvement in Decision Making

(sorted by highest to lowest mean score)



#### Shared Understanding

(sorted by highest to lowest mean score)

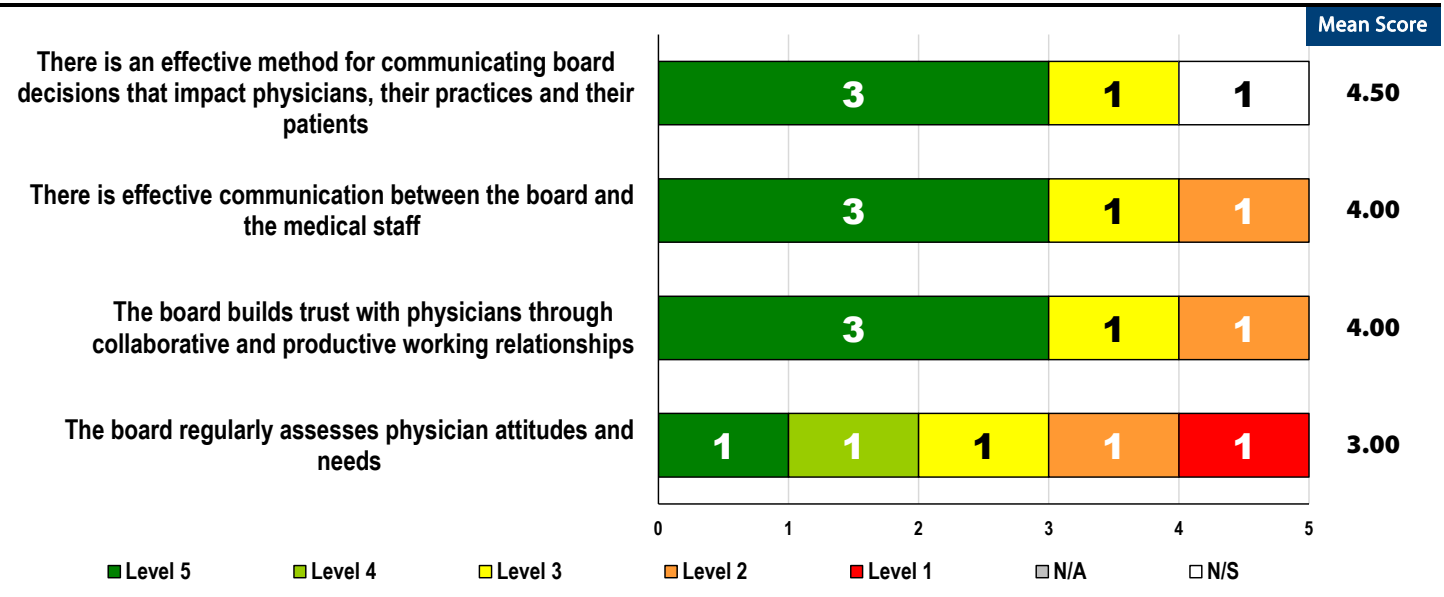


# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Communication and Interaction

(sorted by highest to lowest mean score)



### Suggestions for Governance Improvement

Board members provided the following suggestions for governance improvement in this section:

- Having the doctors present to us.
- Somehow find a way that the Board can meet with the physicians annually.

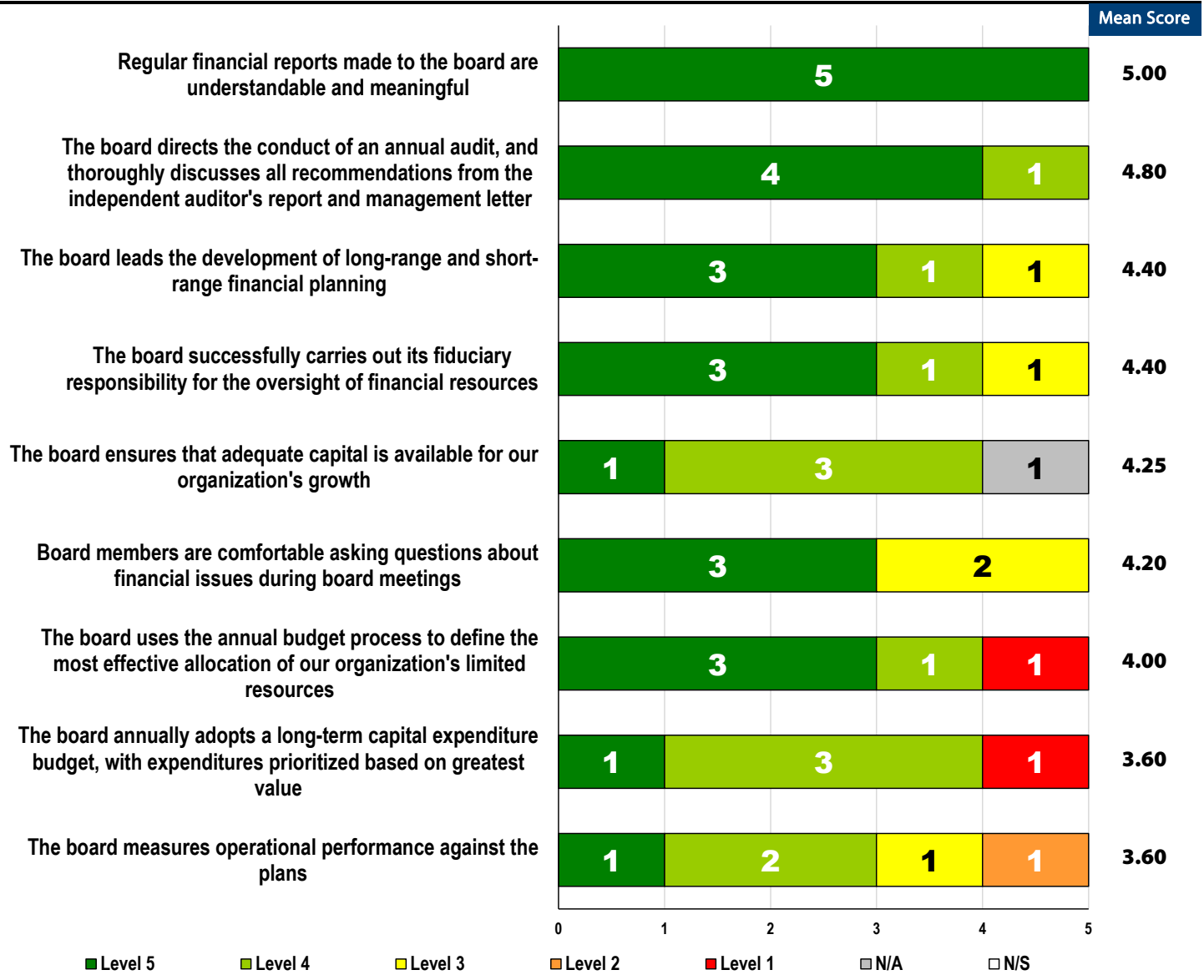
# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Financial Leadership

#### The Fiduciary Responsibility

(sorted by highest to lowest mean score)

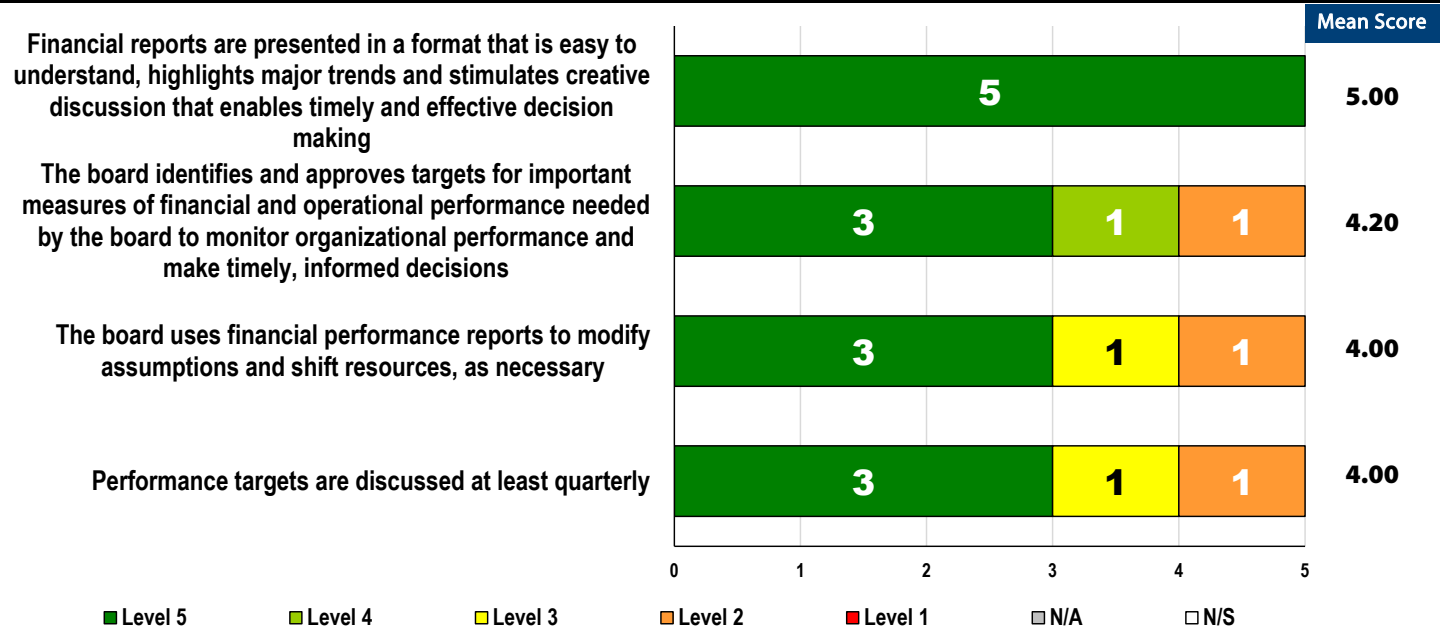


# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Monitoring Progress

(sorted by highest to lowest mean score)



### Suggestions for Governance Improvement

Board members provided the following suggestions for governance improvement in this section:

- This area has improved tremendously under our current CEO.
- Comparing us to industry standards.

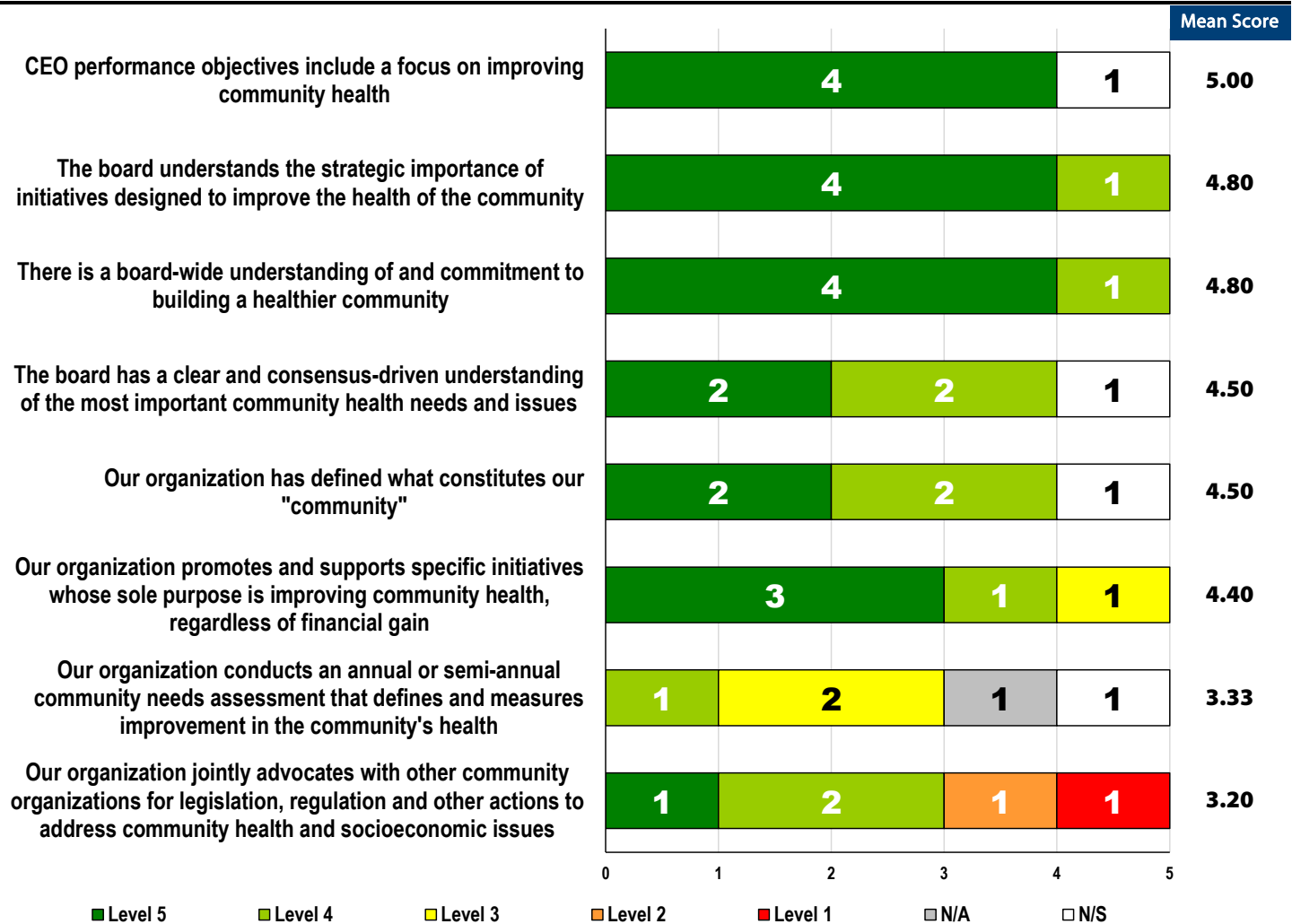
# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Community Health

#### Development and Support of Community Health Initiatives

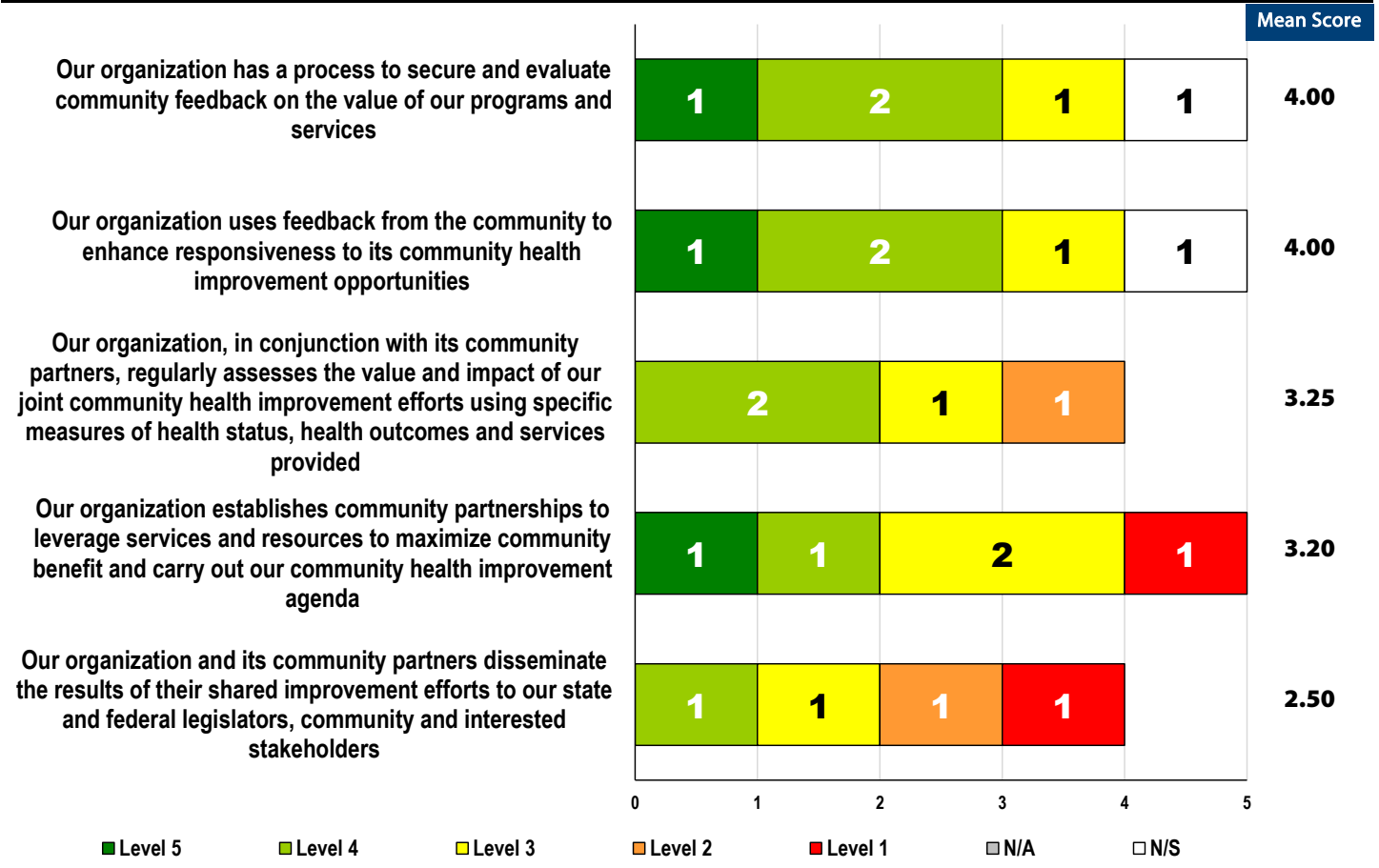
(sorted by highest to lowest mean score)



# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Community Involvement and Communication (sorted by highest to lowest mean score)



### Suggestions for Governance Improvement

Board members provided the following suggestions for governance improvement in this section:

- We could work more on partnering with other entities around service delivery, gap assessment, political advocacy, etc.
- CEO has Town Halls for the community. It really allows the community to ask questions and receive answers.

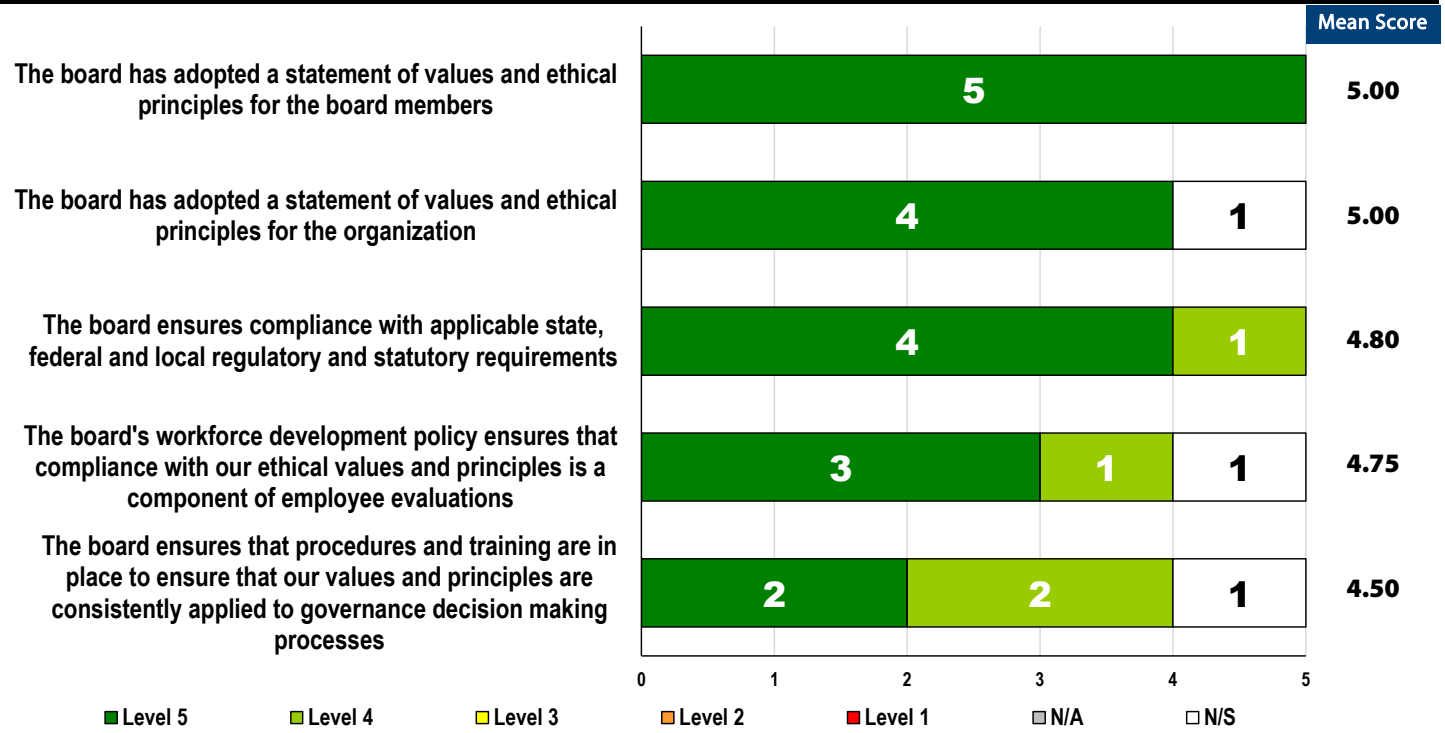
# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Organizational Ethics

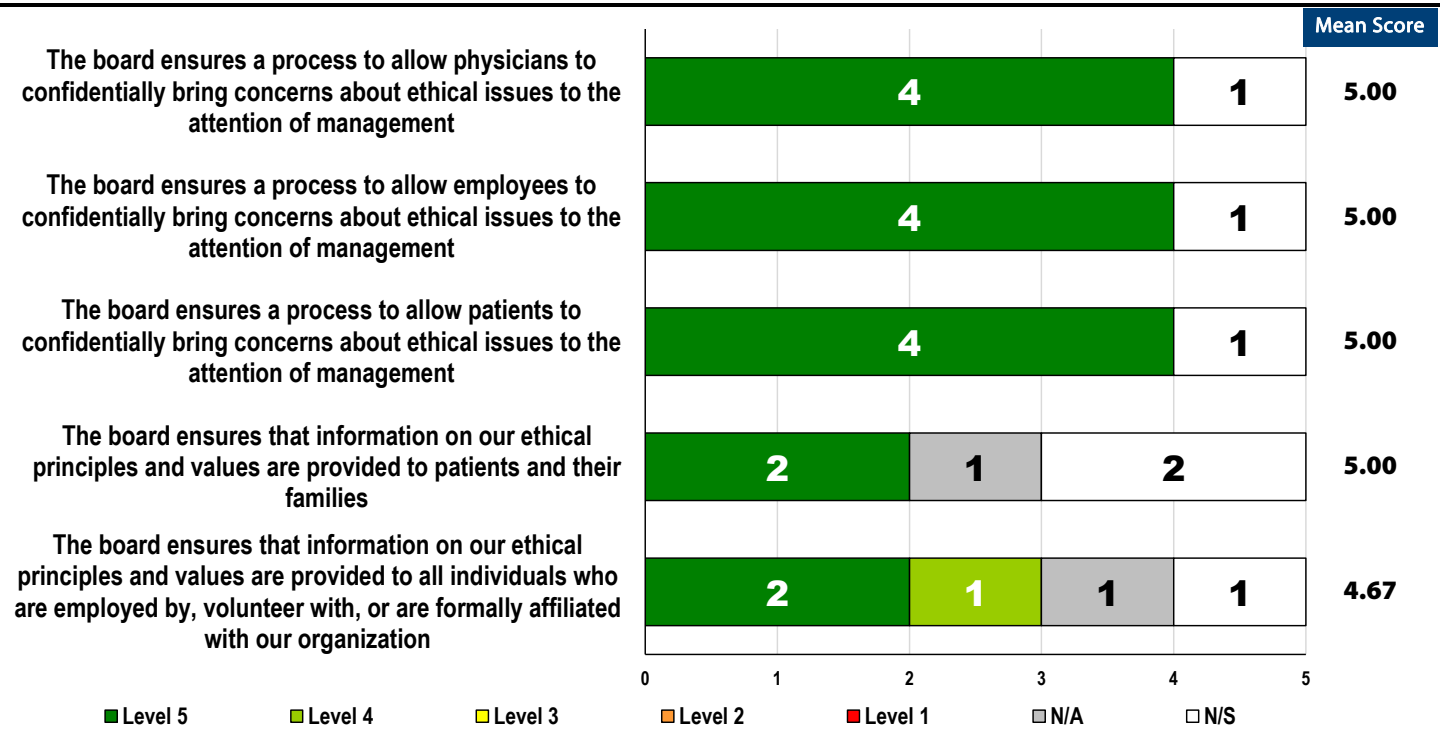
#### Ensuring Development and Implementation of Organizational Ethics

(sorted by highest to lowest mean score)



#### Awareness of Ethical Issues

(sorted by highest to lowest mean score)



# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

### Suggestions for Governance Improvement

*No comments or suggestions for governance improvement were provided in this section.*



# Issues and Priorities

### Highest Priority for the Board in the Next Year

**Question: What is your single highest priority for the board in the next year?**

- Improving the cash on hand number of days!
- To get us operating at a profit.
- Keeping our doors open.
- Working with neighboring health care providers to strengthen the services available to our communities.
- To provide the best service to our community, so they aren't traveling out of town to get it.
- To turn the perception of the hospital around.
- To make sure all providers are inspired both mentally and financially in solving our financial and perception issues.
- To make sure we are not life fighting patients out unnecessarily.
- To make sure our community gets appointments in a timely manner.

### Most Significant Strengths

**Question: What are the board's most significant strengths?**

- Everyone has a different background, different priorities, and different connections in the community.
- Engaged, respectful Board members all subscribe to a culture that supports spirited discussion and disagreement, while still finding a path to consensus decision-making.
- The board is committed and there is a real enthusiasm to solving the issues together.
- There is much respect among the board members.
- Knowledge of the community and history of the hospital.
- Listening to our leadership team and the CEO putting our patients first.

### Most Significant Weaknesses

**Question: What are the board's most significant weaknesses?**

- Not finding a way to be able to discuss important issues. Brown Act seems to hamper this.
- The Brown Act.
- Different understanding of transparency.
- For the most part, this is a really good elected Board, with diverse backgrounds and areas of expertise. We could use more ethnic/racial diversity on the Board to ensure we match the population we serve.

### Key Issues for Board Focus in the Next Year

**Question: What key issues should occupy the board's time and attention in the next year?**

- Number of days of cash on hand, and ensuring the current financial trajectory continues in a positive direction.
- Financial - finding a way to raise money for an RHC building.

# SUMMARY RESULTS

## 2024 Northern Inyo Healthcare District Governance Self-Assessment

- Finances and grant opportunities.
- Partnerships for service delivery.
- Working with other health care partners.
- Looking at services needed.
- Staying abreast of patient care.
- Benchmarks of industry standards and holding the CEO accountable for the success rate in which we achieve the goals.
- Becoming more engaged with our Foundation Board members and staff.
- Greatly enhanced marketing of many of the District's operational strengths.
- Being good ambassadors.

### Significant Trends the Board Must Understand and Deal with in the Next Year

**Question: What do you see as the most significant trends that the board must be able to understand and deal with in the next year?**

- Closely monitor and provide course correction, as needed, with our fiscal picture.
- Define a path towards the goal of a new building for the RHC.
- Begin to change the community perception of our hospital services.
- Cash flow and billing
- Closing of rural hospitals.
- Partnerships.

### Critical Factors to Address to Successfully Achieve Goals

**Question: What factors are most critical to be addressed if the hospital is to successfully achieve its goals?**

- Continue to strengthen all aspects our fiscal operations and oversight (revenue cycle, collections, denials, etc.).
- Billing and providing the right services. Once the service is provided, making sure there are enough employees to service the customer. I am not happy with the negotiated days for our providers. Recruiting is going to be key.
- Finances and transparency.
- Ensuring the Foundation's Board and Executive Director are fully engaged with District goals and strategic planning, and that they set appropriate goals for ensuring our collective success.
- Following our strategic plan.
- Improve the community perception about our services.
- Keep our current CEO, CMO, and COO!

# RatingsDirect®

---

## Northern Inyo County Local Hospital District, California; General Obligation

**Primary Credit Analyst:**

Chloe A Pickett, Englewood + 1 (303) 721 4122; Chloe.Pickett@spglobal.com

**Secondary Contact:**

Aamna Shah, San Francisco + 1 (415) 371 5034; aamna.shah@spglobal.com

### Table Of Contents

---

Credit Highlights

Outlook

Credit Opinion

Enterprise Profile: Vulnerable

Financial Profile: Vulnerable

Credit Snapshot

Related Research

# Northern Inyo County Local Hospital District, California; General Obligation

Credit Profile		
Northern Inyo County Local Hospital District GO (ASSURED GTY)		
<i>Unenhanced Rating</i>	B+(SPUR)/Negative	Current

Many issues are enhanced by bond insurance.

## Credit Highlights

- S&P Global Ratings' rating on Northern Inyo County Local Hospital District (NIHD), Calif.'s general obligation (GO) bonds and revenue bonds is 'B+'.
- The outlook is negative.

## Security

The GO debt is secured by the district's unlimited GO pledge, and the revenue debt is secured by a gross revenue pledge.

## Credit overview

The rating and outlook reflect the district's operating volatility over the past several years, coupled with diminishing balance sheet flexibility. The district experienced significant operating losses in fiscal years 2022 and 2023, attributable to increasing expenses, labor pressure, and a large pension expense recorded in fiscal 2023 related to untimely contributions in the previous year. The significant loss in fiscal 2023 also resulted in the violation of the district's debt service coverage (DSC) covenant, although no event of default was triggered, as it met the days' cash on hand covenant. The district's balance sheet is a limiting factor as well, with declining unrestricted reserves, elevated debt, and an extremely underfunded defined-benefit pension plan. The district's new management team is budgeting for a negative-albeit-improved operating margin in fiscal 2024, as the team has implemented various large-scale improvement initiatives. We believe the assumptions are reasonable, as operations have dramatically improved through the six-month interim period ended Dec. 31, 2023, and are expected to improve further due to the recognition of \$10 million in intergovernmental transfer (IGT) payments by year-end. We believe the NIHD's new management team has made significant progress in stabilizing the district's financial position; however, if the district is unable to maintain the recent operating improvement, violates its DSC covenant again, or unrestricted reserves decrease further, we could lower the rating.

The rating further reflects NIHD's market position in a very small service area with limited growth potential. Although the district has maintained a leading and growing market share in its primary service area (PSA) for several years, this is offset by our view of a small, highly concentrated medical staff and reliance on governmental payers. However, the district's new management team has invested in the growth of several key service lines, significantly increasing market share in fiscal 2023. Following years of significant management turnover, the new team has been in place for more than a year and quickly implemented a large-scale improvement plan to stabilize NIHD's financial position. Although

we view the new management team favorably, continued unexpected turnover in key executive positions could cause us to change that view, particularly if it negatively affected the district's ability to execute on ongoing improvement initiatives.

The rating also reflects a negative adjustment due to the district's small total operating revenue base of less than \$150 million.

The rating reflects our view of the district's:

- Thin and declining unrestricted reserves, specifically low unrestricted reserves-to-long-term debt;
- Ongoing operating losses and weak maximum annual debt service (MADS) coverage, although this improved through the six-month interim period ended Dec. 31, 2023;
- Limited service area and revenue base with modest declines in population and employment projected; and
- Very high debt burden and significantly underfunded defined-benefit pension liability.

Partially offsetting these weaknesses, in our view, are the district's:

- New management team focused on improving operations and cash flow, as well as stability in unrestricted reserves;
- Leading and growing market position, capturing the majority of its PSA population albeit in a remote service area; and
- Stability and durability of the largest taxpayer, which we expect will continue given its essential nature to Los Angeles' water utility.

### **Environmental, social, and governance**

We view NIHD's social capital risk as elevated because its operations are in a modestly sized, limited service area in eastern California that remains challenged, with stagnant population growth. We also view NIHD's physical risk as elevated given its location in an area historically prone to earthquakes and wildfires. That said, NIHD has partially mitigated physical risks by investing in strategic capital projects to meet state-mandated seismic building codes, and by ensuring that the hospital is compliant with seismic standards through 2030.

We also analyzed NIHD's governance risk and determined it is elevated in light of ongoing risks associated with the district's underfunded defined-benefit pension plan, as the plan exposes NIHD to contribution volatility and could pressure operations. In addition, management turnover in recent years has resulted in disruption to timely reporting of financial and enterprise data, although the new management team has made significant improvements. Furthermore, the board of directors is elected by the voters and certified by the county and is not self-perpetuating, which we consider best practice, although we note that this structure has not hampered NIHD's ability to execute on its strategies.

## **Outlook**

The negative outlook reflects ongoing negative-albeit-improved operating performance and decreasing unrestricted reserves. Precluding a lower rating at this time is our expectation that the district's operating improvement plan will

continue to yield results, stabilizing operating performance and unrestricted reserves.

### **Downside scenario**

We could lower the rating if NIHD is unable to sustain the recent trend of operating improvement and maintain or improve unrestricted reserves. We could also lower the rating if NIHD increases its already heavy debt load or violates its financial covenants such that an event of default is triggered. Finally, any deterioration in enterprise profile characteristics or continued management turnover could result in a lower rating.

### **Upside scenario**

We could revise the outlook to stable if NIHD's operating performance continues to improve, generating operating margins approaching breakeven as well as adequate MADS coverage consistently above covenant levels. We would also view positively growth in unrestricted reserves, further reduction in leverage, and steps to address the large pension liability.

## **Credit Opinion**

### **Enterprise Profile: Vulnerable**

#### **Limited PSA with stagnant growth projections**

The district's population is small, at approximately 8,000 residents, about 3,900 of whom are in Bishop, the largest city in the county. However, the district serves about 18,000 in the broader Inyo County, with moderate population and employment decline projected over the next five years. We consider the small service area population a vulnerability of the enterprise profile, because it inherently results in a smaller patient pool to spur future revenue growth.

We consider the district's tax base to be highly concentrated due to the Los Angeles Department of Water and Power's (LADWP) ownership of an aqueduct and land that accounts for the majority of the total tax base. LADWP owns substantial portions of the Owens Valley, which supplies water to the Los Angeles Basin through the Los Angeles Aqueduct, but we believe that the essentiality of LADWP's holdings within the district is strong. There is no significant taxpayer concentration after LADWP holdings. We view the lack of information regarding the trending assessed values and top taxpayers beyond LADWP as a credit risk. The district is supported by tax revenues for operations and debt service, although tax revenues typically account for only 2% of total operating revenues, which we view as modest.

#### **Leading and growing market share with service line expansion**

The district operates a 25-bed, critical-access hospital in Bishop, approximately 300 miles north of Los Angeles and 200 miles south of Reno. The hospital provides emergency medical care, as well as a full range of inpatient and outpatient services for travelers and tourists along the Highway 395 corridor. As part of management's improvement plans, NIHD has expanded and invested in growth in key service lines, which has helped to increase market share. Although the market share remains solid, we will continue to monitor the long-term trend of market share data; however, if recent increases are sustained, this could contribute to an improving enterprise profile over time.

We consider NIHD's payer mix somewhat weak because it has a fairly high Medicare mix, reflecting the aging population in the area. However, as a critical-access hospital, the district receives cost-based reimbursement from

Medicare, which is beneficial. Commercial contracts are largely based on costs the hospital determines rather than being set by the insurer, and the district's remote location results in a limited effect from changing payment models.

### New, experienced management team focused on financial improvement

The district has seen considerable turnover in management over the past several years. The new CEO and controller have been in place for more than a year, implementing a large improvement plan that has resulted in significant operational improvement through the interim period. The district is recruiting for a new CFO, although the current CEO was initially brought on as an interim CFO, so we believe financial leadership is largely stable at this time. Although we believe the turnover has contributed to some performance volatility over the past several years, the new team comes with considerable industry experience and a focus on operating improvement and financial sustainability. In addition, the new management team has improved the district's financial disclosures, changing auditing firms to produce more timely statements. The district has an elected board consisting of five members of the community. Although the board is not self-perpetuating, which we view as best practice, management has not reported issues with the board such that NIHD cannot execute on strategic priorities.

**Table 1**

Northern Inyo County Local Hospital District, California--Enterprise statistics				
	--Six-month interim ended Dec. 31--	--Fiscal year ended June 30--		
	2023	2023	2022	2021
PSA population	N.A.	18,896	18,978	18,600
PSA market share (%)	N.A.	79.0	62.0	62.0
Inpatient admissions	485	820	N.A.	1,050
Equivalent inpatient admissions	2,371	4,072	N.A.	N.A.
Emergency visits	6,101	9,685	8,730	N.A.
Inpatient surgeries	158	219	N.A.	N.A.
Outpatient surgeries	878	1,185	N.A.	N.A.
Medicare case mix index	1.2760	1.3070	N.A.	N.A.
FTE employees	376	427	N.A.	349
Active physicians	62	53	N.A.	68
Top 10 physicians admissions (%)	N.A.	75.0	N.A.	N.A.
Based on net/gross revenues	Gross	Gross	Net	Net
Medicare (%)	35.0	35.0	36.8	44.1
Medicaid (%)	32.0	28.0	13.6	20.3
Commercial/Blues (%)	31.0	34.0	46.4	33.5

Inpatient admissions exclude normal newborn, psychiatric, rehabilitation, and long-term care facility admissions. PSA--Primary service area.  
FTE--Full-time equivalent. N.A.--Not available.

## Financial Profile: Vulnerable

### Significant operating improvement through the interim period expected to continue during the outlook period

NIHD has experienced operating volatility over the past several years, generating extremely weak margins in fiscal years 2022 and 2023. Losses were attributable to rising expenses, revenue cycle issues, staffing pressure, and a large

one-time pension expense recorded in fiscal 2023 related to untimely contributions. As a result, NIHD violated its DSC covenant in fiscal 2023, although an event of default was not triggered, as it met the days' cash on hand covenant. Performance through the six-month interim period ended Dec. 31, 2023, is still negative but improved significantly as a result of management's large scale improvement initiatives. Improvement plans focused on labor reduction, revenue cycle projects, expense optimization, and service line investment to spur topline growth. Management expects further improvement during the outlook period closer to break-even operations, which we believe is reasonable given the significant turnaround through the interim and the continued execution of the initiatives. Furthermore, we expect fiscal 2024 year-end will improve further given the recognition of \$10 million in IGT payments expected in June. Although we expect operations will incrementally improve, we will continue to monitor the district's progress against strategic goals and a failure to maintain recent improvements could lead to a lower rating.

**Weak balance sheet highlighted by modest unrestricted reserves, elevated debt, and a poorly funded pension plan**

The district's unrestricted reserves are relatively modest and have declined over the past few years. Although unrestricted reserves-to-long-term debt remains thin due to the district's heavy debt load, operational liquidity as measured by days' cash on hand is adequate for the rating level. The district has no unrestricted reserves invested, as per California state regulations; therefore, unrestricted reserves are not affected by market volatility. Management said that strengthening unrestricted reserves remains a key focus and it expects to see incremental improvement in line with operational stability. Days' cash on hand through the interim period ended Dec. 31, 2023, is below the covenant level of 75 days, although we expect the district will likely meet the covenant requirement, as it will receive \$10 million in IGT payments through year-end and operations continue to improve. However, failure to improve unrestricted reserves during the outlook period could lead to a lower rating.

Although a significant portion of the district's debt is tax-backed, we consider the debt load high when evaluating NIHD's total debt profile. Leverage and the debt burden remain well above speculative-grade medians and as compared with those of peers; however, we expect the district's leverage will gradually improve during the outlook period, as management has no plans for additional debt in the near term. The district issued the series 2021 direct-purchase bonds, which refunded the series 2010 bonds, although we do not consider this debt to be contingent because covenants, events of default, and remedies align with the master trust indenture.

We consider the funded ratio of the district's defined-benefit pension plan highly vulnerable at 20% as of fiscal 2023, with an unfunded liability of \$47 million. In our view, rising costs associated with this liability could stress future budgetary performance. In fiscal 2023, NIHD paid \$7.4 million in contributions to the pension. We consider the extraordinarily low pension funding and budgetary pressure as a significant credit risk and although the new management team is working to ensure appropriate funding, further deterioration in the funded level or expense pressures could lead to a lower rating over time.



Table 2

	--Six-month interim ended Dec. 31--	--Fiscal year ended June 30--		--Medians for speculative grade rated small hospitals--	
	2023	2023	2022	2021	2022
<b>Financial performance</b>					
Net patient revenue (\$000s)	56,594	89,598	92,008	85,594	90,705
Total operating revenue (\$000s)	56,594	95,088	105,084	113,092	96,271
Total operating expenses (\$000s)	58,348	117,608	115,848	107,067	92,481
Operating income (\$000s)	(1,754)	(22,520)	(10,764)	6,025	2,234
Operating margin (%)	(3.10)	(23.68)	(10.24)	5.33	3.20
Net nonoperating income (\$000s)	3,397	12,566	702	938	2,312
Excess income (\$000s)	1,643	(9,954)	(10,062)	6,963	2,926
Excess margin (%)	2.74	(9.25)	(9.51)	6.11	5.10
Operating EBIDA margin (%)	2.34	(15.45)	(3.79)	12.46	11.70
EBIDA margin (%)	7.87	(1.97)	(3.11)	13.18	13.90
Net available for debt service (\$000s)	4,722	(2,122)	(3,285)	15,024	7,466
Maximum annual debt service (\$000s)	5,787	5,787	5,787	5,787	3,877
Maximum annual debt service coverage (x)	1.63	(0.37)	(0.57)	2.60	3.20
Operating lease-adjusted coverage (x)	1.60	(0.28)	(0.48)	2.50	2.90
<b>Liquidity and financial flexibility</b>					
Unrestricted reserves (\$000s)	21,665	31,886	37,291	41,993	30,754
Unrestricted days' cash on hand	70.2	103.6	121.9	149.0	131.5
Unrestricted reserves/total long-term debt (%)	44.9	66.8	70.5	78.5	95.7
Unrestricted reserves/contingent liabilities (%)	N/A	N/A	N/A	N/A	504.0
Average age of plant (years)	17.3	12.4	14.8	13.9	13.0
Capital expenditures/depreciation and amortization (%)	88.5	88.9	89.8	65.3	126.5
<b>Debt and liabilities</b>					
Total long-term debt (\$000s)	48,260	47,700	52,918	53,463	39,535
Long-term debt/capitalization (%)	63.2	57.5	53.7	53.8	33.1
Contingent liabilities (\$000s)	N/A	N/A	N/A	N/A	10,275
Contingent liabilities/total long-term debt (%)	N/A	N/A	N/A	N/A	28.2
Debt burden (%)	4.82	5.38	5.47	5.07	3.50
Defined-benefit plan funded status (%)	N.A.	20.38	12.00	18.27	83.60
<b>Miscellaneous</b>					
Medicare advance payments (\$000s)*	0	0	2,095	13,690	MNR
Short-term borrowings (\$000s)*	N/A	N/A	500	N/A	MNR
COVID-19 stimulus recognized (\$000s)	0	338	11,994	6,671	MNR
Risk based capital ratio (%)	N/A	N/A	N/A	N/A	MNR

**Table 2**

**Northern Inyo County Local Hospital District, California--Financial statistics (cont.)**

	<b>--Six-month interim ended Dec. 31--</b>	<b>--Fiscal year ended June 30--</b>		<b>--Medians for speculative grade rated small hospitals--</b>	
	<b>2023</b>	<b>2023</b>	<b>2022</b>	<b>2021</b>	<b>2022</b>
Total net special funding (\$000s)	2,008	14,433	14,597	20,296	MNR

N/A--Not applicable. N.A.--Not available. Inpatient admissions exclude normal newborn, psychiatric, rehabilitation, and long-term care facility admissions. \*Excluded from unrestricted reserves, long-term debt, and contingent liabilities. N.A.--Not available. N/A--Not applicable. MNR--Median not reported.

**Credit Snapshot**

- Organization description: The district operates a 25-bed, critical-access hospital in Bishop, Calif., serving the residents of Northern Inyo County.

**Related Research**

- Through The ESG Lens 3.0: The Intersection Of ESG Credit Factors And U.S. Public Finance Credit Factors, March 2, 2022

This report does not constitute a rating action.

Copyright © 2024 by Standard & Poor's Financial Services LLC. All rights reserved.

No content (including ratings, credit-related analyses and data, valuations, model, software or other application or output therefrom) or any part thereof (Content) may be modified, reverse engineered, reproduced or distributed in any form by any means, or stored in a database or retrieval system, without the prior written permission of Standard & Poor's Financial Services LLC or its affiliates (collectively, S&P). The Content shall not be used for any unlawful or unauthorized purposes. S&P and any third-party providers, as well as their directors, officers, shareholders, employees or agents (collectively S&P Parties) do not guarantee the accuracy, completeness, timeliness or availability of the Content. S&P Parties are not responsible for any errors or omissions (negligent or otherwise), regardless of the cause, for the results obtained from the use of the Content, or for the security or maintenance of any data input by the user. The Content is provided on an "as is" basis. S&P PARTIES DISCLAIM ANY AND ALL EXPRESS OR IMPLIED WARRANTIES, INCLUDING, BUT NOT LIMITED TO, ANY WARRANTIES OF MERCHANTABILITY OR FITNESS FOR A PARTICULAR PURPOSE OR USE, FREEDOM FROM BUGS, SOFTWARE ERRORS OR DEFECTS, THAT THE CONTENT'S FUNCTIONING WILL BE UNINTERRUPTED OR THAT THE CONTENT WILL OPERATE WITH ANY SOFTWARE OR HARDWARE CONFIGURATION. In no event shall S&P Parties be liable to any party for any direct, indirect, incidental, exemplary, compensatory, punitive, special or consequential damages, costs, expenses, legal fees, or losses (including, without limitation, lost income or lost profits and opportunity costs or losses caused by negligence) in connection with any use of the Content even if advised of the possibility of such damages.

Credit-related and other analyses, including ratings, and statements in the Content are statements of opinion as of the date they are expressed and not statements of fact. S&P's opinions, analyses and rating acknowledgment decisions (described below) are not recommendations to purchase, hold, or sell any securities or to make any investment decisions, and do not address the suitability of any security. S&P assumes no obligation to update the Content following publication in any form or format. The Content should not be relied on and is not a substitute for the skill, judgment and experience of the user, its management, employees, advisors and/or clients when making investment and other business decisions. S&P does not act as a fiduciary or an investment advisor except where registered as such. While S&P has obtained information from sources it believes to be reliable, S&P does not perform an audit and undertakes no duty of due diligence or independent verification of any information it receives. Rating-related publications may be published for a variety of reasons that are not necessarily dependent on action by rating committees, including, but not limited to, the publication of a periodic update on a credit rating and related analyses.

To the extent that regulatory authorities allow a rating agency to acknowledge in one jurisdiction a rating issued in another jurisdiction for certain regulatory purposes, S&P reserves the right to assign, withdraw or suspend such acknowledgment at any time and in its sole discretion. S&P Parties disclaim any duty whatsoever arising out of the assignment, withdrawal or suspension of an acknowledgment as well as any liability for any damage alleged to have been suffered on account thereof.

S&P keeps certain activities of its business units separate from each other in order to preserve the independence and objectivity of their respective activities. As a result, certain business units of S&P may have information that is not available to other S&P business units. S&P has established policies and procedures to maintain the confidentiality of certain non-public information received in connection with each analytical process.

S&P may receive compensation for its ratings and certain analyses, normally from issuers or underwriters of securities or from obligors. S&P reserves the right to disseminate its opinions and analyses. S&P's public ratings and analyses are made available on its Web sites, [www.spglobal.com/ratings](http://www.spglobal.com/ratings) (free of charge), and [www.ratingsdirect.com](http://www.ratingsdirect.com) (subscription), and may be distributed through other means, including via S&P publications and third-party redistributors. Additional information about our ratings fees is available at [www.spglobal.com/usratingsfees](http://www.spglobal.com/usratingsfees).

STANDARD & POOR'S, S&P and RATINGSDIRECT are registered trademarks of Standard & Poor's Financial Services LLC.



**NORTHERN INYO HEALTHCARE DISTRICT**

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

150 Pioneer Lane  
Bishop, California 93514

(760) 873-5811

DATE: April 2024

TO: Board of Directors  
Northern Inyo Healthcare District

FROM: Stephen DelRossi, CFO  
Marnie Davis, HIM Manager

RE: Department Update for HIM

---

## **REPORT DETAIL**

### **NEW BUSINESS**

HIM has continued working with several departments and clinical staff within NIHD to develop a more efficient and effective workflow for producing clean and complete charts. We are also working with RSM and Gloria on a custom deficiency report, as it has been manual. With this report, we can address items needing attention and resolve the issue. This allows for quicker and faster coding and billing, leading to speedier reimbursement.

We have hired a new HIM Specialist after almost a year of being short-staffed. Our latest employee will start May 6, and we are looking forward to having a new team member in the HIM family.

### **OLD BUSINESS**

None



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

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

DATE: April 2024

TO: Board of Directors  
Northern Inyo Healthcare District

FROM: Stephen DelRossi, CFO  
Fabiola Esparza, Business Office Manager

RE: Department Update for Business Office

---

## REPORT DETAIL

### NEW BUSINESS

- We are thinking about bringing the self-pay/self-pay after insurance back in-house as Med-Plan, our current early out vendor, is only collecting 15% and isn't collecting what they should be collecting. That would require 4 more staff members. If this is a go, we will look into where there will be set up.
- We just completed a charge capture audit with Clifton Larson Allen LLP (CLA), and a final written report will be sent to us shortly with their recommendations. We received an overall rate of 97% which is where we want to be.
- In the middle of February, we hired an RN Defense Auditor. She is a 100% remote worker, responsible for charge audits, denial reviews, appeals, denial reporting, and staff education. She has 11+ years' experience in nursing, utilization review and defense auditing.

### OLD BUSINESS

- Charge Reconciliation Process- This is still a work in progress with all revenue-generating departments in which we can all say we have learned quite a bit. We have found charges that were not dropping correctly, (incorrect rev codes, CPT). There are still some anomalies that we are working with, but together, we are getting there.
- The 340B Pharmacy is now live. Our newest issue is finding a way to add the UD modifier on Medicaid payers. 250 meds being rolled up to one line, for Ventegra to price them, they cannot be rolled up, SR will be needed.



**NORTHERN INYO HEALTHCARE DISTRICT**

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

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

DATE: April 2024

TO: Board of Directors  
Northern Inyo Healthcare District

FROM: Stephen DelRossi, CFO  
Neil Lynch, Purchasing Director

RE: Department Update for Purchasing

---

## **REPORT DETAIL**

### **NEW BUSINESS**

Warehouse management, Inventory cleanup, shelf label reprinting, developing PPE surplus budget to replace outdated surplus. Covering warehouse staffing shortage, Training very new employee Gary Mull.

### **OLD BUSINESS**

Training newly promoted Buyer James Nichols new duties and workflows.

Working with Medline on “Renewable Program” Items like Surgical Tourniquets, SpO2 sensors, gurney transfer assist device, etc. are eligible for reprocessing and purchased back for use at a significantly discounted price. Gurney Transfer assist device or Comfort Glide has been transitioned to and will yield us \$20,000 savings annually.

(Ongoing) Assisting AP staff, refining workflows for more-timely invoice payment.

(Ongoing) Purchasing is working on behalf of TAG to decrease supply spend. We are working closely with GPO HealthTrust and Medline to ensure we are buying under the appropriate contracts. Warehouse staff are working closely with management to reduce waste.

(Complete) Training new employee Shiloh Smith Shipping and Receiving duties and workflows.  
(Resigned).

(Complete) Reviewing policy and procedure to ensure that they are up to date and accurately reflect current industry standards and that they still work departmentally and for the district.

(Complete) Preparing for inventory to be completed at the end of May.

(Complete) Currently working with HR to fill vacancies in the Purchasing Department.

(Complete) Business as usual. Purchasing staff have been rotating vacation schedules causing resources to be tight.

(Complete) Year-end fiscal inventory was rescheduled with a new completion date of 7/15/2022. We are very happy to be able to participate in weekend holiday activities around the 4<sup>th</sup> of July without inventory activities overwhelming the department.

(Complete) Shipping delays have been minimal and PPE supply is more than sufficient. Purchasing will continue to monitor supply chain to ensure adequate supply.

(Complete) Purchasing is preparing for fiscal yearend inventory (6/30/2022). In preparation we will be analyzing inventory processes for Purchasing and Surgery departments, prepping the warehouse, and doing some item master maintenance. All of this is necessary to ensure an accurate fiscal year end valuation.

(Complete) Process review. Purchasing will be process mapping workflows to ensure accuracy and efficiency in supply chain processes with a focus on Cerner driven workflows.

(Complete) Back orders. We are experiencing significant delays across most supply chain categories. Covid-19, weather, shipping bottle necks, and manufacturing delays have made ordering difficult. Most resources are focused on minimizing delays.

(Complete) Purchasing continues to work on GPO (Group Purchasing Organization) transition. We are compiling data for analysis to determine contract compliance rate.

(Complete) GHX EDI integration has begun. IT continues has completed set up on the back end, purchasing staff is training and will be testing system through October.

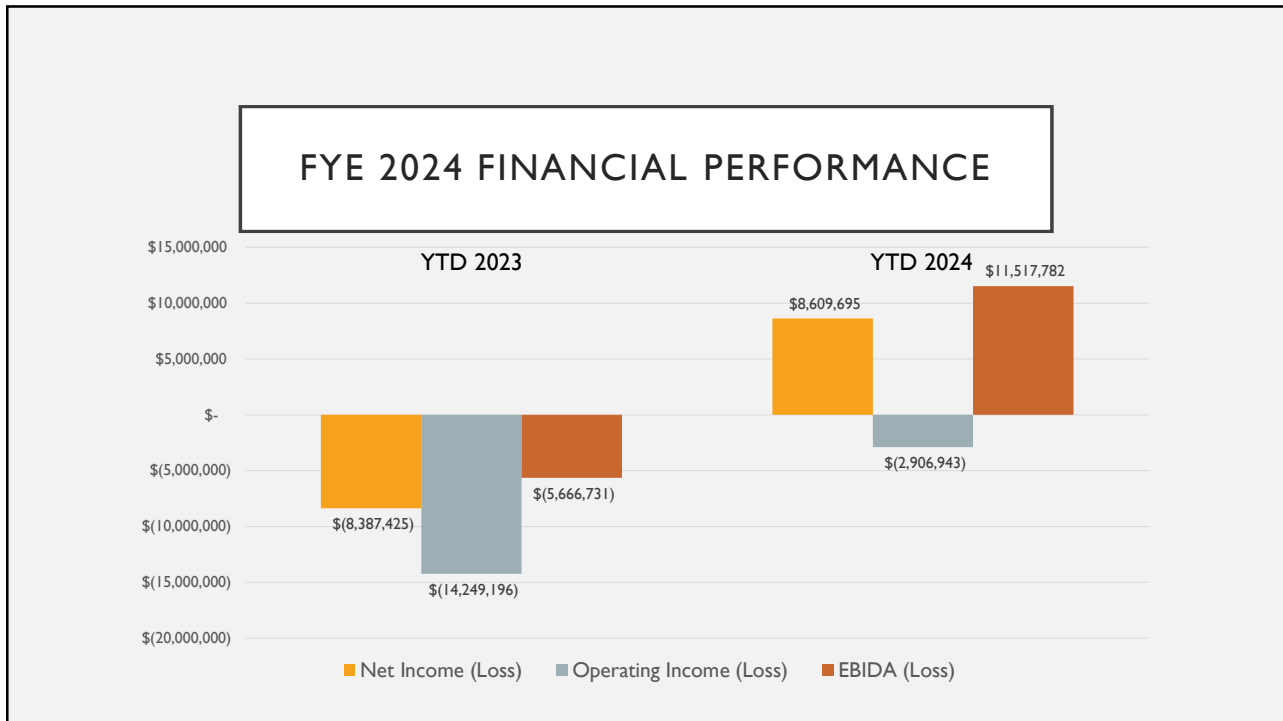
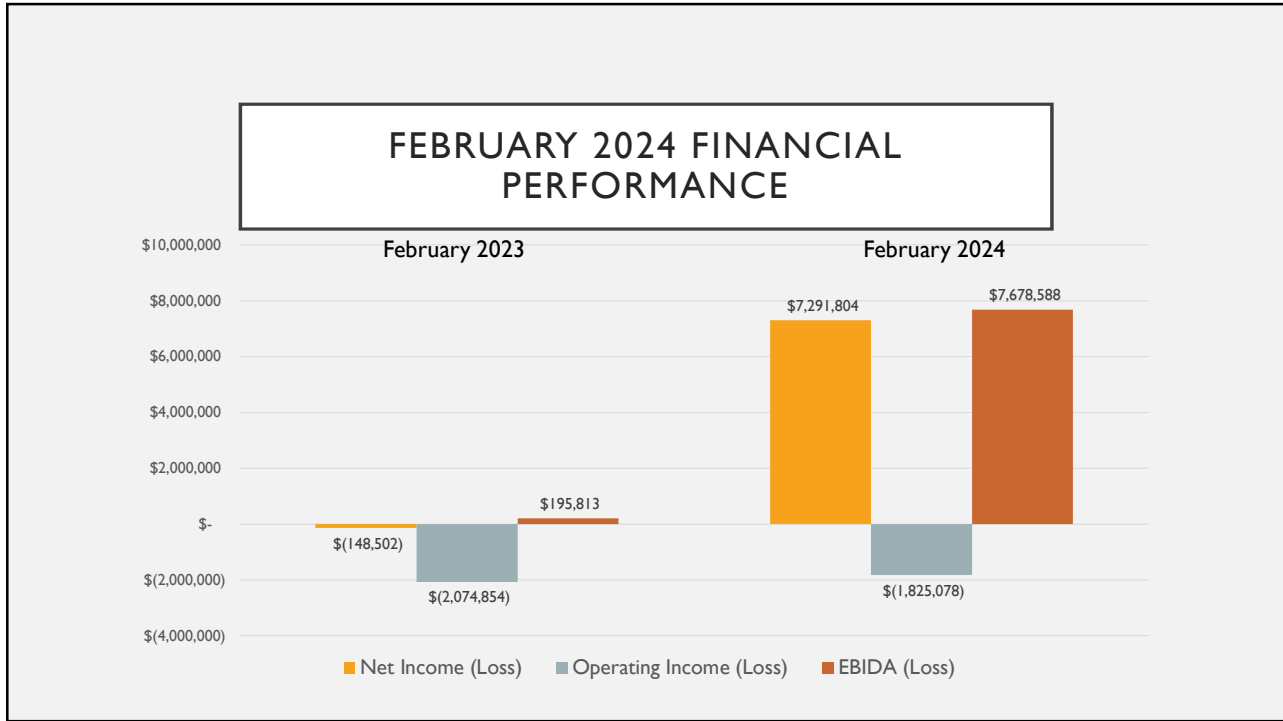


# NIHD FINANCIAL UPDATE

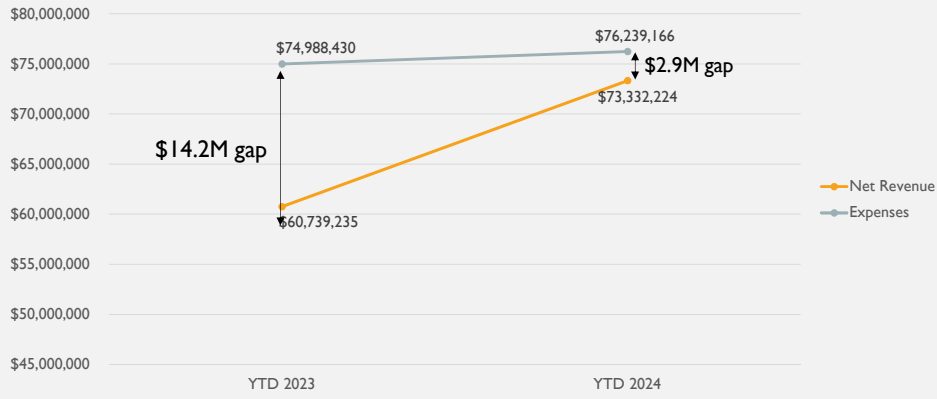
February 2024

# INCOME

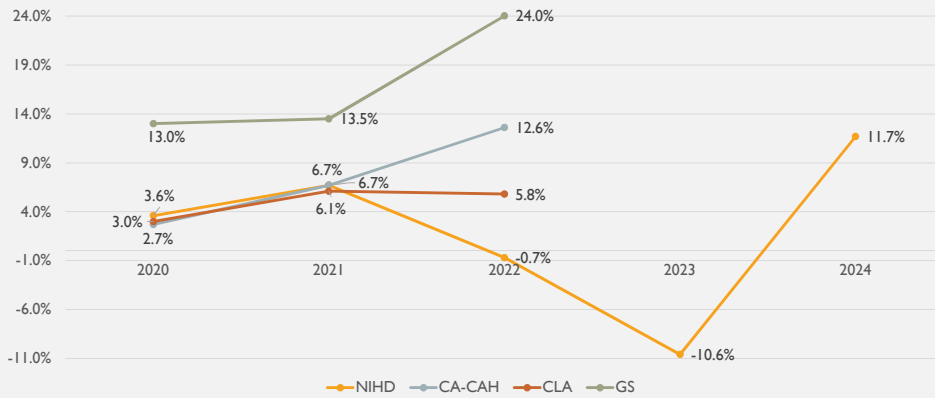




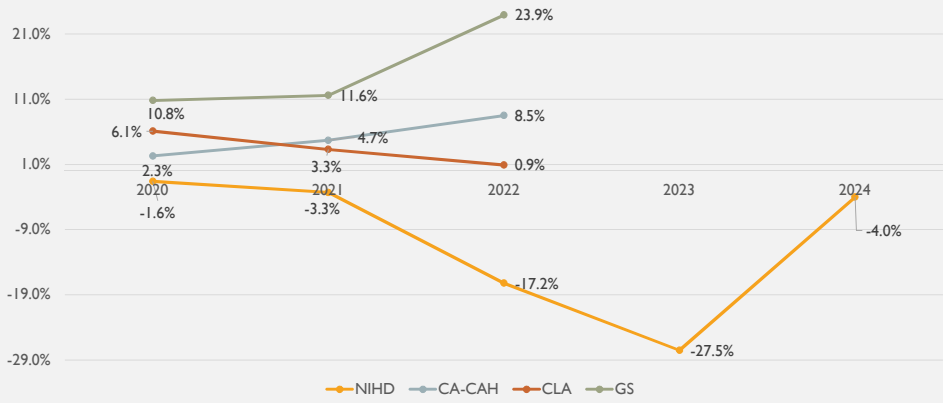
### YTD OPERATING INCOME (LOSS) PERFORMANCE



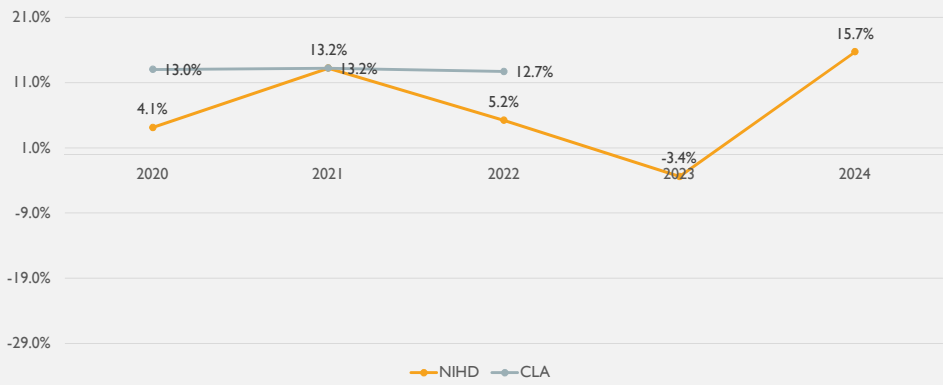
### NET PROFIT MARGIN



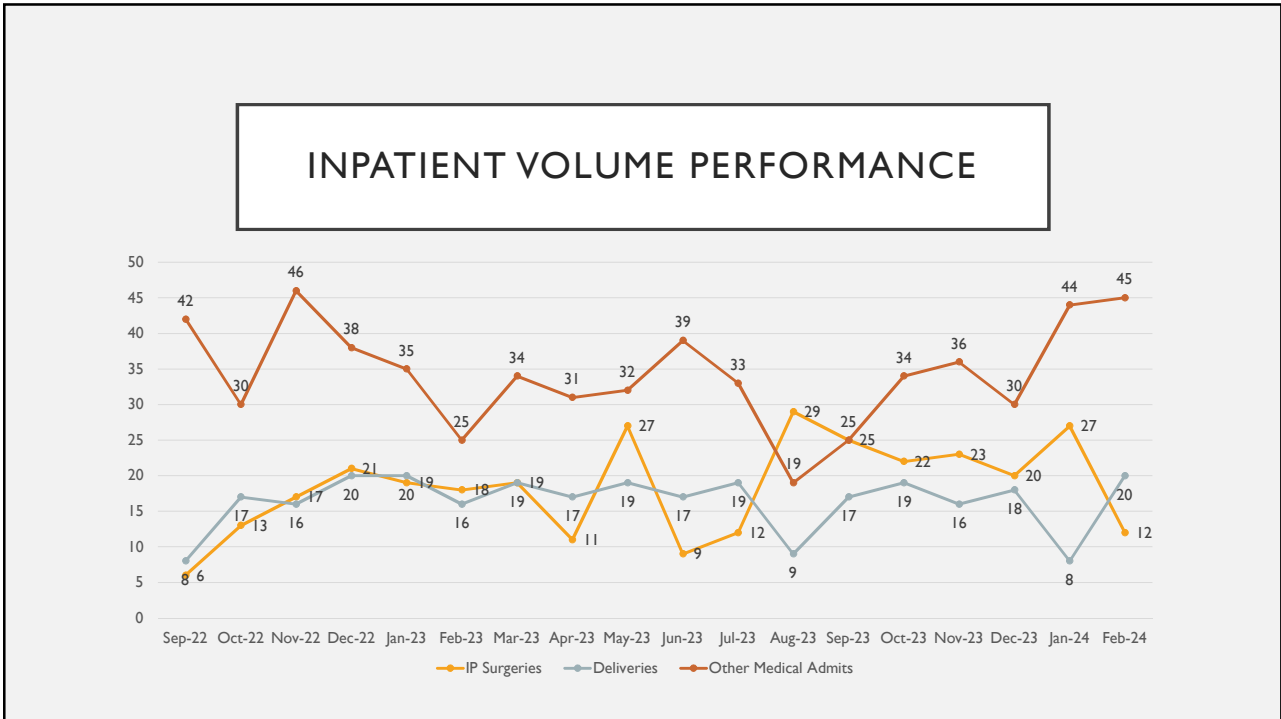
### OPERATING MARGIN



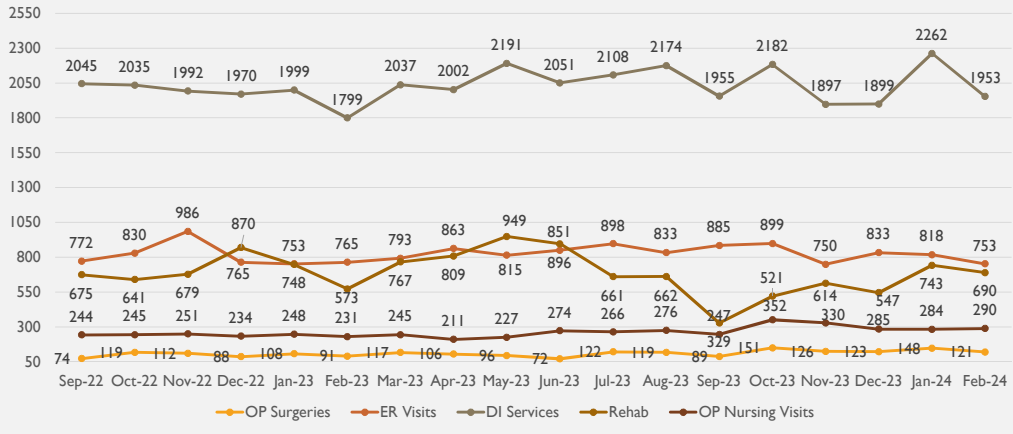
### EBIDA MARGIN



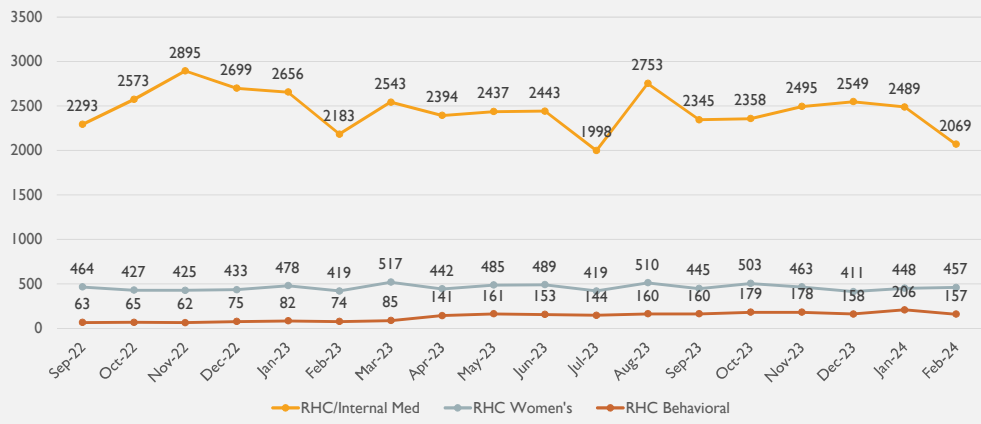
# VOLUMES



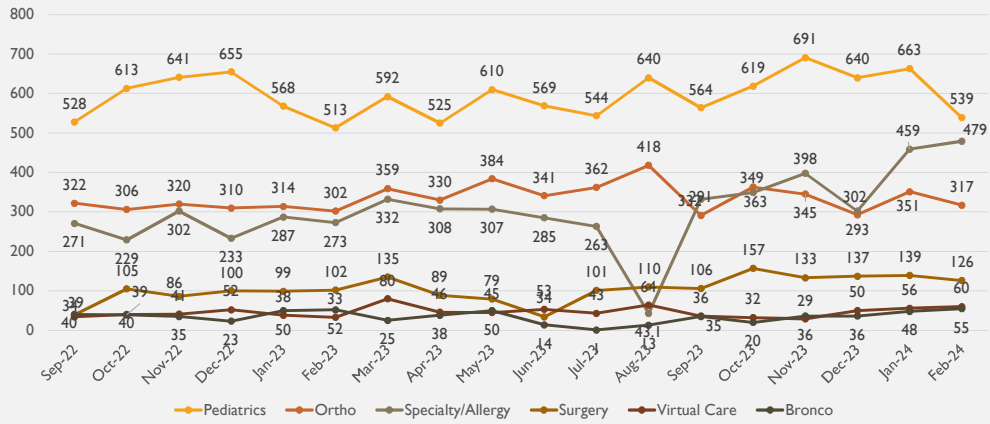
### OUTPATIENT VOLUME PERFORMANCE



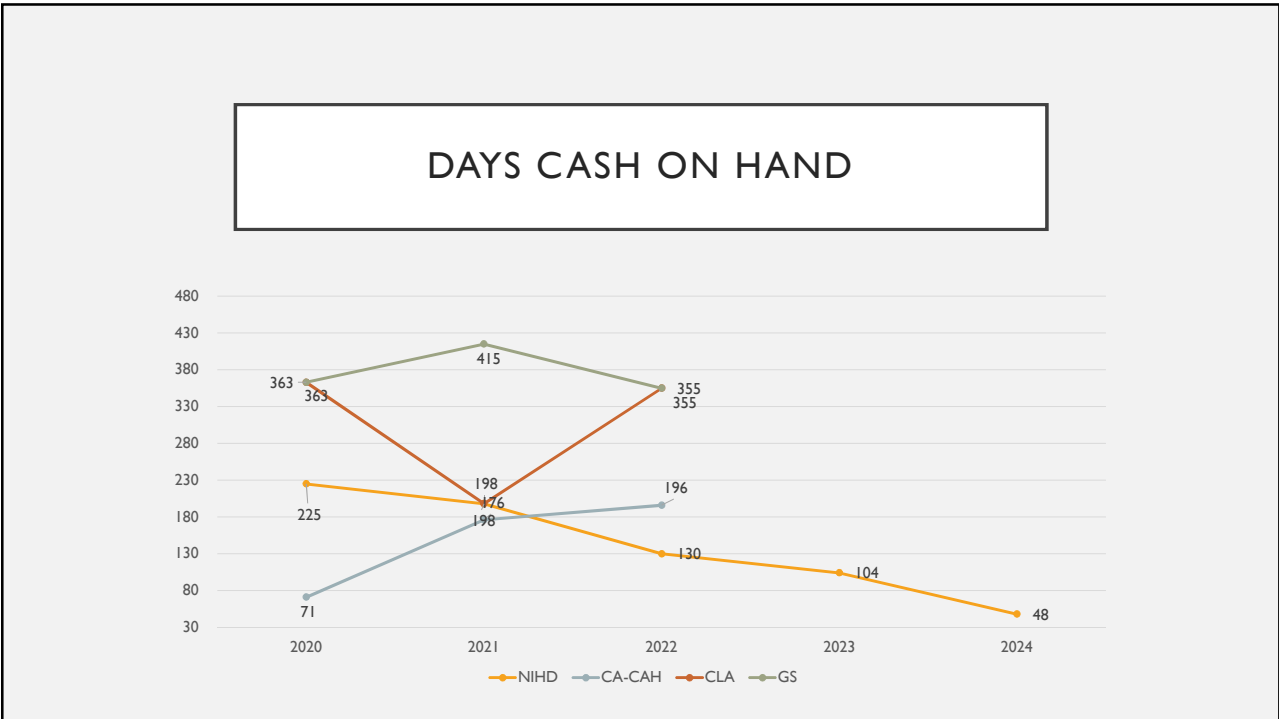
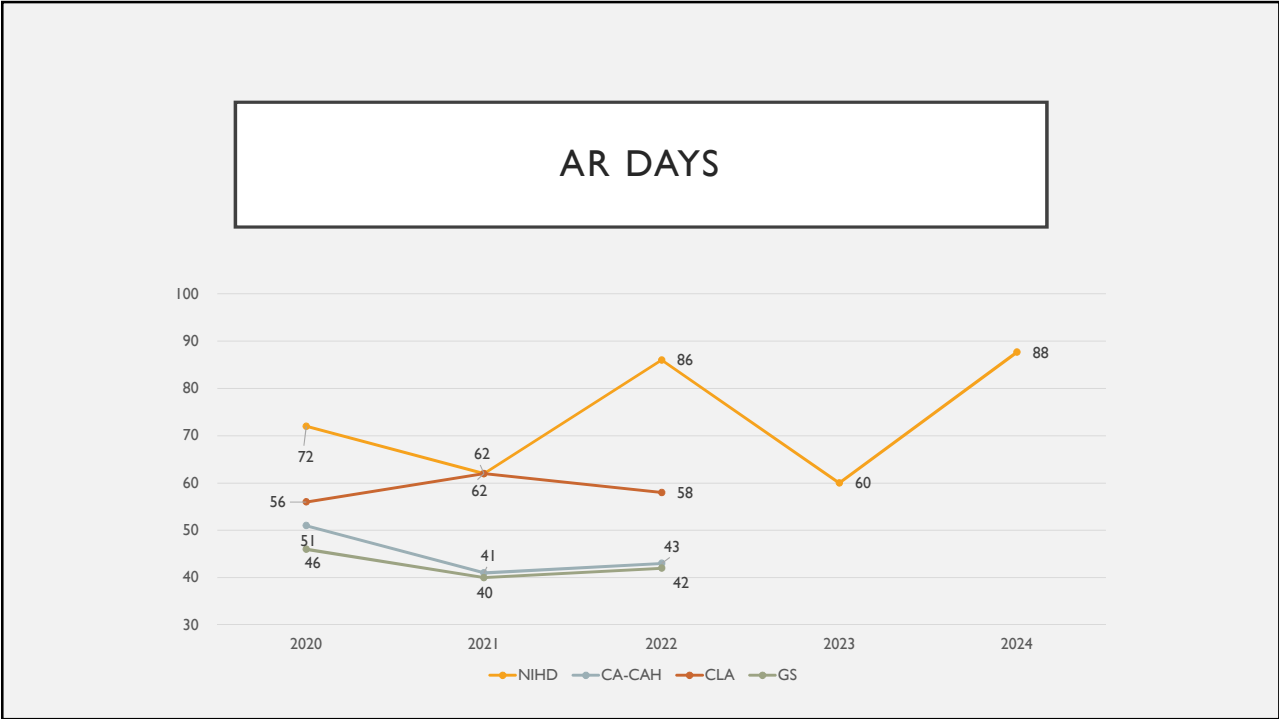
### RHC VOLUME PERFORMANCE



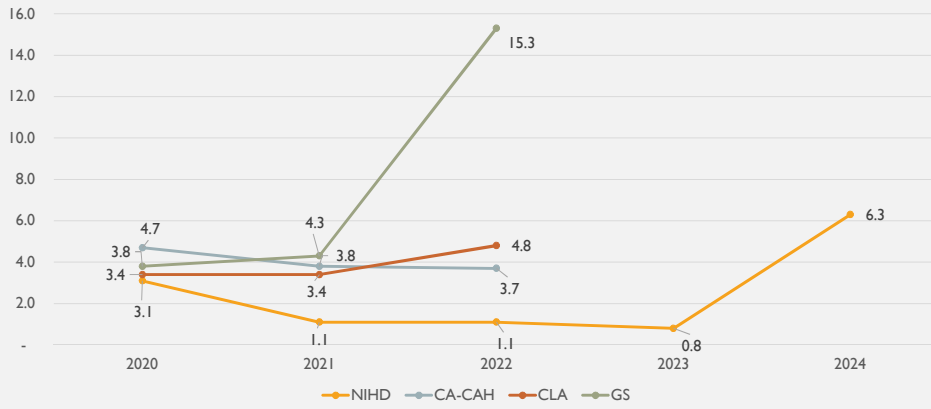
## CLINIC VOLUME PERFORMANCE



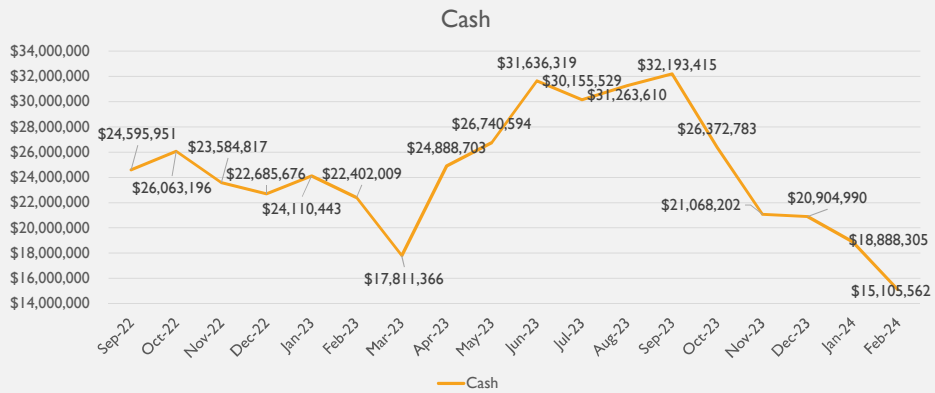
## KEY PERFORMANCE INDICATORS



## DEBT SERVICE COVERAGE RATIO



## UNRESTRICTED FUNDS





## WAGE COSTS

YTD 2023	YTD 2023	YTD 2024	% Change
Total Paid FTEs	433	376	-13%
Salaries, Wages, Benefits (SWB) Expense	\$43.1M	\$42.1M	-1%
SWB % of total expenses	57%	56%	-1%
Employed Average Hourly Rate	\$48.71	\$60.09	23%
Benefits % of Wages	68%	51%	-18%

**Northern Inyo Healthcare District**  
**Income Statement**  
**Fiscal Year 2024**

	12/31/2023	12/31/2022	1/31/2024	1/31/2023	2/29/2024	2/28/2023	2024 YTD	2023 YTD	PYM Change	PYTD Change
<b>Gross Patient Service Revenue</b>										
Inpatient Patient Revenue	3,205,729	3,417,547	4,415,671	3,898,882	3,063,000	2,545,535	27,951,320	25,470,570	517,464	2,480,750
Outpatient Revenue	13,872,841	11,309,707	14,723,154	11,943,811	12,719,309	11,030,636	109,721,389	94,942,114	1,688,673	14,779,275
Clinic Revenue	1,672,912	1,602,344	1,668,331	1,552,193	1,500,716	1,266,634	12,535,466	11,042,104	234,082	1,493,362
Gross Patient Service Revenue	18,751,482	16,329,598	20,807,156	17,394,886	17,283,024	14,842,805	150,208,176	131,454,789	2,440,219	18,753,387
<b>Deductions from Revenue</b>										
Contractual Adjustments	(8,812,993)	(8,204,159)	(9,802,285)	(7,536,311)	(9,066,535)	(6,829,397)	(67,644,575)	(59,837,954)	(2,237,139)	(7,806,621)
Bad Debt	(20,311)	(2,354,124)	(1,227,065)	(687,018)	(285,977)	(1,387,069)	(5,496,184)	(7,907,194)	1,101,092	2,411,010
A/R Writeoffs	(350,060)	(344,283)	(402,752)	(380,030)	(567,860)	(234,813)	(3,739,008)	(3,457,866)	(333,047)	(281,142)
Other Deductions from Revenue	-	410	-	-	-	-	-	449,438	-	(449,438)
Deductions from Revenue	(9,183,363)	(10,902,156)	(11,432,101)	(8,603,358)	(9,920,372)	(8,451,279)	(76,879,768)	(70,753,577)	(2,828,743)	(6,126,191)
<b>Other Patient Revenue</b>										
Incentive Income	-	-	-	-	-	-	-	-	-	-
Other Oper Rev - Rehab Thera Serv	1,568	3,545	-	566	862	1,660	3,816	38,022	(799)	(34,206)
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	1,568	3,545	-	566	862	1,660	3,816	38,022	(799)	(34,206)
<b>Net Patient Service Revenue</b>	<b>9,569,687</b>	<b>5,430,987</b>	<b>9,375,055</b>	<b>8,792,094</b>	<b>7,363,514</b>	<b>6,393,187</b>	<b>73,332,224</b>	<b>60,739,235</b>	<b>582,961</b>	<b>12,592,989</b>
<b>CNR%</b>	<b>51%</b>	<b>33%</b>	<b>45%</b>	<b>51%</b>	<b>43%</b>	<b>43%</b>	<b>49%</b>	<b>46%</b>	<b>-5%</b>	<b>3%</b>
<b>Cost of Services - Direct</b>										
Salaries and Wages	2,811,390	2,158,750	2,783,144	2,338,917	2,516,276	1,959,005	22,148,958	17,537,812	557,271	4,611,146
Benefits	1,069,389	1,064,181	1,093,886	1,867,561	1,537,835	1,681,176	11,223,120	13,605,814	(143,341)	(2,382,694)
Professional Fees	1,648,663	1,652,265	1,923,668	1,652,745	1,623,461	1,942,950	14,010,216	13,480,304	(319,489)	529,912
Contract Labor	422,431	(20,338)	379,756	1,001,828	405,743	219,870	3,205,453	6,448,376	185,873	(3,242,922)
Pharmacy	468,935	268,920	373,723	360,384	474,631	327,171	3,463,543	2,626,784	13,339	836,759
Medical Supplies	340,164	448,838	785,869	476,757	218,356	203,442	3,833,874	3,154,246	309,112	679,628
Hospice Operations	-	-	-	-	-	-	-	-	-	-
EHR System Expense	168,118	54,304	150,509	126,194	126,094	138,908	992,479	1,208,100	24,315	(215,621)
Other Direct Expenses	585,553	471,021	839,875	598,990	696,431	531,119	5,331,562	4,989,773	240,884	341,788
Total Cost of Services - Direct	7,514,645	6,097,940	8,330,430	8,423,377	7,598,828	7,003,641	64,209,205	63,051,210	(92,947)	1,157,995
<b>General and Administrative Overhead</b>										
Salaries and Wages	491,917	373,193	468,569	401,590	427,743	368,344	3,668,125	2,994,457	59,399	673,668
Benefits	182,190	(788,291)	154,751	262,752	264,414	272,374	1,869,690	2,194,988	(7,960)	(325,298)
Professional Fees	139,099	191,161	139,446	291,948	344,426	278,757	1,886,284	2,345,014	65,670	(458,730)
Contract Labor	86,055	(102,132)	4,050	(25,859)	24,000	27,901	327,670	288,473	(3,901)	39,197
Depreciation and Amortization	344,330	340,523	520,628	342,452	386,783	344,315	2,908,087	2,720,694	42,468	187,393
Other Administrative Expenses	156,693	152,489	161,466	191,302	142,398	172,710	1,370,106	1,393,595	(30,312)	(23,489)
<b>Total General and Administrative Overhead</b>	<b>1,400,284</b>	<b>166,944</b>	<b>1,448,910</b>	<b>1,464,185</b>	<b>1,589,765</b>	<b>1,464,400</b>	<b>12,029,962</b>	<b>11,937,221</b>	<b>125,365</b>	<b>92,741</b>
<b>Total Expenses</b>	<b>8,914,928.18</b>	<b>6,264,884</b>	<b>9,779,340</b>	<b>9,887,562</b>	<b>9,188,592</b>	<b>8,468,041</b>	<b>76,239,166</b>	<b>74,988,430</b>	<b>720,552</b>	<b>1,250,736</b>
Financing Expense	180,113	183,171	180,628	180,418	184,336	172,904	1,443,360	1,443,918	11,432	(558)
Financing Income	228,125	247,716	228,125	247,716	228,125	247,716	1,824,996	1,981,726	(19,591)	(156,730)
Investment Income	59,633	50,390	(186,959)	124,884	(105,802)	41,183	425,030	412,094	(146,984)	12,937
Miscellaneous Income	238,538	2,271,115	220,899	485,200	9,178,896	1,810,358	10,709,971	4,911,869	7,368,538	5,798,103
<b>Net Income (Change in Financial Position)</b>	<b>1,000,942</b>	<b>1,552,152</b>	<b>(322,849)</b>	<b>(418,086)</b>	<b>7,291,804</b>	<b>(148,502)</b>	<b>8,609,695</b>	<b>(8,387,425)</b>	<b>7,440,306</b>	<b>16,997,120</b>
Operating Income	654,759	(833,897)	(404,286)	(1,095,469)	(1,825,078)	(2,074,854)	(2,906,943)	(14,249,196)	249,776	11,342,253
EBITDA	1,345,271	1,892,676	197,779	(75,634)	7,678,588	195,813	11,517,782	(5,666,731)	7,482,774	17,184,513
Net Profit Margin	10.5%	28.6%	-3.4%	-4.8%	99.0%	-2.3%	11.7%	-13.8%	101.3%	25.5%
Operating Margin	6.8%	-15.4%	-4.3%	-12.5%	-24.8%	-32.5%	-4.0%	-23.5%	7.7%	19.5%
EBITDA Margin	14.1%	34.8%	2.1%	-0.9%	104.3%	3.1%	15.7%	-9.3%	101.2%	136.5%

Northern Inyo Healthcare District  
Balance Sheet  
Fiscal Year 2024

	PY Balances	12/31/2023	12/31/2022	1/31/2024	1/31/2023	2/29/2024	2/28/2023	MOM Change
<b>Assets</b>								
<b>Current Assets</b>								
Cash and Liquid Capital	17,558,072	9,536,326	7,573,136	8,555,307	9,828,615	8,770,199	7,914,764	855,435
Short Term Investments	10,497,077	10,810,616	16,815,916	10,332,998	16,922,335	6,335,363	10,418,390	(4,083,027)
PMA Partnership	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	14,932,580	20,452,310	17,300,274	20,997,993	14,758,093	19,458,681	19,699,808	(241,127)
Other Receivables	3,244,845	3,258,427	9,949,468	6,140,920	8,454,896	19,050,631	9,308,827	9,741,804
Inventory	5,159,474	5,159,051	3,037,613	5,161,688	3,039,453	5,158,222	3,063,026	2,095,195
Prepaid Expenses	1,793,630	1,773,403	1,341,558	1,707,236	1,268,913	1,276,680	1,401,834	(125,155)
<b>Total Current Assets</b>	<b>53,185,677</b>	<b>50,990,133</b>	<b>56,017,967</b>	<b>52,896,141</b>	<b>54,272,305</b>	<b>60,049,776</b>	<b>51,806,650</b>	<b>8,243,126</b>
<b>Assets Limited as to Use</b>								
Internally Designated for Capital Acquisitions	-	-	-	-	-	-	-	-
Short Term - Restricted	1,466,355	1,467,036	182,501	1,467,164	162,508	1,467,283	1,446,108	21,175
Limited Use Assets	-	-	-	-	-	-	-	-
LAIF - DC Pension Board Restricted	798,218	175,992	771,724	-	774,348	-	778,293	(778,293)
Other Patient Revenue	15,684,846	13,076,830	19,296,858	15,684,846	19,296,858	15,684,846	19,296,858	(3,612,012)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	-	573,097	-	573,097	20,075,151	(19,502,054)
Total Limited Use Assets	17,056,161	13,825,919	20,068,582	16,257,943	20,071,206	16,257,943	20,075,151	(3,817,208)
Revenue Bonds Held by a Trustee	1,078,187	754,688	1,092,945	1,057,556	1,087,201	1,051,852	1,081,516	(29,664)
<b>Total Assets Limited as to Use</b>	<b>19,600,703</b>	<b>16,047,643</b>	<b>21,344,028</b>	<b>18,782,662</b>	<b>21,320,914</b>	<b>18,777,078</b>	<b>22,602,775</b>	<b>(3,825,697)</b>
<b>Long Term Assets</b>								
Long Term Investment	2,767,655	1,318,315	2,745,703	1,831,405	2,749,221	1,831,779	2,744,893	(913,114)
Fixed Assets, Net of Depreciation	85,078,613	76,904,399	76,714,369	85,031,471	76,561,422	85,151,277	76,485,894	8,665,382
<b>Total Long Term Assets</b>	<b>87,846,268</b>	<b>78,222,714</b>	<b>79,460,072</b>	<b>86,862,876</b>	<b>79,310,643</b>	<b>86,983,056</b>	<b>79,230,787</b>	<b>7,752,269</b>
<b>Total Assets</b>	<b>160,632,647</b>	<b>145,260,490</b>	<b>156,822,066</b>	<b>158,541,680</b>	<b>154,903,862</b>	<b>165,809,910</b>	<b>153,640,212</b>	<b>12,169,697</b>
<b>Liabilities</b>								
<b>Current Liabilities</b>								
Current Maturities of Long-Term Debt	12,139,814	1,339,056	1,381,851	11,675,726	953,873	11,105,240	957,628	10,147,612
Accounts Payable	5,088,334	6,383,025	6,121,299	4,881,333	6,181,858	4,346,694	5,482,703	(1,136,009)
Accrued Payroll and Related	8,318,121	6,924,804	7,039,248	6,556,620	5,708,653	7,226,154	5,321,872	1,904,282
Accrued Interest and Sales Tax	92,441	94,216	94,617	164,562	168,763	238,080	238,573	(493)
Notes Payable	1,532,689	1,633,708	2,133,708	1,532,689	2,133,708	1,035,689	2,133,708	(1,098,019)
Unearned Revenue	(4,542)	(4,542)	129,191	(4,542)	29,191	(4,542)	(4,542)	1
Due to 3rd Party Payors	693,247	693,247	693,247	693,247	693,247	693,247	478,242	215,005
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension	1,942,292	1,861,577	2,146,080	1,927,805	2,146,080	1,925,736	2,146,080	(220,344)
<b>Total Current Liabilities</b>	<b>29,802,396</b>	<b>18,925,091</b>	<b>19,739,240</b>	<b>27,427,440</b>	<b>18,015,372</b>	<b>26,566,297</b>	<b>16,754,263</b>	<b>9,812,034</b>
<b>Long Term Liabilities</b>								
Long Term Debt	30,305,060	30,380,530	33,053,530	28,565,060	33,455,530	29,290,060	33,455,530	(4,165,470)
Bond Premium	203,263	184,441	222,085	181,303	218,948	178,166	215,811	(37,645)
Accreted Interest	16,540,170	17,694,537	16,553,354	17,206,094	16,648,086	17,302,780	16,743,218	559,563
Other Non-Current Liability - Pension	47,257,663	47,257,663	47,821,876	47,257,663	47,821,876	47,257,663	47,821,876	(564,213)
<b>Total Long Term Liabilities</b>	<b>94,306,156</b>	<b>95,517,170</b>	<b>97,650,846</b>	<b>93,210,120</b>	<b>98,144,440</b>	<b>94,028,670</b>	<b>98,236,435</b>	<b>(4,207,765)</b>
Suspense Liabilities	-	-	-	-	-	-	-	-
Uncategorized Liabilities	44,693	107,118	831,523	106,018	561,672	124,918	615,594	(490,676)
<b>Total Liabilities</b>	<b>124,153,245</b>	<b>114,549,379</b>	<b>118,221,609</b>	<b>120,743,579</b>	<b>116,721,484</b>	<b>120,719,885</b>	<b>115,606,292</b>	<b>5,113,593</b>
<b>Fund Balance</b>								
Fund Balance	45,515,489	26,459,404	43,831,306	35,013,047	43,831,306	35,013,046	43,831,306	(8,818,260)
Temporarily Restricted	1,466,354	2,610,967	2,589,989	1,467,163	2,589,995	1,467,283	2,590,039	(1,122,756)
Net Income	(10,502,442)	1,640,740	(7,820,838)	1,317,891	(8,238,924)	8,609,695	(8,387,425)	16,997,120
<b>Total Fund Balance</b>	<b>36,479,402</b>	<b>30,711,111</b>	<b>38,600,457</b>	<b>37,798,100</b>	<b>38,182,378</b>	<b>45,090,024</b>	<b>38,033,921</b>	<b>7,056,104</b>
<b>Liabilities + Fund Balance</b>	<b>160,632,647</b>	<b>145,260,490</b>	<b>156,822,066</b>	<b>158,541,679</b>	<b>154,903,862</b>	<b>165,809,909</b>	<b>153,640,212</b>	<b>12,169,697</b>
(Decline)/Gain	-	(334,256)	(1,759,462)	13,281,189	(1,918,204)	7,268,230	(1,263,649)	8,531,880
	0	0	0	0	0	0	0	0

**Northern Inyo Healthcare District**  
**Long-Term Debt Service Coverage Ratio**  
**FYE 2024**

Calculation method agrees to SECOND and THIRD SUPPLEMENTAL INDENTURE OF TRUST 2021 Bonds Indenture

**Long-Term Debt Service Coverage Ratio Calculation**

<u>Numerator:</u>	<b>HOSPITAL FUND ONLY</b>	
Excess of revenues over expense	\$ 8,609,695	7 months of earnings
+ Depreciation Expense	2,908,087	
+ Interest Expense	1,443,360	
Less GO Property Tax revenue	1,128,251	
Less GO Interest Expense	343,371	
<b>"Income available for debt service"</b> (definition per 2010 and 2013 and 2021 Indenture)	<b>\$ 11,489,521</b>	
<u>Denominator:</u>		
<b>Supplemental Indenture of Trust)</b>		
2021A Revenue Bonds	\$ 112,700	
2021B Revenue Bonds	905,057	
2009 GO Bonds (Fully Accreted Value)		
2016 GO Bonds		
Financed purchases and other loans	1,704,252	
<b>Total Maximum Annual Debt Service</b>	<b>\$ 2,722,009</b>	Full year of debt
	1,814,673	YTD debt
Ratio: (numerator / denominator)	<b>6.33</b>	YTD debt service coverage
Required Debt Service Coverage Ratio:	1.10	
In Compliance? (Y/N)	<b>No</b>	

**Unrestricted Funds and Days Cash on Hand**

	<b>HOSPITAL FUND ONLY</b>
Cash and Investments-current	\$ 15,105,562
Cash and Investments-non current	1,831,779
Sub-total	16,937,342
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	(1,051,852)
Building and Nursing Fund	(1,467,283)
<b>Total Unrestricted Funds</b>	<b>\$ 14,418,207</b>
Total Operating Expenses	\$ 76,239,166
Less Depreciation	2,908,087
Net Expenses	73,331,079
Average Daily Operating Expense	\$ 300,537
Days Cash on Hand	<b>48</b>

Key Financial Performance Indicators	Industry Benchmark	Feb-23	Jun-23	FYE 2023 Average	Dec-23	Jan-24	Feb-24	Variance to Prior Month	Variance to 2023 Average	Variance to		Reduction Target	Comment
										Prior Year Month	Benchmark		
<b>Volume</b>													
Admits	41	59	83	68	68	79	77	(2)	9	18	36		Mammoth monthly average in 2022 per HCAI
Deliveries	n/a	16	17	17	18	8	20	12	3	4	n/a		
Adjusted Patient Days	n/a	805	1,105	984	969	1,009	940	(69)	(44)	135	n/a		
Total Surgeries	153	109	81	120	143	175	133	(42)	13	24	(20)		Mammoth monthly average in 2022 per HCAI
ER Visits	659	765	851	810	833	818	753	(65)	(57)	(12)	94		Mammoth monthly average in 2022 per HCAI
RHC and Clinic Visits	n/a	3,950	4,381	4,353	4,576	4,859	4,246	(613)	(107)	296	n/a		
Diagnostic Imaging Services	n/a	1,799	2,051	2,020	1,899	2,262	1,953	(309)	(67)	154	n/a		
Rehab Services	n/a	573	896	762	547	743	690	(53)	(72)	117	n/a		
<b>AR &amp; Income</b>													
Gross AR (Cerner only)	n/a	\$ 57,856,486	\$ 50,668,396	\$ 53,638,580	\$ 53,913,830	\$ 56,381,675	\$ 55,489,238	\$ (892,437)	\$ 1,850,658	\$ (2,367,248)	n/a		
AR > 90 Days	\$ 7,688,895.45	\$ 26,753,439	\$ 25,752,910	\$ 23,440,542	\$ 26,961,876	\$ 27,771,536	\$ 27,534,816	\$ (236,720)	\$ 4,094,274	\$ 781,377	\$ 19,845,921	(19,845,921)	15% of gross AR is benchmark
AR % > 90 Days	15%	52.78%	51.55%	45.3%	50.78%	50.04%	50.37%	0.3%	5.1%	-2.4%	35.4%		Industry average
AR Days	43.00	93.93	89.78	91.35	86.28	90.02	87.68	(2.34)	(3.67)	(6)	44.68		California CAH
Net AR	n/a	\$ 19,699,808	\$ 9,351,360	\$ 17,800,084	\$ 20,452,310	\$ 20,997,993	\$ 19,458,681	\$ (1,539,313)	\$ 1,658,597	\$ (241,127)	n/a		
Net AR % of Gross	n/a	34.0%	18.5%	33.1%	37.9%	37.2%	35.1%	-2.2%	2.0%	1.0%	n/a		
Gross Patient Revenue/Calendar Day	n/a	\$ 530,100	\$ 543,011	\$ 546,652	\$ 604,887	\$ 671,199	\$ 595,966	\$ (75,232)	\$ 49,315	\$ 65,866	n/a		
Net Patient Revenue/Calendar Day	n/a	\$ 228,328	\$ 198,702	\$ 243,317	\$ 308,700	\$ 302,421	\$ 253,914	\$ (48,507)	\$ 10,598	\$ 25,586	n/a		
Net Patient Revenue/APD	n/a	\$ 7,942	\$ 5,395	\$ 7,622	\$ 9,876	\$ 9,291	\$ 7,834	\$ (1,458)	\$ 212	\$ (108)	n/a		
<b>Wages</b>													
Wages	n/a	\$ 2,604,870	\$ 5,954,820	\$ 3,281,173	\$ 3,303,307	\$ 3,251,713	\$ 2,944,019	\$ (307,694)	\$ (337,154)	\$ 339,149	n/a		
Employed paid FTEs	n/a	378.50	364.62	384.63	346.65	346.54	346.25	(0.29)	(38.38)	(32.25)	n/a	-8%	
Employed Average Hourly Rate	\$ 38.00	\$ 43.01	\$ 95.27	\$ 48.51	\$ 53.79	\$ 52.97	\$ 51.31	\$ (1.66)	\$ 2.80	\$ 8.30	\$ 13.31		According to California Hospital Association data
Benefits	n/a	\$ 1,676,029	\$ 1,610,167	\$ 1,907,194	\$ 1,251,579	\$ 1,248,638	\$ 1,802,249	\$ 553,611	\$ (104,945)	\$ 126,219	n/a		
Benefits % of Wages	30%	64.3%	27.0%	58.7%	37.9%	38.4%	61.2%	22.8%	2.5%	-3.1%	31.2%	(563,323)	Industry average
Contract Labor	n/a	\$ 247,771	\$ 803,281	\$ 808,284	\$ 508,486	\$ 383,806	\$ 429,743	\$ 45,937	\$ (378,541)	\$ 181,972	n/a		
Contract Labor Paid FTEs	n/a	36.15	39.55	40.27	22.52	21.60	23.86	2.26	(16.41)	(12.29)	n/a		
Total Paid FTEs	n/a	414.65	404.17	424.90	369.17	368.14	370.11	1.97	(54.79)	(44.54)	n/a		
Contract Labor Average Hourly Rate	\$ 81.04	\$ 42.84	\$ 118.48	\$ 112.84	\$ 127.46	\$ 100.31	\$ 108.69	\$ 8.38	\$ (4.15)	\$ 65.85	\$ 27.65	(105,836)	Per zip recruiter as of August 2023 for California, higher range is benchmark
Total Salaries, Wages, & Benefits	n/a	\$ 4,528,670	\$ 8,368,268	\$ 5,996,651	\$ 5,063,372	\$ 4,884,157	\$ 5,176,011	\$ 291,854	\$ (820,640)	\$ 647,341	n/a		
SWB% of NR	50%	70.8%	140.4%	79.8%	61.0%	52.1%	70.3%	18.2%	-9.5%	-0.5%	\$ 0	(278,529)	be 50%
SWB/APD	2,613	\$ 5,626	\$ 7,573	\$ 5,912	\$ 5,225	\$ 4,841	\$ 5,506	\$ 666	\$ (406)	\$ (119)	\$ 2,894	(6,032)	Industry average
SWB % of total expenses	50%	49.9%	92.2%	66.0%	56.8%	49.9%	56.3%	6.4%	-9.7%	6.5%	6%	(564,390)	Industry average
<b>Physician Spend</b>													
Physician Expenses	n/a	\$ 1,353,272	\$ 1,428,974	\$ 1,400,634	\$ 1,416,488	\$ 1,099,861	\$ 1,378,852	\$ 278,991	\$ (21,783)	\$ 25,580	n/a		
Physician expenses/APD	n/a	\$ 1,681	\$ 1,293	\$ 1,451	\$ 1,462	\$ 1,090	\$ 1,467	\$ 377	\$ 16	\$ (214)	n/a		
<b>Supplies</b>													
Supply Expenses	n/a	\$ 530,612	\$ (985,032)	\$ 544,557	\$ 809,100	\$ 1,159,592	\$ 837,141	\$ (322,451)	\$ 292,584	\$ 306,529	n/a		
Supply expenses/APD	n/a	\$ 659	\$ (891)	\$ 579	\$ 835	\$ 1,149	\$ 891	\$ (259)	\$ 312	\$ 231	n/a		
<b>Other Expenses</b>													
Other Expenses	n/a	\$ 2,667,892	\$ 268,236	\$ 1,138,604	\$ 1,625,968	\$ 2,635,236	\$ 1,796,588	\$ (838,648)	\$ 657,985	\$ (871,303)	n/a		
Other Expenses/APD	n/a	\$ 3,314	\$ 243	\$ 1,178	\$ 1,678	\$ 2,612	\$ 1,911	\$ (700)	\$ 734	\$ (1,403)	n/a		
<b>Margin</b>													
Net Income	n/a	\$ (148,502)	\$ (5,031,592)	\$ (1,448,727)	\$ 1,000,942	\$ (322,354)	\$ 7,291,804	\$ 7,614,158	\$ 8,740,531	\$ 7,440,306	n/a		
Net Profit Margin	n/a	-2.3%	-84.4%	-20.8%	10.5%	-3.4%	99.0%	102.4%	119.8%	101.3%	#VALUE!		
Operating Income	n/a	\$ (2,074,854)	\$ (5,308,483)	\$ (2,495,327)	\$ 654,759	\$ (403,791)	\$ (1,825,078)	\$ (1,421,287)	\$ 670,249	\$ 249,776	n/a		
Operating Margin	2.9%	-32.5%	-89.1%	-33.0%	6.8%	-4.3%	-24.8%	-20.5%	8.2%	7.7%	-27.7%		Per Kaufman Hall September National Hospital Flash
EBITDA	n/a	\$ (492,817)	\$ (5,370,917)	\$ (1,789,289)	\$ 1,345,271	\$ 198,274	\$ 7,678,588	\$ 7,480,314	\$ 9,467,877	\$ 8,171,405	n/a		
EBITDA Margin	12.7%	-7.7%	-90.1%	-22.6%	14.1%	2.1%	104.3%	102.2%	126.9%	112.0%	91.6%		CLA critical access hospitals
Debt Service Coverage Ratio	3.70		(5.8)	(5.8)	2.3	2.4	6.3	3.90	12.11	6.30	2.60		Per bond requirement, need to be at 1.1
<b>Cash</b>													
Avg Daily Disbursements (excl. IGT)	n/a	\$ 559,596	\$ 489,123	\$ 363,636	\$ 264,416	\$ 424,036	\$ 390,998	\$ (33,038)	\$ 27,362	\$ (168,599)	n/a	\$ 52,332	-53%
Average Daily Cash Collections (excl. IGT)	n/a	\$ 261,927	\$ 482,340	\$ 340,919	\$ 316,748	\$ 289,440	\$ 307,834	\$ 18,394	\$ (33,085)	\$ 45,907	n/a	\$ (52,332)	13%
Average Daily Net Cash	n/a	\$ (297,669)	\$ (6,783)	\$ (22,716)	\$ 52,332	\$ (134,596)	\$ (83,164)	\$ 51,432	\$ (60,447)	\$ 214,506	n/a	\$ (52,332)	453%
Unrestricted Funds	n/a	\$ 22,402,009	\$ 31,636,319	\$ 25,185,410	\$ 20,904,990	\$ 18,888,305	\$ 15,105,562	\$ (3,782,743)	\$ (10,079,848)	\$ (7,296,447)	n/a		-28%
Change of cash per balance sheet	n/a	\$ (1,708,434)	\$ 4,895,725	\$ 204,360	\$ (163,212)	\$ (2,016,685)	\$ (3,782,743)						
Days Cash on Hand (assume no more cash is collected)	196	69	105	83	79	45	48	3	(35)	(21)	n/a		Per bond requirement, we need 75 minimum. Other California CAH average 196
Estimated Days Until Depleted (assumes cash continues and spend continues)		75	4,664	1,109	486	337	254	(83)	(855)	179	n/a		
Years Unit Cash Depletion		0.21	12.78	3.04	1.33	0.92	0.70	(0.23)	(2.34)	0.49	n/a		

Northern Inyo Healthcare District

Feb 2024 – Financial Summary

	<u>CY</u> <u>MONTH</u>	<u>PY</u> <u>MONTH</u>	<u>BUDGET</u>	<u>PY</u> <u>Variance</u>	<u>Budget</u> <u>Variance</u>	<u>YTD</u>	<u>PY</u> <u>YTD</u>	<u>BUDGET</u>	<u>PY</u> <u>Variance</u>	<u>Budget</u> <u>Variance</u>	<u>MOM %</u> <u>Variance</u>	<u>YOY %</u> <u>Variance</u>	<u>YTD Budget</u> <u>% Variance</u>
<b>Net Income (Loss)</b>	7,291,804	(148,502)	(540,832)	7,440,306	7,832,636	8,609,695	(8,387,425)	(12,522,351)	16,997,120	21,132,046	5010%	203%	169%
<b>Operating Income (Loss)</b>	(1,825,078)	(2,074,854)	(2,464,779)	249,776	639,701	(2,906,943)	(14,249,196)	(18,067,290)	11,342,253	15,160,348	12%	80%	84%

Income is favorable to prior year due to IGT accruals in current year which increased misc income by \$7.4M. Operating income is negative due to higher expenses.

<b>IP Gross Revenue</b>	3,026,735	2,542,353	2,551,608	484,382	475,127	27,954,795	25,462,019	23,443,734	2,492,776	4,511,061	19%	10%	19%
<b>OP Gross Revenue</b>	12,719,309	11,030,636	10,973,303	1,688,673	1,746,006	109,721,389	94,942,114	97,221,582	14,779,275	12,499,807	15%	16%	13%
<b>Clinic Gross Revenue</b>	1,500,716	1,266,634	1,219,420	234,082	281,296	12,535,466	11,042,104	10,053,833	1,493,362	2,481,633	18%	14%	25%
<b>Net Patient Revenue</b>	7,363,514	6,393,187	6,200,913	970,327	1,162,601	73,332,224	60,739,135	54,983,749	12,593,089	18,348,475	15%	21%	33%
<b>Cash Net Revenue % of Gross</b>	43%	43%	42%	0%	1%	49%	46%	42%	3%	7%	0%	3%	16%

Revenue is favorable to prior year for the month and year due to increased volumes in most areas.

<b>Admits (excl. Nursery)</b>	77	59		18		562	546		16		31%	3%	
<b>IP Days</b>	198	163		35		1,655	1,693		(38)		21%	-2%	
<b>IP Days (excl. Nursery)</b>	165	138		27		1,461	1,504		(43)		20%	-3%	
<b>Average Daily Census</b>	5.69	4.93		0.76		5.99	6.16		(0.18)		15%	-3%	
<b>ALOS</b>	2.14	2.34		(0.20)		2.60	2.75		(0.15)		-8%	-6%	
<b>Deliveries</b>	20	16		4		126	130		(4)		25%	-3%	
<b>OP Visits</b>	3,535	3,165		370		28,084	28,585		(501)		12%	-2%	
<b>RHC Visits</b>	2,670	2,390		280		24,041	20,982		3,059		12%	15%	
Rural Health Clinic Visits	2,069	1,897		172		19,056	16,974		2,082		9%	12%	
Rural Health Women Visits	457	419		38		3,656	3,451		205		9%	6%	
Rural Health Behavioral Visits	144	74		70		1,329	557		772		95%	139%	
<b>NIA Clinic Visits</b>	1,576	1,561		15		12,276	13,376		(1,100)		1%	-8%	
Bronco Clinic Visits	55	52		3		244	243		1		6%	0%	
Internal Medicine Clinic Visits	-	286	N	(286)	N	-	2,989		(2,989)		-100%	-100%	N
Orthopedic Clinic Visits	317	302	o	15	o	2,740	2,521		219		5%	9%	o
Pediatric Clinic Visits	539	513	t	26	t	4,900	4,502		398		5%	9%	t
Specialty Clinic Visits	479	273		206		3,013	2,067		946		75%	46%	
Surgery Clinic Visits	126	102	A	24	A	1,009	740		269		24%	36%	A
Virtual Care Clinic Visits	60	33	v	27	v	370	314		56		82%	18%	v
<b>Surgeries IP</b>	12	18	a	(6)	i	170	153		17		-33%	11%	i
<b>Surgeries OP</b>	121	91	l	30	l	999	794		205		33%	26%	l
<b>Total Surgeries</b>	133	109	a	24	a	1,167	947		220		22%	23%	a
Cardiology			b	-	b	-	-		-		#DIV/0!	#DIV/0!	b
General	71	39	l	32	l	545	394		151		82%	38%	l
Gynecology & Obstetrics	13	12	e	1	e	122	95		27		8%	28%	e
Ophthalmology	22	27		(5)		199	213		(14)		-19%	-7%	
Orthopedic	16	30		(14)		215	224		(9)		-47%	-4%	
Pediatric	-	-		-		-	1		(1)		#DIV/0!	-100%	
Podiatry	-	-		-		1	3		(2)		#DIV/0!	-67%	
Urology	11	1		10		85	17		68		1000%	400%	
<b>Diagnostic Imaging</b>	1,953	1,799		154		16,430	15,959		471		9%	3%	
<b>Emergency Visits</b>	753	767		(14)		6,508	6,514		(6)		-2%	0%	
<b>ED Admits</b>	45	25		20		266	263		3		80%	1%	
<b>ED Amits % of ED Visits</b>	6.0%	3.3%		2.7%		4.1%	4.0%		0.0%		83%	1%	
<b>Rehab</b>	690	573		117		4,767	5,591		(824)		20%	-15%	
<b>Nursing Visits</b>	290	231		59		2,330	2,013		317		26%	16%	
<b>Observation Hours</b>	1,901	1,589		312		13,667	14,281		(614)		20%	-4%	

Admissions increased due to higher acuity in the ER. For the year, admissions are higher due to more surgical volume due to added providers and higher ED volume. Deliveries are slightly over prior month but slightly under prior year. RHC/internal medicine is higher than prior year. Total surgeries are 22% higher compared to last February and 23% higher compared to last fiscal year. This is due to new physicians Dr. Wiles and Dr. Clayton Davis

<b>Payor mix</b>													
Blue Cross	26.0%	29.2%		-3.2%		27.0%	27.8%		-0.8%		-11%	-3%	
Commercial	5.0%	4.5%		0.5%		5.0%	6.4%		-1.4%		12%	-22%	
Medicaid	19.0%	21.2%		-2.2%		19.0%	21.6%		-2.6%		-10%	-12%	
Medicare	45.0%	40.2%	N/A	4.8%	N/A	43.0%	39.3%	N/A	3.7%	N/A	12%	9%	N/A

Northern Inyo Healthcare District  
Feb 2024 – Financial Summary

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Self-pay	2.0%	2.6%		-0.6%		3.0%	2.9%		0.1%		-23%	4%	
Workers' Comp	2.0%	1.7%		0.3%		1.0%	1.4%		-0.4%		16%	-29%	
Other	1.0%	0.7%		0.3%		1.0%	0.6%		0.4%		46%	69%	

**DEDUCTIONS**

Contract Adjust	9,066,535	6,829,397	7,960,392	2,237,139	1,106,143	67,644,575	59,837,954	70,563,930	7,806,621	(2,919,355)	33%	13%	-4%
Bad Debt	285,977	1,387,069	291,513	(1,101,092)	(5,536)	5,496,184	7,907,194	2,585,735	(2,411,010)	2,910,449	-79%	-30%	113%
Write-off	567,860	151,401	291,513	416,458	276,347	3,725,349	3,114,779	2,585,735	610,570	1,139,614	275%	20%	44%

Payor mix shifted from Blue Cross and Medicaid to Medicare for the month.

**DENIALS**

Denials relatively consistent with the 6-month average and \$1.9M less than December 2022 (baseline for RSM revenue cycle project)

<b>CHARITY</b>	-	83,412	-	(83,412)	-	13,659	343,087	-	(329,427)		-100%	-96%	
----------------	---	--------	---	----------	---	--------	---------	---	-----------	--	-------	------	--

Charity discounts have decreased compared to prior year.

**BAD DEBT**

Bad debt write offs were \$96k.

**CASH**

Cash deficit for February was -\$6.3M and included \$3.9M in IGT disbursements which we will recoup by June plus dividends

**CENSUS**

Patient Days	165	138		27		1,461	1,504		(43)		20%	-3%	
Adjusted Days	940	806		135		7,851	7,764		86		17%	1%	
Employed Paid FTE	346.25	378.50		(32.25)		353.02	391.51		(38.49)		-9%	-10%	
Contract Paid FTE	23.86	36.15	N/A	(12.29)	N/A	22.99	47.61	N/A	(24.62)	N/A	-34%	-52%	N/A
Total Paid FTE	370.11	414.64		(44.53)		376.01	439.12		(63.11)		-11%	-14%	
EPOB (Employee per Occupied Bed)	2.24	3.00		(0.76)		2.06	2.34		(0.28)		-25%	-12%	
Adjusted EPOB	0.39	0.51		(0.12)		0.38	0.45		(0.07)		-24%	-15%	

**SALARIES**

Per Adjust Bed Day	\$ 3,131	\$ 2,889	\$ 3,034,286	\$ 242	\$ (90,267)	\$ 3,289	\$ 2,644	\$ 25,567,837	\$ 644	\$ 5,284,814	249,246	8%	24%
Total Salaries	\$ 2,944,019	\$ 2,327,349	\$ 3,034,286	\$ 616,671	\$ (90,267)	\$ 25,817,082	\$ 20,532,269	\$ 25,567,837	\$ 5,284,814	\$ 249,246	26%	26%	1%
Normalized Salaries (incl PTO used)	\$ 2,944,019	\$ 2,604,869	\$ 3,034,286	\$ 339,150	\$ (90,267)	\$ 25,817,082	\$ 23,101,999	\$ 25,567,837	\$ 2,715,084	\$ 249,246	13%	12%	1%
Average Hourly Rate	\$ 51.31	\$ 43.01	\$ 8.30	\$ 8.30	\$ 60.09	\$ 48.71	\$ 11.38	\$ 11.38	\$ 19%	\$ 23%			
Employed Paid FTEs	346.25	378.50	(32.25)	353.02	391.51	(38.49)							

Salaries are up for the month and the year compared to prior year due to merit increases. Total paid employed FTEs are down due to RIFFs that occurred during April and July along with staffing management. Employee per occupied bed is lower than prior year meaning we are staffing more efficiently given the higher volume.

**BENEFITS**

Per Adjust Bed Day	\$ 1,917	\$ 2,425	\$ (508)	\$ 1,668	\$ 2,035	\$ (367)					-21%	-18%	
Total Benefits	\$ 1,802,249	\$ 1,953,550	\$ 1,805,644	\$ (151,301)	\$ (3,395)	\$ 13,092,810	\$ 15,800,802	\$ 15,752,580	\$ (2,707,993)	\$ (2,659,770)	-8%	-17%	-17%
Benefits % of Wages	61%	84%	60%	-23%	51%	77%	62%	-26%	-27%	-34%			
Pension Expense	\$ 542,575	\$ 839,798	\$ 731,496	\$ (297,223)	(188,922)	\$ 3,705,457	\$ 6,795,875	\$ 6,263,367	\$ (3,090,419)	\$ (2,557,911)	-35%	-45%	-41%
MDV Expense	\$ 230,961	\$ 192,158	\$ 228,734	\$ 38,803	2,226	\$ 1,902,705	\$ 1,636,532	\$ 1,989,739	\$ 266,173	\$ (87,034)	20%	16%	-4%
Payroll Taxes & WC insurance	\$ 309,182	\$ 273,879	\$ 315,143	\$ 35,304	(5,961)	\$ 2,530,942	\$ 2,186,646	\$ 2,717,613	\$ 344,296	\$ (186,670)	13%	16%	
PTO Incurred	\$ 277,521	\$ (277,521)	\$ -	\$ 2,569,730	\$ (2,569,730)	\$ -	\$ -	\$ -	\$ -	\$ -	-100%	-100%	
PTO Accrued	\$ 24,367	\$ 252,478	\$ 262,979	\$ (228,111)	(238,611)	\$ (84,775)	\$ 2,299,089	\$ 2,332,457	\$ (2,383,864)	\$ (2,417,233)	-90%	-104%	
Reimbursements	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,021	\$ 1,437	\$ -	\$ 1,584	\$ 3,021	#DIV/0!	110%	
Sick	\$ -	\$ 1,395	\$ 12,256	\$ (1,395)	(12,256)	\$ 4,442	\$ 175,095	\$ 106,639	\$ (170,653)	\$ (102,197)	-100%	-97%	
Other	\$ -	\$ 1,237	\$ -	\$ (1,237)	\$ -	\$ -	\$ 11,393	\$ -	\$ (11,393)	\$ -	-100%	-100%	
Normalized Benefits	\$ 1,802,249	\$ 1,953,550	\$ 1,805,644	\$ (151,301)	\$ (151,301)	\$ 13,092,810	\$ 15,800,802	\$ 15,752,580	\$ (2,707,993)	\$ (2,659,770)	-8%	-17%	-17%
Normalized Benefits % of Wages	61%	75%	60%	-14%	51%	68%	62%	-18%	0%				

Benefits at a % of Wages are down due to reduced pension now that employees are matching pension contributions. MDV increased due to higher volume of usage/claims.

Northern Inyo Healthcare District  
Feb 2024 – Financial Summary

	<u>CY</u> <u>MONTH</u>	<u>PY</u> <u>MONTH</u>	<u>BUDGET</u>	<u>PY</u> <u>Variance</u>	<u>Budget</u> <u>Variance</u>	<u>YTD</u>	<u>PY</u> <u>YTD</u>	<u>BUDGET</u>	<u>PY</u> <u>Variance</u>	<u>Budget</u> <u>Variance</u>	MOM % Variance	YOY % Variance	YTD Budget % Variance
<b>Salaries, Wages &amp; Benefits</b>	\$ 4,746,268	\$ 4,558,419	\$ 4,839,930	\$ 187,849	(93,662)	\$ 38,909,892	\$ 38,902,801	\$ 41,320,416	\$ 7,091	\$ (2,410,524)	4%	0%	-6%
<b>SWB/APD</b>	\$ 5,048	\$ 5,659.11		\$ (611)		\$ 4,956	\$ 5,010		\$ (54)		-11%	-1%	
Total SWB for the month and year were similar to prior year. Wage increases offset decreases in pension benefits. Total YTD SWB is over 4% due to an increase in MDV expenses and taxes/worker's comp insurance. However, on a per patient basis, our SWB per patient is lower than last year.													
<b>PROFESSIONAL FEES</b>													
Per Adjust Bed Day	\$ 2,550	\$ 3,066		\$ (516)	2,550	\$ 2,475	\$ 2,906	\$ -	\$ (431)	\$ 2,475	-17%	-15%	
Total Physician Fee	\$ 1,378,852	\$ 1,353,272	\$ 1,077,585	\$ 25,580	301,267	\$ 11,817,408	\$ 11,070,701	\$ 8,702,190	\$ 746,708	\$ 3,115,218	2%	7%	36%
Total Contract Labor	\$ 429,743	\$ 247,771	\$ 399,931	\$ 181,972	29,812	\$ 3,533,123	\$ 6,736,848	\$ 3,402,544	\$ (3,203,725)	\$ 130,579	73%	-48%	4%
Total Other Pro-Fees	\$ 589,036	\$ 868,435	\$ 494,791	\$ (279,399)	\$ 94,245	\$ 4,079,091	\$ 4,754,617	\$ 4,242,994	\$ (675,525)	\$ (163,903)	-32%	-14%	-4%
Total Professional Fees	\$ 2,397,631	\$ 2,469,478	\$ 1,972,307	\$ (71,847)	425,324	\$ 19,429,623	\$ 22,562,166	\$ 16,347,728	\$ (3,132,543)	\$ 3,081,895	-3%	-14%	19%
Contract Paid FTEs	23.86	36.15		(12.29)		22.99	47.61		(24.62)		-34%	-52%	
Physician Fee per Adjust Bed Day	1,467	1,680		(213)		1,505	1,426		79				
Physician expense increase due to adding a general surgeon and urology. However, this is contributing to higher volumes and revenue. Contract labor reductions have occurred and is being limited to essential personnel for a savings of \$3.2M.													
<b>PHARMACY</b>													
Per Adjust Bed Day	\$ 505	\$ 406		\$ 99		\$ 441	\$ 338		\$ 103		24%	30%	
Total Rx Expense	\$ 474,631	\$ 327,171	\$ 358,101	\$ 147,460	116,530	\$ 3,463,543	\$ 2,626,784	\$ 2,877,789	\$ 836,759	\$ 585,754	45%	32%	20%
Supplies are higher due to volume and rising pricing for drug shortages.													
<b>MEDICAL SUPPLIES</b>													
Per Adjust Bed Day	\$ 232	\$ 253		\$ (20)		\$ 488	\$ 406		\$ 82		-8%	20%	
Total Medical Supplies	\$ 218,356	\$ 203,442	\$ 364,420	\$ 14,915	(146,064)	\$ 3,833,874	\$ 3,154,246	\$ 2,968,328	\$ 679,628	\$ 865,546	7%	22%	29%
Supplies are higher for the month and year due to higher volume due to rising prices.													
<b>EHR SYSTEM</b>													
Per Adjust Bed Day	\$ 134	\$ 172		\$ (38)		\$ 126	\$ 156		\$ (29)		-22%	-19%	
Total EHR Expense	\$ 126,094	\$ 138,908	\$ 151,595	\$ (12,814)	(25,501)	\$ 992,479	\$ 1,208,100	\$ 1,212,760	\$ (215,621)	\$ (220,281)	-9%	-18%	-18%
YTD is under last year due to prior year invoicing backlog paid in prior year													
<b>OTHER EXPENSE</b>													
Per Adjust Bed Day	\$ 892	\$ 874		\$ 18		\$ 854	\$ 822		\$ 32		2%	4%	
Total Other	\$ 838,829	\$ 703,829	\$ 610,245	\$ 135,000	228,584	\$ 6,701,668	\$ 6,383,268	\$ 5,371,294	\$ 318,399	\$ 1,330,374	19%	5%	25%
Other expenses are up due to higher utilities, insurance, and sales taxes on supplies which has increased.													
<b>DEPRECIATION AND AMORTIZATION</b>													
Per Adjust Bed Day	\$ 411	\$ 378		\$ 33		\$ 370	\$ 351		\$ 19		9%	6%	
Total Depreciation and Amortization	\$ 386,783	\$ 304,838	\$ 369,094	\$ 81,946	17,689	\$ 2,908,087	\$ 2,725,858	\$ 2,952,724	\$ 182,230	\$ (44,637)	27%	7%	-2%
Amortization is higher due to a change in lease (GASB 87) and software accounting (GASB 96) requiring assets to be added for contracts and those assets are amortized over the life of the contract. Correcting entries made in January based on audit results.													
<b>Total Expenses</b>	\$ 9,188,592	\$ 8,428,563	\$ 8,665,692	\$ 760,029	522,900	\$ 76,239,166	\$ 74,993,494	\$ 73,051,039	\$ 1,245,673	3,188,127	9%	2%	4%
For the year, expenses are higher due to higher volume and rising costs in utilities, supplies, and insurance													





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

Medical Staff Office  
(760) 873-2174 voice  
(760) 873-2130 fax

TO: NIHD Board of Directors  
FROM: Sierra Bourne, MD, Chief of Medical Staff  
DATE: April 2, 2024  
RE: Medical Executive Committee Report

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

A. Policies (*action item*)

1. *Cleaning the Pharmacy Sterile IV Preparation Area. (Clean Room)*
2. *Interim Guidance For Environmental Infection Control For Patients With Probable/Suspected Viral Hemorrhagic Fever (VHF)*
3. *Triage of Patients Suspected of Viral Hemorrhagic Fever (VHF)*
4. *Standardized Protocol – Minor Surgical Policy for the Physician Assistant*
5. *Procedural Sedation*
6. *Nursing Management of the Infant and Pediatric Security System*

B. Medical Executive Committee Meeting Report (*information item*)



## NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Cleaning the Pharmacy Sterile IV Preparation Area. (Clean Room)		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: Pharmacy, Environmental Services, Infection Prevention		
Date Last Modified: 03/27/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/21/2018	

### PURPOSE:

To give Environmental Services (EVS) personnel the proper guidelines and training to ensure proper cleaning and disinfecting of the Pharmacy Sterile IV Preparation area (Clean Room).

### POLICY:

1. Monthly: Use an EPA-registered sporicidal detergent to clean. This will occur on the first Saturday of the month.
2. Daily: Cleaning will be completed using an EPA and NIHD approved germicidal product. Alcohol has no detergent properties, so is unacceptable for this purpose.
3. All cleaning and disinfection supplies (e.g., wipers, sponges, pads, and mop heads) with the exception of tool handles must be low lint.
4. Designated cleaning equipment must be used when cleaning Pharmacy Sterile IV Preparation area.
5. Disposable mops are preferred. Reusable mops may be acceptable if they are laundered to clean room standards.
6. Personal Protective Equipment (PPE) must be applied prior to entering Pharmacy Clean Room and removed when exiting.
7. Remove hand, wrist and other exposed jewelry including piercings that could interfere with donning and doffing PPE.
8. A daily cleaning and a monthly log must be posted inside of pharmacy this will be completed by EVS staff.
9. Every EVS attendant must be trained upon hire and annually if they are responsible for cleaning the Pharmacy Sterile IV Preparation area. Documentation of training will be located in Pharmacy and in the employee file.
10. Cleaning of Pharmacy Sterile IV Preparation (clean room) areas will occur when there are no compounding activities being performed.
11. Makeup, nail polish, and artificial nails *are prohibited* in Pharmacy Sterile IV Area (clean room). Per CCR section 1751.5 (a) (6).
12. Individuals must clean and disinfect their personal eyeglasses prior to entering compounding area.
13. No food, drinks, gum, or candy allowed in the clean room.
14. Remove headphones and earbuds before entering clean room.
15. Documentation of each occurrence with cleaning and sanitizing of the compounding area shall include a record of the identity of the person completing the cleaning and sanitizing as well as the product name of the cleaning and sanitizing agent.

**Table: Purpose of Cleaning, Disinfecting, and Sporicidal Disinfectants:**

Type of Agent	Purpose
Cleaning	An agent, usually containing a surfactant, used for the removal of substances (e.g. dirt, debris, microbes, and residual drugs or chemicals) from surfaces
Disinfectant	A chemical or physical agent used on inanimate surfaces and objects to destroy fungi, viruses, and bacteria
Sporicidal	A chemical or physical agent that destroys bacterial and fungi spores when used at a sufficient concentration for a specified contact time. It is expected to kill all vegetative microorganisms

**Table: Minimum Frequency for Cleaning and Disinfecting Surfaces and Applying Sporicidal Disinfectants**

Site	Cleaning	Disinfecting	Sporicidal Disinfectant
Pass-through chamber	<b>Daily</b> on days compounding occurs	<b>Daily</b> on days compounding occurs	<ul style="list-style-type: none"> <li><b>Monthly</b> if compounding Category 1 and/or Category 2 Compounding sterile preparations (CSPs)</li> <li><b>Weekly</b> if compounding Category 3 CSPs</li> </ul>
Work surfaces outside the Primary Engineering Control (PEC)	<b>Daily</b> on days compounding occurs	<b>Daily</b> on days compounding occurs	
Floors	<b>Daily</b> on days compounding occurs	<b>Daily</b> on days compounding occurs	
Walls, doors, and door frames	<b>Monthly</b>	<b>Monthly</b>	<b>Monthly</b>
Ceilings			
Storage shelving and bins			
Equipment outside PEC			

**PROCEDURE:**

1. Perform Hand Hygiene
2. Don Proper Personal Protective Equipment prior to entering clean room (Gown, mask, gloves, hairnet, booties, and eye protection). Remove and discard PPE when exiting.
3. Disposable soap containers must be replaced they are not to be refilled or topped off.
4. Daily: clean- wipe all horizontal surfaces, mop the floor with a designated mop and wipe the plastic curtains inside and out using EPA germicidal agent.
5. Monthly cleaning: Walls, doorframes, ceilings, storage shelving and bins, tables, stools, and all other items and surfaces in the Pharmacy Clean Room using approved sporicidal/germicidal product; after cleaning repeat with sterile water using new disposable mop pad.
6. No sweeping, dusting or spraying will be done while in Pharmacy Clean Room.
7. Daily: Empty all trash containers. The outside of the waste containers shall be wiped out with the approved germicidal cleaning and disinfecting solutions.
8. Monthly: Cleaning of the inside and outside of trash containers with approved sporicidal agent.

9. All waste containers will be properly disposed of when at fill line.
10. Complete daily and monthly log.

## REFERENCES:

1. Association for Professionals in Infection Control and Epidemiology (APIC). August 2023. Ten Key Points the Infection Preventionist Needs to Know about (USP) <797>: Pharmaceutical Compounding-Sterile Preparations. Retrieved from [https://apic.org/wp-content/uploads/2023/08/APIC\\_PGC\\_Ten-Key-Points-the-Infection-Preventionist-Needs-to-Know.pdf](https://apic.org/wp-content/uploads/2023/08/APIC_PGC_Ten-Key-Points-the-Infection-Preventionist-Needs-to-Know.pdf)
2. California Hospital Association. (2018). Record and Data Retention Schedule. Retrieved from <file:///H:/Public/CHA/CHA%20Record%20and%20Data%20Retention%20Schedule%202018.pdf>
3. The Joint Commission Infection Prevention and Control IC.02.02.01. (2017). IC.02.02.01: The critical access hospital reduces the risk of infections associated with medical equipment, devices, and supplies. Retrieved from <https://e-dition.jcrinc.com/MainContent.aspx>
4. The Joint Commission Infection Prevention and Control IC.02.02.01. (2017). IC.02.02.01: The critical access hospital reduces the risk of infections associated with medical equipment, devices, and supplies. Retrieved from <https://e-dition.jcrinc.com/MainContent.aspx>
5. The Joint Commission Medication Management MM.05.01.07 The Critical Access Hospital safely prepares medications. Retrieved from <https://e-dition.jcrinc.com/ASearch.aspx>
6. United States Pharmacopeia (USP). 11/1/23. <797> Faqs. Retrieved from [https://go.usp.org/USP\\_GC\\_797\\_FAQs](https://go.usp.org/USP_GC_797_FAQs)
7. United States Pharmacopeia (USP). 11/22. <797> Pharmaceutical Compounding-Sterile Preparations. Retrieved from [https://online.uspnf.com/uspnf/document/1\\_GUID-A4CAA8B-6F02-4AB8-8628-09E102CBD703\\_7\\_en-US](https://online.uspnf.com/uspnf/document/1_GUID-A4CAA8B-6F02-4AB8-8628-09E102CBD703_7_en-US)
8. United States Pharmacopeia (USP). 2017. USP General Chapter <800> Hazardous Drugs-Handling in Healthcare Settings. Retrieved from [www.usp.org](http://www.usp.org)

## RECORD RETENTION AND DESTRUCTION:

Cleaning and disinfecting records must be kept for at least 3 years.

## CROSS-REFERENCE P&P:

1. [MEDICAL WASTE MANAGEMENT PLAN](#)
2. [Sterile Products: Compounding Quality Assurance Program\\*](#)
3. [Pharmacy Sterile Compounding: Training Requirements, General Conduct, and Aseptic Compounding](#)

Supersedes: v.1 Cleaning the Pharmacy Sterile IV Preparation Area. (Clean Room)
---



## NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Interim Guidance For Environmental Infection Control For Patients With Probable/Suspected Viral Hemorrhagic Fever (VHF)		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: District Wide		
Date Last Modified: 02/15/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/19/2015	

**PURPOSE:**

To provide guidance to control and minimize risk of potential contamination or spread of Viral Hemorrhagic Fever (VHF).

**POLICY:**

Northern Inyo Hospital District (NIHD) shall follow federal, state, and local authorities recommendations for environmental infection control as part of the care of patients who are persons under investigation or with suspected or confirmed VHF infections. Ensuring early identification and isolation of potentially infectious people is a key step in preventing the spread of VHF, including to workers who may be exposed on the job to a person with the virus.

**PROCEDURE:**

1. NIHD will follow CDC Infection Prevention and Control Recommendations for Patients in U.S. Hospitals who are Suspected or Confirmed to have Selected Viral Hemorrhagic Fevers (VHF). Located <https://www.cdc.gov/vhf/ebola/clinicians/evd/infection-control.html>

Component	Recommendation	Comments
Patient Placement	<ul style="list-style-type: none"> <li>• Single patient room (containing a private bathroom) with the door closed or isolation tent               <ul style="list-style-type: none"> <li>○ Adequate space for donning (putting on) and doffing (taking off) PPE</li> </ul> </li> <li>• Maintain a log of all people entering the patient’s room</li> </ul>	Consider posting personnel at the patient’s door to ensure appropriate and consistent use of PPE by all people entering the patient room

<p>Personal Protective Equipment (PPE)</p>	<p><a href="#"><u>Guidance on Personal Protective Equipment (PPE) in U.S. Healthcare Settings during Management of Patients Confirmed to have Selected Viral Hemorrhagic Fevers or Patients Suspected to have Selected Viral Hemorrhagic Fevers who are Clinically Unstable or Have Bleeding, Vomiting, or Diarrhea</u></a></p> <p><a href="#"><u>Guidance on Personal Protective Equipment (PPE) in U.S. Healthcare Settings for Evaluating Patients Suspected to have Selected Viral Hemorrhagic Fevers Who Are Clinically Stable and Do Not Have Bleeding, Vomiting, or Diarrhea</u></a></p>	<p>Recommended PPE varies depending on the symptoms of the patient</p>
<p>Patient Care Equipment</p>	<ul style="list-style-type: none"> <li>• Dedicated medical equipment (preferably disposable, when possible) should be used for the provision of patient care</li> <li>• All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer’s instructions and hospital policies</li> </ul>	
<p>Patient Care Considerations</p>	<ul style="list-style-type: none"> <li>• Limit the use of needles and other sharps as much as possible</li> <li>• Phlebotomy, procedures, and laboratory testing should be limited to the minimum necessary for essential diagnostic evaluation and medical care</li> <li>• All needles and sharps should be handled with extreme care and disposed in puncture-proof, sealed containers</li> </ul>	
<p>Aerosol Generating Procedures (AGPs)</p>	<ul style="list-style-type: none"> <li>• Avoid AGPs for patients with VHF, if possible.</li> <li>• If performing AGPs, use a combination of measures to reduce exposures from aerosol-generating procedures when performed on these patients.</li> <li>• Visitors should not be present during aerosol-generating procedures.</li> </ul>	<ul style="list-style-type: none"> <li>• Although there are limited data available to definitively define a list of AGPs, procedures that are usually included are Bilevel Positive Airway Pressure (BiPAP), bronchoscopy, sputum induction, intubation and extubation, and open suctioning of airways. Additional</li> </ul>

	<ul style="list-style-type: none"> <li>• Limiting the number of HCP present during the procedure to only those essential for patient care and support.</li> <li>• Conduct the procedures in a private room and ideally in an Airborne Infection Isolation Room (AIIR) when feasible. Room doors should be kept closed during the procedure except when entering or leaving the room, and entry and exit should be minimized during and shortly after the procedure.</li> <li>• HCP should wear <a href="#">appropriate PPE</a> during aerosol-generating procedures.</li> <li>• Conduct environmental surface cleaning following procedures (see section below on environmental infection control).</li> </ul>	<p>information about AGPs is available in <a href="#">Which procedures are considered AGPs in healthcare settings?</a>.</p> <ul style="list-style-type: none"> <li>• Because of the potential risk to individuals reprocessing reusable respirators, disposable filtering face piece respirators are preferred.</li> </ul>
Hand Hygiene	<ul style="list-style-type: none"> <li>• HCP should perform hand hygiene frequently, including before and after all patient contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves.</li> <li>• Healthcare facilities should ensure that supplies for performing hand hygiene are available.</li> </ul>	<p>Hand hygiene in healthcare settings can be performed by washing with soap and water or using alcohol-based hand rubs. If hands are visibly soiled, use soap and water, not alcohol-based hand rubs.</p>
Environmental Infection Control	<ul style="list-style-type: none"> <li>• Blood and body fluid spills shall be managed in accordance with the United States Occupational Safety and Health Administration (OSHA) Bloodborne Pathogen Standards (29 CFR 1910.1030).</li> </ul>	<p><a href="#">Environmental Cleaning Guidance</a></p> <p>Refer to <a href="#">Clorox Total 360 System Electrostatic Sprayer</a> policy and procedure</p>

	<ul style="list-style-type: none"> <li>• Follow CDC guidelines recommend removal of bulk spill matter, cleaning the site, and then disinfecting the site.</li> <li>• For large spills, use a chemical disinfectant with sufficient potency to overcome the tendency of proteins in blood and other body substances to neutralize the disinfectant's active ingredient.</li> <li>• Use an EPA-registered hospital disinfectant with label claims for non-enveloped viruses (i.e., norovirus, rotavirus, adenovirus, and poliovirus) and instructions for cleaning and decontaminating surfaces or objects soiled with blood or body fluids according to those instructions.</li> </ul> <p>Frequent cleaning and disinfection of hard, non-porous surfaces (i.e., high-touch surfaces such as bed rails and over bed tables, housekeeping surfaces such as floors and counters) shall be performed</p>	
<p>Elimination of biological waste</p>	<ul style="list-style-type: none"> <li>• Sharp objects (for example, needles, syringes, glass items) and tubes that have been in contact with blood or body fluids, should be discarded in puncture resistant containers for further destruction (incineration).</li> <li>• Infective solid waste, non-cut sharp items should be collected in leak proof biological risk bags and placed within covered containers.</li> <li>• Solid waste should be sterilized by high pressure</li> </ul>	<p><a href="#">VHF-Associated Waste Management</a></p>



	<p>steam heat (in autoclave of sufficient size that permits the adequate steam flow and with physical or biological indicators that ensure effectiveness of the process) or directly incinerated (in conventional double chamber incinerator).</p> <ul style="list-style-type: none"> <li>• Wastes such as stool, urine and vomit, or liquids from the washing, can be discarded directly in the drainage, toilet or latrine</li> <li>• The designated area for treatment and final disposal of the waste should have controlled access to avoid the entry of unauthorized persons.</li> <li>• For the final disposal, previously sterilized waste landfills authorized by the responsible health authority and according to the current legal standards.</li> </ul>	
Safe Injection practices	Facilities should follow safe injection practices as specified under Standard Precautions	Any injection equipment or parenteral medication container that enters the patient treatment area should be dedicated to that patient and disposed of at the point of use.
Duration of Infection Control Precautions	Duration of precautions should be determined on a case-by-case basis, in conjunction with local, state, and federal health authorities.	Factors that should be considered include, but are not limited to, presence of symptoms, date symptoms resolved, other conditions that would require specific precautions (e.g. tuberculosis, <i>Clostridium difficile</i> ) and available laboratory information.
Monitoring and Management of Healthcare Personnel	<i>Facility HCP monitoring and sick leave policies</i>	

- Facilities should develop policies for monitoring and management of HCP with [potential VHF exposure](#)
- Facilities should develop sick leave policies for HCP that are non-punitive, flexible and consistent with public health guidance
  - Ensure that all HCP, including staff who are not directly employed by the healthcare facility but provide essential daily services, are aware of the sick leave policies.

*HCP with high-risk exposures*

- Per [CDC interim guidance](#), people with high-risk exposures, including HCP, should be quarantined, monitored daily, and restricted from traveling by commercial transport until 21 days<sup>1</sup> after their last high-risk exposure
  - [High-risk exposures](#) include (but are not limited to):
    - Percutaneous, mucous membrane, or skin contact with blood or body fluids of a person suspected or confirmed to have VHF
    - Direct contact<sup>2</sup> with person suspected or confirmed to have VHF
    - Providing care to a patient suspected or confirmed to have VHF without use of all recommended PPE, or while experiencing a breach in recommended PPE that results in the potential for percutaneous, mucous membrane, or skin contact with the blood or body fluids of the patient
  - Living in the same household as a person suspected or confirmed to have VHF
  - Asymptomatic HCP who had a high-risk exposure should
    - Receive medical evaluation and follow-up care including fever monitoring twice daily for 21days<sup>1</sup> after the last known high-risk exposure
    - Be restricted from work and follow all other [recommendations](#) related to quarantine and restriction from commercial transport during the 21-day<sup>1</sup> monitoring period
- HCP who have a percutaneous or mucous membrane exposure to blood or body fluids, secretions, or excretions from a person suspected or confirmed to have VHF should
  - Stop working and immediately wash the affected skin surfaces with soap and water. Mucous

	<p>membranes (e.g., conjunctiva) should be irrigated with copious amounts of water or eyewash solution.</p> <ul style="list-style-type: none"> <li>○ Immediately contact their supervisor and occupational health program for assessment and access to postexposure management services for all appropriate pathogens (e.g., Human Immunodeficiency Virus, Hepatitis C, etc.).</li> </ul> <p><sup>1</sup>This time period is based on the outer limit of the incubation period for the suspected pathogen. For Ebola, Marburg, Lassa, and the South American Hemorrhagic Fevers, this is 21 days. However, for Crimean Congo Hemorrhagic Fever 14 days should be used.</p> <p><sup>2</sup> Direct contact means physical contact with a person with VHF (alive or dead) or with objects contaminated with the body fluids of a person with VHF (alive or dead) while not wearing recommended PPE or while experiencing a breach in PPE that could result in unprotected contact with the patient or their blood or body fluids.</p> <p><i>Additional Considerations for HCP with potential unrecognized VHF exposures</i></p> <ul style="list-style-type: none"> <li>• CDC has provided guidance for persons, including HCP, with the potential for unrecognized exposures in the absence of reported high-risk exposures. Such HCP should be evaluated by their occupational health program and have their recommended postexposure management, including work restrictions, determined in collaboration with public health authorities. <ul style="list-style-type: none"> <li>○ In general, asymptomatic HCP with potential unrecognized exposures in the absence of high-risk exposures do not require work restriction</li> </ul> </li> </ul> <p><i>Considerations for HCP who develop signs or symptoms after caring for patients suspected or confirmed to have VHF or with potential unrecognized exposures</i></p> <ul style="list-style-type: none"> <li>• HCP who develop symptoms of VHF (e.g., sudden onset of fever, fatigue, intense weakness or muscle pains, vomiting, diarrhea, or any signs of hemorrhage) should <ul style="list-style-type: none"> <li>○ Not report to work, or should immediately stop working</li> <li>○ Notify their supervisor and occupational health program, who should in turn notify local and state public health authorities</li> <li>○ Seek prompt medical evaluation and testing</li> <li>○ Comply with directives until they are to others</li> </ul> </li> </ul>
--	--

<p>Monitoring, Management, and Training of Visitors</p>	<ul style="list-style-type: none"> <li>• Avoid entry of visitors into the patient’s room <ul style="list-style-type: none"> <li>○ Exceptions may be considered on a case-by-case basis for those who are essential for the patient’s wellbeing.</li> </ul> </li> <li>• Establish procedures for monitoring managing and training visitors.</li> <li>• Visits should be scheduled and controlled to allow for: <ul style="list-style-type: none"> <li>○ Screening for VHF (fever and other symptoms) before entering or upon arrival to the hospital.</li> <li>○ Evaluating risk to the health of the visitor and ability to comply with precautions.</li> <li>○ Providing instruction, before entry into the patient care area on hand hygiene, limiting surfaces touched, and use of PPE according to the current facility policy while in the patient’s room.</li> <li>○ Visitor movement within the facility should be restricted to the patient care area and an immediately adjacent waiting area.</li> </ul> </li> </ul>	<p>Visitors who have been in contact with the patient before and during hospitalization are a possible source of VHF for other patients, visitors, and staff.</p>
---	--	---

**REFERENCES:**

1. California Hospital Association. (2018). Record Retention. Retrieved from file:///H:/Public/CHA/CHA%20Record%20and%20Data%20Retention%20Schedule%202018.pdf
2. Centers for Disease Control and Prevention (CDC) October 20, 2022. Ebola Hemorrhagic Fever, Interim Guidance for Environmental Infection Control in Hospitals for Ebola Virus, , <http://www.cdc.gov/vhf/ebola/healthcare-us/cleaning/hospitals.html>
3. US Occupational Safety and Health Administration (OSHA) Bloodborne Pathogens Standard (29 CFR 1910.1030), [https://www.osha.gov/pls/oshaweb/owadisp.show\\_document?p\\_id=10051&p\\_table=STANDARDS](https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=10051&p_table=STANDARDS)
4. United States Department of Labor, Occupational Safety and Health Administration (OSHA) (Date Accessed 12/14/2023). Ebola. Retrieved from <https://www.osha.gov/ebola/control-prevention>

5. Centers for Disease Control and Prevention (CDC). (September 11, 2023). Infection Prevention and Control Recommendations for Patients in U.S. Hospitals who are Suspected or Confirmed to have Selected Viral Hemorrhagic Fevers (CHF). Retrieved from <https://www.cdc.gov/vhf/ebola/clinicians/evd/infection-control.html>

#### **RECORD RETENTION AND DESTRUCTION:**

1. Maintain cleaning logs for a minimum of 2 years at Northern Inyo Healthcare District. Discard cleaning logs in regular trash, provided they contain no protected health information.
2. Employee Exposure Records will be maintained time of employment plus 30 years after separation.

#### **CROSS-REFERENCE P&P:**

1. [Triage of Patients Suspected of Ebola\\*](#)
2. [MEDICAL WASTE MANAGEMENT PLAN](#)
3. [Bloodborne Pathogen Exposure Control Plan](#)
4. [Infectious/Non-Infectious Waste Disposal Procedure](#)
5. [Clorox Total 360 System Electrostatic Sprayer](#)

Supersedes: v.1 Interim Guidance For Environmental Infection Control For Patients With Probable/Suspected Ebola Virus*
--



## NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Triage of Patients Suspected of Viral Hemorrhagic Fever (VHF)		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: Emergency Department		
Date Last Modified: 02/15/2024	Last Review Date: No Review Date 05/17/2017	Version: 2
Final Approval by: NIHD Board of Directors		Original Approval Date: 08/20/2015

### PURPOSE:

To provide guidance on triage and identification of Viral Hemorrhagic Fever (VHF) implement appropriate infection prevention practices to control and minimize the spread of VHF, and internal and external notification process.

### POLICY:

Northern Inyo Healthcare District shall follow federal, state, and local authorities for triaging patients suspected of having VHF and/or travel history as identified in high-risk countries.

### PROCEDURE:

1. A three (3) step process for triage of Viral Hemorrhagic Fever (VHF) shall be followed:

a. **Identify exposure history and VHF -compatible symptoms:**

- i. Take relevant patient history, including exposure criteria of whether the patient lived in or traveled to a country with widespread or ongoing VHF transmission or had contact with an individual with confirmed VHF within the previous 21 days, attendance to funeral of VHF confirmed or suspected person.

- ii. Check patient for the below symptoms.

*Note: Fever (subjective or greater than or equal to 100.4 degrees F or 38.0 degrees C)*

Disease	Signs and Symptoms	Additional information (hyperlinks)
Ebola Virus Disease	Fever, headache, muscle pain, fatigue, weakness, diarrhea, vomiting, abdominal pain, conjunctival injection, chest pain, hemorrhage	<a href="#">Ebola: Signs and Symptoms</a>
Marburg Virus Disease	Fever, chills headache, muscle pain, maculopapular, rash, nausea, vomiting, chest pain, sore throat, abdominal pain, diarrhea, jaundice, hemorrhage	<a href="#">Marburg hemorrhagic fever (Marburg HF): Signs and Symptoms</a>

Lassa Fever	Fever, nausea, vomiting, diarrhea, retrosternal chest pain, sore throat, muscle pain, enlarged cervical lymph nodes, abdominal pain, bleeding, maculopapular rash, conjunctivitis, headache	<a href="#">Lassa Fever: Signs and Symptoms</a>
Crimean-Congo Hemorrhagic Fever	Fever, headache, back pain, joint pain, abdominal pain, vomiting, conjunctival injection, facial flushing, petechial rash, jaundice, bleeding, photophobia, sore throat	<a href="#">Crimean-Congo Hemorrhagic Fever: Signs and Symptoms</a>

- iii. Notify ED physician of patient high risk for VHF
- iv. Call Code Triage – Internal Communicable Disease

2. **Isolate the patient and determine personal protective equipment (PPE) needed:**

- a. Place patient surgical mask on patient and place in private room with private bathroom, covered bedside commode (BSC), or have patient wait in private vehicle while triage tent is assembled. **(See Patient Management Section)**
  - i. Only essential personnel with designated roles should evaluate patient and provide care to minimize transmission risk.
  - ii. NIHD staff to designate clean area for donning PPE and designate a separate doffing area.
  - iii. Segregate waste until diagnosis is established.
  - iv. Follow tent assembly and required equipment instructions (attached).
  - v. Follow NIHD policy and procedure titled Triage of Patients Suspected of Viral Hemorrhagic Fever (VHF).
- b. Healthcare worker to don appropriate PPE and follow appropriate transmission based precautions.

3. **Inform:**

- a. Notify the below:
  - ii. House Supervisor
  - iii. Infection Prevention
  - iv. Administrator on call (AOC)
  - v. Local County Health Department
  - vi. Local California Department of Public Health District Office
- b. Triage RN and/or Infection Prevention team member, ED leadership, or House Supervisor to initiate the Situation Communication Report Form.

3. **Patient Management**

- a. Patient’s exhibiting VHF-like symptoms shall, immediately upon entrance to the ED, or in advance of entry using phone line (760-873-2020) for patient triage if possible, be identified and isolated if a relevant exposure history assessed, including whether the patient has resided in or traveled to a country with widespread VHF transmission or had contact with an individual with confirmed VHF within the previous 21 days.

Note: Because the signs and symptoms of VHF may be nonspecific and are present in other infectious and noninfectious conditions that are more frequently encountered in the United States, relevant exposure history should be first elicited to determine whether VHF should be considered further. If the patient is unable to provide history due to clinical condition or other communication barrier, history should be elicited from the next most reliable source (e.g., family, friend or EMS provider).

- b. Patients who meet the exposure criteria shall be further questioned regarding the presence of signs or symptoms compatible with VHF and travel history. Complete Ebola Virus Disease Travel History Form (located in attachments)
- c. Clinical judgment shall be used to determine whether to empirically implement the following protocol.
- d. If a relevant exposure history is reported and signs or symptoms consistent with VHF present, the following measures shall be implemented IMMEDIATELY:
  - i. Move patient to isolation tent or to a determined room/area and adhere to procedures and precautions designed to prevent transmission by direct or indirect contact (e.g., dedicated equipment, hand hygiene, and restricted patient movement).
  - ii. If the patient is arriving by EMS transport, the ED shall be prepared to receive the patient in a designated tent or to a determine room/area (away from other patients) and the process safely transporting the patient on the stretcher to the isolation area with minimal contact with non-essential healthcare workers or the public will be in place (taped zone).
- e. To minimize transmission risk healthcare workers with designated roles shall provide patient care:
  - i. A log should be maintained of all personnel who have had contact or enter the patient's area.
  - ii. All healthcare workers who have contact with the patient should put on appropriate PPE based on the patient's clinical status.
    - a. If the patient is exhibiting obvious bleeding, vomiting, copious diarrhea or a clinical condition that warrants invasive or aerosol-generating procedures (e.g., intubation, suctioning, active resuscitation), don high level PPE designated for the care of hospitalized patients as outlined in CDC Guidance (<http://www.cdc.gov/vhf/ebola/hcp/procedures-for-ppe.html>) should be used.
  - iii. Active resuscitation will be determined by the ED physician with minimal invasive treatment.
  - iv. If these signs and symptoms are not present and the patient is clinically stable, healthcare workers will wear High Level PPE
    - a. All equipment used in the care of these patients should not be used for the care of other patients until appropriate evaluation and decontamination (<http://www.cdc.gov/vhf/ebola/hcp/environmental-infection-control-in-hospitals.html>).
  - v. Once High Level PPE has been put on, continue obtaining additional history and performing physical examination and routine diagnostics and interventions which may include placement of peripheral IV and phlebotomy. The decision to test patient for VHF Disease should be made in consultation with the relevant local health department and NIHD leadership. Patient evaluation should be conducted with dedicated equipment as required for patients on transmission-based precautions.



- vi. Any persons entering the room will have trained observer monitoring donning and doffing to prevent employee exposure to VHF.

## REFERENCES:

1. California Department of Public Health (CDPH). 2/3/2023. Ebola Virus Disease: Information for Local Health Departments. Retrieved from <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/EbolaLHDs.aspx>
2. Centers for Disease Control and Prevention. March 23, 2023. Signs and Symptoms. Retrieved from <https://www.cdc.gov/vhf/ebola/symptoms/index.html>
3. Centers for Disease Control and Prevention. September 11, 2023. Infection Prevention and Control Recommendations for Patients in U.S. Hospitals who are Suspected or Confirmed to have Selected Viral Hemorrhagic Fevers (VHF). Retrieved from <https://www.cdc.gov/vhf/ebola/clinicians/evd/infection-control.html>
4. Centers for Disease Control and Prevention. 2014. Checklist for Patients Being Evaluated for Ebola Virus Disease (EVD) in the United States. Retrieved from [file://root.nih.org/home/Users/User\\_Folders/robinchristensen/Downloads/cdc\\_25712\\_DS1.pdf](file://root.nih.org/home/Users/User_Folders/robinchristensen/Downloads/cdc_25712_DS1.pdf)
5. Centers for Disease Control and Prevention. September 11, 2023. Guidance on Personal Protective Equipment (PPE) in U.S. Healthcare Settings During Management of Patients Confirmed to have Selected Viral Hemorrhagic Fevers or Patients with Suspected to Selected Viral Hemorrhagic Fevers who are Clinically Unstable or Have Bleeding, Vomiting, or Diarrhea. Retrieved from <https://www.cdc.gov/vhf/ebola/healthcare-us/ppe/guidance.html>
6. California Department of Public Health. (11/15/2022). All Facilities Letter 22-24: Ebola Virus Disease Information and Preparedness. Retrieved from <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-24.aspx>
7. California Department of Public Health. (11/21/2022). Information for Health Professionals and Laboratories. Retrieved from <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/EbolaHealthProfessionals.aspx>

## CROSS REFERENCE P&P:

1. Infection Control Guidelines For Potential Agents of Bioterrorism
2. [Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program](#)
3. [Airborne Infection Isolation Rooms \(AIIR\)](#)
4. [Bloodborne Pathogen Exposure Control Plan](#)
5. [Biosafety Plan](#)
6. [Triage of Patients Suspected of Viral Hemorrhagic Fever \(VHF\) Interim Guidance For Environmental Infection Control For Patients With Probable/Suspected Ebola Virus\\*](#)

Supersedes: v.1 Triage of Patients Suspected of Ebola*
--



**NORTHERN INYO HEALTHCARE DISTRICT  
CLINICAL STANDARDIZED PROTOCOL**

Title: Standardized Protocol – Minor Surgical Policy for the Physician Assistant		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Physician Assistants		
Date Last Modified: 04/04/2024	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/20/2019	

**PURPOSE:**

1. This standardized protocol is designed to establish guidelines that will allow the Physician Assistant (PA) to perform minor surgical procedures incidental to the provision of routine primary care to ambulatory patients of Northern Inyo Healthcare District and affiliated locations.

**POLICY:**

1. This standardized protocol and those authorized to work through this standardized protocol will meet all guidelines as outlined in the *General Policy for the Physician Assistant*.
2. Circumstances:
  - a. Patient population: pediatric and adult patients
  - b. Setting: Northern Inyo Healthcare District (NIHD) and affiliated locations.
  - c. Supervision: Physician consultation is available at all times, either on-site, by phone, or by electronic means.

**PROTOCOL:**

1. Conditions: after appropriate training and experience (which includes a minimum of 5 proctored procedures each by a practitioner with unrestricted privileges in that procedure), minor procedures that can be performed by the PA without direct physician supervision include:
  - a. Pessary placement
  - b. Electrocautery of external, non-malignant, e.g. warts
  - c. Epidermal cyst removal
  - d. Incision and drainage of abscess (excluding peri-rectal abscesses)
  - e. Suture laceration without nerve or tendon involvement
  - f. Mole removal
  - g. Punch or shave biopsy
  - h. Toe nail removal
  - i. Cryotherapy
  - j. IUD insertion and removal
  - k. Excision of simple lesions
  - l. Simple foreign body removal

- m. Endometrial biopsy
  - n. Arthrocentesis/Steroid joint injection
  - o. Excision of hemorrhoid thrombus
  - p. Nexplanon insertion/removal
  - q. Circumcision of newborn
  - r. Vasectomy
2. Data Base:
    - a. Subjective:
      - i. Obtain pertinent history including involved organ system, injury, trauma, dermatology problems, etc.
      - ii. Obtain information regarding review of system, risk taking behaviors, prior surgery, allergies, and immunizations.
    - b. Objective:
      - i. Perform physical examination pertinent to assessment of the problem.
      - ii. Collect appropriate diagnostic/radiological studies.
  3. Assessment:
    - a. Formulate diagnosis consistent with the above data base.
    - b. Document
  4. Plan:
    - a. Develop therapeutic regimen
      - i. Perform appropriate procedure utilizing standard aseptic technique.
      - ii. Obtain additional diagnostic studies as indicated.
      - iii. Physician consultation/assistance in performing the procedure as per policy statement or above conditions.
      - iv. Patient education and self-care techniques.
      - v. Development of appropriate follow-up care plan.
      - vi. Update problem list.
    - b. Provide written discharge instructions to the patient.

**REFERENCES:**

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource

**ATTACHMENTS:**

1. List of Authorized Physician Assistants and Supervising Physicians

Supersedes: v.3 Standardized Protocol – Minor Surgical Policy for the Physician Assistant
---



## NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Procedural Sedation		
Owner: Perioperative Manager	Department: PACU	
Scope: Practitioners with Procedural Sedation Privileges		
Date Last Modified: 04/04/2024	Last Review Date: No Review Date	Version: 7
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/16/2015	

**PURPOSE:**

To provide a consistent standard for the administration of sedation by non-anesthesia providers during procedures performed at Northern Inyo Hospital

**DEFINITIONS:**

- 1) Minimal Sedation – A drug-induced state in which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilator and cardiovascular functions are unaffected. ‘Minimal Sedation’ includes analgesia, anxiolysis and/or the use of a soporific for the purpose of performing a procedure.
  - a. Analgesia – Pain control, often with a narcotic, which is expected to have no significant effect on the patient’s level of consciousness.
  - b. Anxiolysis – Control of anxiety, most commonly with a benzodiazepine, which is expected to have no effect on a patient’s level of consciousness.
  - c. Soporific – A sleeping agent, which, at the usual dose and route, is expected to induce sleep from which a patient can be easily aroused.
- 2) Dissociative Sedation – A trance-like state of unconsciousness in which the patient is unresponsive to pain and of which the patient will have no memory. Airway reflexes are maintained and vital signs remain stable. This state is unique to Ketamine in appropriate doses.
- 3) Moderate Sedation – A drug-induced depression of consciousness during which the patient responds purposefully to verbal commands, either alone or with light tactile stimulation. No interventions are required to maintain a patent airway and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. Moderate Sedation using Propofol or Etomidate may be administered in the Emergency Department (ED) by an Emergency Department registered nurse under the direct supervision of an appropriately privileged practitioner.
- 4) Deep Sedation - A drug-induced depression of consciousness during which patients are not easily aroused, but respond purposely after repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
- 5) General Anesthesia – A drug-induced unconsciousness during which it is expected that respirations, motor tone and protective airway reflexes may be abolished, requiring complete airway and respiratory support. General anesthesia may only be administered by an Anesthesiologist or CRNA with appropriate clinical privileges. ED physicians may induce general anesthesia only when the goal is endotracheal intubation, as in Rapid Sequence Intubation, and as delineated in their Hospital privileges.

## **POLICY:**

- 1) Procedural sedation in the hospital shall be monitored and evaluated by the Surgery, Tissue, Transfusion and Anesthesia Committee according to the policy and performed to assure optimal patient outcomes. The physician providing sedation must be thoroughly familiar with the use and potential complications of the drugs used.
- 2) This policy applies in the hospital when patients receive, by any route, for any purpose, moderate, deep or dissociative sedation.
- 3) This policy does not apply to situations which do not constitute procedural sedation, such as: patients receiving medications for pain control, seizures, insomnia, preoperative medications, anxiety management, or medications given to intubated patients while on ventilatory support. This policy also does not apply to anesthesiologists or CRNAs providing General Anesthesia.
  - a. Minimal sedation, as defined above, does not require any special monitoring or facilities other than maintaining verbal or visual contact with the patient until the effects of the medication have reached their peak, but continuous Pulse Oximetry may be considered.
- 4) Sedation may only be performed by a practitioner with the appropriate privileges at NIH. Medications ordered for the purpose of sedation may be administered by the RN; medications for moderate or deep sedation must be administered under the direct supervision of the ordering practitioner who must be present in the department.
- 5) The following resources shall be available in all locations where medications are administered to induce sedation:
  - a. Equipment to monitor vital signs including pulse, respiratory rate and oxygenation.
  - b. Appropriately sized equipment for establishing and providing airway maintenance, including a selection of laryngoscope blades with handle and endotracheal tubes.
  - c. Suction and supplemental oxygen with the appropriately sized adjuncts.
  - d. Crash cart equipped with a defibrillator.
  - e. Appropriate selection of masks and airways.
  - f. Means to administer positive-pressure ventilation (e.g. ambu bag).
  - g. Pharmacologic antagonists, including naloxone and flumazenil.
- 6) Because deep sedation carries a high level of risk, the administration must be carefully planned. A sedation plan will be developed to meet patient needs identified through a pre-sedation assessment.
- 7) Practitioners providing moderate or deep sedation must have training and experience in:
  - a. Evaluating patients prior to performing moderate or deep sedation.
  - b. Performing the sedation, including methods and techniques required to rescue those patients who unavoidably or unintentionally slip into a deeper level of sedation than desired.
  - c. Managing an unstable cardiovascular system as well as a compromised airway and inadequate ventilation.
- 8) All physicians requesting privileges in moderate, dissociative and deep sedation must meet the following criteria:
  - a. Satisfactory completion of the sedation reading list or tutorial and completion of the post-test at least every 2 years.
  - b. Documentation of 6 successful sedation procedures within 2 years.
  - c. Current ACLS certification and/or Emergency Medicine Board Certification.

## **EXCEPTIONS**

Anesthesiologists who have completed an anesthesiology residency and CRNAs who have completed an accredited nurse anesthesia program are considered qualified to administer moderate, dissociative, and/or deep sedation and analgesia by virtue of their training and experience. They are therefore exempt from the requirements listed in Section 8a of this document.

- 9) The Registered Nurse administering the medications to be used for sedation must be competent in the following areas:
  - a. Basic arrhythmia recognition
  - b. Airway management
  - c. Current in BLS, ACLS and PALS
  - d. Clinical pharmacology and hemodynamic variables of the medications to be used and their antagonists
  - e. Knowledge of the appropriate monitoring equipment.
- 10) Sufficient numbers of qualified personnel will be present during sedation to:
  - a. Appropriately evaluate the patient prior to sedation.
  - b. Provide the sedation. The sedation nurse will have no additional responsibilities during the procedure.
  - c. Perform the procedure.
  - d. Monitor the patient.
  - e. Recover and discharge the patient from the department where sedation has been administered except in the Diagnostic Imaging Department. These patients will be recovered in the Perioperative Department.
- 11) The patient's response to sedation and the procedure will be documented in the patient's record.
- 12) Outcomes of patients undergoing moderate, dissociative or deep sedation will be collected and analyzed within the Peer Review process in order to identify opportunities to improve.
- 13) Procedural Sedation is not to be done in the Medical-Surgical Unit or Perinatal Unit.

**PROCEDURE:**

**PRE-SEDATION:**

The nurse will complete a pre-procedure assessment with documentation to include:

- Patient identified using 2 patient identifiers (MR#, DOB, Name or Acct#)
- Baseline vital signs including oxygen saturation
- Physical assessment including age, weight, level of consciousness and pregnancy status
- Allergies
- Current medications
- Current medical problems
- Preferred NPO status
  - May not be obtainable due to nature of emergency
  - Consider addition of Reglan or Bicitra 20-30 minutes prior to procedure for patients with a full stomach
  - Pregnancy greater than 20 weeks, obesity and prior history of reflux should always be considered a potential full stomach
  - Non-emergency NPO guidelines:

Previous 2 hours - clear liquids
Previous 4 hours – breast milk
Previous 6 hours - light meal

Previous 8 hours - heavy meal

- Signed consent for the procedure including sedation, if condition permits
- IV status (patent, running, saline lock)
- Verification that a responsible adult is available to transport the patient home
- Equipment available
- Reversal agents

Physician documentation will include:

- Focused history and physical for the chief complaint
- History of patient or family complications to sedation
- Risks, benefits and alternatives of the procedure and types of sedation have been discussed with the patient and family prior to administration.
- An immediate pre-procedure assessment including a review of vital signs and patient status.
- Airway assessment with classification based on the American Society of Anesthesiology (ASA) classification system listed below. Any patient assessed an ASA-IV or greater requires consultation from the anesthesiologist or CRNA.

SEDATION:

- 1) The patient will be monitored continuously throughout the procedure. Monitoring will be done by the medication/monitoring RN who will not assist with the procedure.
  - a. Vital signs, including sedation scale and oxygen saturation levels will be recorded every 5 minutes throughout the procedure.
    - a. For deep sedation, vital signs should be monitored more closely, at least every 3 minutes.
  - b. Medications given, including dose, route and response will be documented throughout the procedure.
  - c. A change of 20% or more from baseline in pulse, heart rate or oxygen saturation should be reported to the physician.
  - d. Documentation should also include the patient's tolerance of the procedure, estimated blood/fluid loss, acute changes in the patient's status, interventions performed and disposition of the patient.
- 2) A respiratory therapist will be at the bedside for any moderate or deep sedation performed outside of the OR.
- 3) ETCO<sub>2</sub> Monitoring will be used, if available.

POST-PROCEDURE:

- 1) Immediately after the procedure, the physician will document the outcome of the procedure, the patient's response to the sedation and any complications.
- 2) Routine nursing recovery care will include, but not be limited to:
  - a. Admission Aldrete score
  - b. Blood pressure, respirations and heart rate every 15 minutes
  - c. Continuous monitoring of oxygen saturation, respirations, and cardiac rhythm

- d. Documentation of vital signs will continue every 15 minutes until the patient reaches discharge criteria defined as an Aldrete score of 8 for 30 minutes or achieves a score equivalent to pre-procedure levels. If a reversal agent was administered, this monitoring time will be extended to at least one hour after the last reversal agent was administered.
- 3) Any abrupt deterioration of the patient's condition will be reported to the physician immediately. These include, but are not limited to:
- a. Respiratory rate greater than 20 or less than 10
  - b. Oxygen saturation less than 90% or less than pre-procedure levels
  - c. Stridor, wheezing or croup symptoms
  - d. Shallow or inadequate tidal volumes
  - e. Sudden onset of cyanosis
  - f. Repeated respiratory obstruction
  - g. Systolic blood pressure less than 80% under or more than 20% over preoperative values
  - h. Pulse greater than 120 or less than 50
  - i. Any cardiac dysrhythmias
  - j. Any deterioration in mental status

**DISCHARGE:**

- 1) Patients who have received procedural sedation may be discharged when the following criteria are met:
  - a. Discharge order from the physician
  - b. Vital signs to within +/- 20% of pre-procedure level
  - c. Level of consciousness returned to pre-procedure state
  - d. Return of baseline motor function, including able to ambulate without assistance (if applicable)
  - e. Able to tolerate oral fluids (unless contraindicated)
  - f. Pain is manageable
  - g. Oxygen saturation maintained at 94% or greater or is stable at pre-procedural level
- 2) Patient and family education and discharge planning is done and validation that learning took place is documented. Written discharge instructions should cover the following:
  - a. Limitations of activity (including operating a motor vehicle or heavy machinery)
  - b. Dietary precautions
  - c. Medications
  - d. Signs and symptoms of complications with a course of action to take
  - e. Name and phone number of physician and hospital
  - f. Follow-up instructions
- 3) Transportation home shall be by a responsible adult other than the patient.

**REFERENCES:**

- 1. Department of Health and Human Services: CMS: Anesthesia Services: 482.52 Condition of participation: Anesthesia services 2002
- 2. The Joint Commission, Critical Access Hospital Accreditation Requirements, Provisions of Care, Treatment, and Services (PC) 03.01.01, 03.01.03, 03.01.05 and 03.01.07 2022
- 3. AORN Guidelines for Perioperative Practice. Guideline: for Care of the Patient Receiving Moderate Sedation/Analgesia 2022
- 4. American Association of Nurse Anesthesiology (AANA). Non-anesthesia Provider Procedural Sedation and Analgesia, Policy Considerations 2016
- 5. American Society of Anesthesiologists (ASA). Practice Guidelines for Moderate Procedural Sedation and Analgesia 2018



6. California Code of Regulations. Title 22 - Social Security. Division 5 - Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies. Chapter 1 - General Acute Care Hospitals. Article 3 - BASIC SERVICES. Section 70233 - Anesthesia Service General Requirements 2022
7. California Code of Regulations. Title 22 - Social Security. Division 5 - Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies. Chapter 1 - General Acute Care Hospitals. Article 3 - BASIC SERVICES. Section 70237 - Anesthesia Service Equipment and Supplies 2022

**CROSS REFERENCE POLICIES / PROCEDURES:**

1. Nursing Care of Outpatient Interventional Radiology Patient
2. Anesthesia in Ancillary Departments
3. Propofol Use in Critical Care Areas

**RECORD RETENTION AND DESTRUCTION:**

Documentation of procedural sedation occurs within the patient medical record, which is maintained by the NIHD Medical Records Department.

Supersedes: v.6 Procedural Sedation*
--------------------------------------

## ASA SCORING:

American Society of Anesthesiologists grading for anesthetic assessment

1. ASA I - A normal healthy patient without medical problems
2. ASA II - A patient with mild systemic disease (that does not limit activity)
3. ASA III - A patient with moderate or multiple controlled systemic diseases (limits activity, but not incapacitating)
4. ASA IV - A patient with severe systemic disease that is incapacitating and is a constant threat to life
5. ASA V - A moribund patient who is not expected to survive with or without the operation

If any of the above categories is an emergency, it is suffixed with 'E'.

## ALDRETE SCORING:

### ACTIVITY

Able to move 4 extremities voluntarily or on command = 2

Able to move 2 extremities voluntarily or on command = 1

Able to move 0 extremities voluntarily or on command = 0

### RESPIRATION

Able to deep breathe and cough freely = 2

Dyspnea or limited breathing = 1

Apneic = 0

### CIRCULATION

BP" 20% of Preanesthetic level = 2

BP" 20-50% of Preanesthetic level = 1

BP" 50% of Preanesthetic level = 0

### CONSCIOUSNESS

Fully Awake = 2

Arousable on calling = 1

Not responding = 0

## COLOR

Pink = 2

Pale, dusky blotchy, jaundiced, other = 1

Cyanotic = 0

**DOSING STANDARDS:**

**Maximum doses are for procedures without the presence of Anesthesiologist or CRNA**

**Moderate Sedation Agents - Intravenous Administration**

Trade Name	Generic Name	Initial Dose	Repeat Dose	Minimal Repeat Dose Interval	Maximum Dose Per Hour
Morphine	morphine sulfate	0.025mg/kg- 0.1mg/kg	0.025mg/kg	2 minutes	20 mg
Sublimaze	fentanyl	0.5-1mcg/kg	0.5mcg/kg	2 minutes	500 mcg
Demerol	Meperidine	25-50mg		5-10 minutes	100mg
Versed	midazolam hydrochloride	0.025mg/kg- 0.05mg/kg	0.025mg/kg	2 minutes	10mg*

**Midazolam (Versed)**

\*The Physician may exceed the upper dose limit of midazolam (10mg) if in his/her judgement a higher upper limit dose is indicated and the physician remains at the bedside until the patient is transferred to an appropriate level of care.

For Midazolam and Fentanyl given together:

- Use smaller doses and longer intervals between doses in the elderly and patients with compromised hepatic or renal function
- Fentanyl may cause chest wall rigidity, apnea, respiratory depression or hypotension; elicits minimal cardiovascular depression; may cause dysphoria, nausea or vomiting, reversed by naloxone
- Midazolam may cause respiratory depression or hypotension, particularly when administered with a narcotic, reversed by flumazenil

**Pediatric Moderate Sedation Agents**

Name/Route	Initial Dose	Repeat Dose	Minimal Repeat Dose Interval	Onset/Duration	MAX Dose Per Procedure

Morphine IV	0.05-0.1mg/kg	0.05mg/kg	2 minutes	Duration 60 minutes	0.3mg/kg
Fentanyl IN	2mcg/kg			Onset 10 min	
Fentanyl IV	0.5-1mcg/kg	0.5mcg/kg	2 minutes		5mcg/kg
Versed Oral	0.5-1mg/kg	0.5mg/kg	*	Onset 20-30 minutes Duration 60-90 min	20 mg
Versed IN	0.2-0.4mg/kg	0.2mg/kg	*	Onset 10 min Duration 60 min	*
Versed IV	0.025-0.05mg/kg	0.025-0.05mg/kg	2 minutes	Onset 1-2 minutes Duration 30-60min	*

**\*Check current pediatric sedation references**

### Reversal Agents - Intravenous or Intranasal Administration

Trade Name	Generic Name	Initial Dose	Repeat Dose	Minimal Repeat Dose Interval	MAX Dose Per Procedure
Narcan	naloxone	0.1- 0.4 mg SC/IM/IV	0.4mg	3 minutes	2mg/dose May need continuous drip
Romazicon	flumazenil	0.2 mg IV over 15 seconds	0.2mg	1 minute	1mg/dose & 3mg/hr Repeat doses may be given at 20-minute intervals

- Rebound sedation can occur with either reversal agent and may require repeat doses.
- Naloxone can precipitate acute withdrawal symptoms in chronic opioid users.
- Flumazenil can precipitate acute withdrawal seizures in chronic benzodiazepine users which are unresponsive to benzos.

### Dissociative Sedation Agent - Ketamine

Route	Initial Dose	Repeat Dose	Minimal Repeat Dose Interval	Onset/Duration	MAX Dose Per Procedure

IM	4-5mg/kg	2mg/kg	5 minutes	5-10 minutes 30 minutes	
IV	1-1.5mg/kg over 1-2 minutes	0.5mg/kg	3 minutes	1-2 minutes 20 minutes	

- Increases bronchial and salivary secretions, heart rate, blood pressure and intracranial pressure, emergence hallucinations observed >15 years old, NOT reversible
- May add atropine 0.01mg/kg (min 0.1mg, max 0.5mg) to same syringe to decrease salivation
- May add midazolam 0.1mg/kg IM or 0.05mg/kg IV for emergence reactions or agitation, will slow recovery time.
- May cause vomiting during recovery

### Deep Sedation Agents

Trade Name	Generic/Route	Initial Dose	Repeat Dose	Min Interval	Onset/Duration	MAX Dose Per Procedure
Brevital	Methohexital -Rectal	25mg/kg			Onset 15 min	500mg
	Methohexital -IV	1-1.5mg/kg slow IVP	0.5mg/kg	3 minutes	Duration 5-7 min	
Amidate	Etomidate -IV	0.1-0.2mg/kg	0.1mg/kg	2 minutes	Onset <1 min Duration 5-10 min	
Diprivan	Propofol IV	0.5-1mg/kg	0.5mg/kg	1 minute	Onset <1 min Duration 5-10 min	4mg/kg

- Methohexital is an ultra-short-acting barbiturate providing good immobilization and hypnosis, paradoxical excitation may occur, NOT reversible

- Etomidate commonly causes myoclonus and pain upon injection; may cause adrenal suppression, nausea, vomiting, or lower the seizure threshold; no hemodynamic effect; causes a slight to moderate decrease in intracranial pressure for several minutes; useful for patients with trauma and hypotension, NOT reversible
- Propofol provides rapid onset and recovery phase of deep sedation with brief duration of action, has anticonvulsant properties; causes cardiovascular depression and hypotension, NOT reversible



**NORTHERN INYO HEALTHCARE DISTRICT  
CLINICAL POLICY AND PROCEDURE**

Title: Nursing Management of the Infant and Pediatric Security System		
Owner: DON Inpatient Services	Department: Acute/Subacute Unit	
Scope: Acute/Subacute Unit, Perinatal		
Date Last Modified: 03/27/2024	Last Review Date: No Review Date	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/14/2016	

**PURPOSE:**

To provide and maintain a safe environment for infants and pediatric patients through standardized use of a security system. To guide staff on proper use of the infant and pediatric security system.

**DEFINITIONS:**

Neonate: An infant from birth through the 28<sup>th</sup> day of life.

Pediatrics: Any patient between the ages of 29 days of life through the 12<sup>th</sup> year of life.

**POLICY:**

1. All admitted neonatal and pediatric patients will have a functional security monitor from the time of admission until the time of discharge.
2. The type of security monitor placed on the patient will be appropriate for the patient based on age and manufacturer recommendation.
3. Any employee with proper training and access to clear an infant or pediatric security alarm, will verify the patient’s location and safety prior to clearing the alarm.

**PROCEDURE:** Tag application and removal

Tummy tags:

1. Remove the tag from the foil container when ready to use. Within the electronic infant security system, assign the tag to the patient. This may be done prior to delivery.
2. The tummy tag is designed to fit into the hinge of a universal umbilical cord clamp. Insert the post of the tag into the clamp hinge, ensuring a secure fit.
3. Position the clamp parallel to the neonate’s abdomen, leaving approximately 1 inch between the clamp and abdomen.
4. Lock the clamp in place using both hands, applying gentle pressure. Confirm the clamp is secure.
5. Tags are waterproof, and the patient may be bathed with the tag in place.
6. Do not remove the tag until the patient is ready to exit the hospital. If a tag is loose, tampered with, or the baby is taken near an exciter, an alarm will sound. Appropriate action to clear the alarm will be taken within the electronic system by a trained RN, LVN, CNA or Department Clerk, only after the location and safety of the patient has been verified.
7. Prior to removing the tag, discharge the patient in the electronic infant security system. To remove the tag, cut the umbilical clamp using the approved clamp removal device.



8. After the tag is removed from the place it in the used tag box, located on the perinatal department.

#### Cut tags or Sensing tags:

1. Remove the tag from the foil container when ready to use. Within the electronic infant security system, assign the tag to the patient.
2. Thread the cut-band up through one side of the tag from the bottom, then repeat for the other side, creating a loop. The white side of the cut band should be next to the patient's skin.
3. Slip the loop over the patient lower extremity. Tags must be loose enough to rotate, but tight enough of avoid slipping off. Trim the straps.
  - a. Sensing tags should be tight enough to maintain contact with the skin and will alarm if that contact with skin is broken.
4. Tags are waterproof, and the patient may be bathed with the tag in place.
5. Do not remove the tag until the patient is ready to exit the hospital. If a tag is loose, tampered with, or the baby is taken near an exciter, an alarm will sound. Appropriate action will be taken on the computer to clear the alarm on the location and safety of the patient has been verified. Trained RN's, LVN's, CNA's, and department clerks have the ability to clear the alarm once the safety of the infant is confirmed.
6. Prior to removing the tag, discharge the patient in the electronic infant security system. Cut the band close to the tag by positioning scissors between the tag and the patient's limb.
7. After the tag is removed from the patient place it in the used tag box, located on the perinatal department.

#### ALARMS:

There are 3 alarm levels integrated into the system. A Level 3 alarm will call a Code Pink through the overhead speakers. When this occurs, all available staff will secure an exit until the alarm is cleared. No staff, patient or visitor will be permitted to enter or exit the department during an active Level 3 alarm. In the instance of a false alarm, ensure the safety of the infant/child prior to troubleshooting or clearing the alarm. The episode will be audible and displayed on the infant and pediatric security system workstation. Please refer to the Quick Reference Guide located by the workstation on the meaning and handling of the alarms.

#### REFERENCES:

1. <https://help.mychildcloud.com/books/mychild6-clinical/page/cut-band-tag-application-removal-and-disinfection-guide>
2. <https://help.mychildcloud.com/books/mychild6-clinical/page/tummy-tag-application-removal-and-disinfection-guide>
3. <https://help.mychildcloud.com/books/mychild6-clinical/page/step-program>
4. <https://help.mychildcloud.com/books/mychild6-clinical/chapter/alarms>
5. National Center for Missing and Exploited Children; January, 2016, "For Healthcare Professionals: Guidelines on Prevention of and Response to Infant Abductions"

#### CROSS REFERENCED POLICIES AND PROCEDURES:

1. [Newborn & Pediatric Abduction Prevention Safety and Security](#)
2. [Admission, Care, and Discharge and transfer of the Newborn](#)
3. [Admission Procedure of the Pediatric Patient](#)

Supersedes: v.2 HUGS/PEDZ Policy
----------------------------------

**CALL TO ORDER**

Northern Inyo Healthcare District (NIHD) Board Chair Melissa Best-Baker called the meeting to order at 5:30 p.m.

**PRESENT**

Melissa Best-Baker, Chair  
Jean Turner, Vice Chair  
Ted Gardner, Secretary  
David McCoy Barrett, Treasurer  
Mary Mae Kilpatrick, Member at Large  
Stephen DelRossi, MSA, Chief Executive Officer  
Allison Partridge RN, MSN, Chief Operations Officer / Chief Nursing Officer  
Adam Hawkins, DO, Chief Medical Officer  
Alison Murray, MBA HRM, SHRM-CP, Chief Human Resources Officer  
Sierra Bourne, MD, Chief of Staff

**ABSENT**

**OPPORTUNITY FOR  
PUBLIC COMMENT**

Chair Best-Baker reported that at this time, members of the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Public comments shall be received at the beginning of the meeting and are limited to three minutes per speaker, with a total time limit of thirty minutes for all public comment unless otherwise modified by the Chair. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.

There were no comments from the public.

**NEW BUSINESS**

**NIHD BOARD OF  
DIRECTORS GENERAL  
ELECTION INFORMATION  
PRESENTATION**

Chair Best-Baker called attention to the NIHD Board of Directors General Election Information presentation.

Patty Dickson, NIHD Compliance Officer presented a PowerPoint presentation to the Board about the upcoming elections for Zone I, III, and IV. Discussion ensued. The Board requested more information at the next Board meeting on information about filing for the November election open seats. Ms. Dickson agreed to reach out to Inyo County and will report back to the Board at the next regular meeting.

**RESOLUTION 24-02,  
ELECTION  
CONSOLIDATION**

Chair Best-Baker called attention to District Board Resolution 24-01, Election Consolidation.

Chair Best-Baker read Resolution 24-02 aloud. Discussion ensued. There were no questions or comments.

**Motion by:** Mary Mae Kilpatrick  
**Seconded by:** Jean Turner  
**Passed 5-0 vote**

BOARD SELF-ASSESSMENT

Chair Best-Baker called attention to the Board Self-Assessment.

Vice Chair Turner introduced the Association of California Healthcare District (ACHD)-sponsored board self-assessment to the full Board of Directors. ACHD has partnered with The Walker Company to complete CEO and Board self-assessments. The Board received an email link from The Walker Company today, March 20, 2024 to complete with a due date of March 31, 2024. Discussion ensued.

CHIEF EXECUTIVE OFFICER REPORT

Chair Best-Baker called attention to the Chief Executive Officer Report.

- **Strategic Plan** – Mr. DelRossi reported that there is a Special Board meeting planned for the following day 3/21/2024 to present a draft Strategic Plan to the Board for the next three years.
- **Women’s Services collaboration with Southern Inyo Healthcare District** – Mr. DelRossi reported that he has been in conversation with Southern Inyo Healthcare District to possibly implement an agreement to use Southern Inyo’s location with NIHD’s providers to provide reasonable access to OB/GYN services who have been affected by the Ridgecrest women’s services closure. Mr. DelRossi wanted to highlight that this agreement would not benefit NIHD from a financial standpoint but would help Southern Inyo financially as well as support the patients in need of women’s services who have to travel for prenatal care.
- **Preliminary discussions with Toiyabe dialysis / Connor Wiles, MD** – Mr. DelRossi introduced Dr. Hawkins to give an update on the preliminary talks between Dr. Wiles and Toiyabe. Dr. Hawkins reported that Dr. Wiles has been with NIHD for a little over a year and has spearheaded the potential project to provide support to the area’s dialysis patients in collaboration with Toiyabe. Dr. Wiles possesses the expertise to perform services that would support the dialysis patient population. These procedures and future procedure maintenance would happen in NIHD operating room on campus.
- **Update on Ridgecrest** – Mr. DelRossi reported that he has been in communication with Ridgecrest CEO about their recent discontinuation of women’s services and the possible collaboration with them for patients’ in the Eastern Sierra that need OB/GYN testing done. Mr. DelRossi wanted to make it clear that this collaboration would have no financial impact on NIHD at all but would benefit the patients of the Easter Sierra that are in need of women’s testing services.
- **Women’s Clinic – OB/GYN** – Mr. DelRossi reported that NIHD

is currently in the process of hiring a Midwife that will provide much needed support to our current women's services. Mr. DelRossi also added that NIHD is currently looking at a possible future separation of the GYN clinic apart from the RHC where our women's services providers would be able to perform procedures in office that are not capped by payments.

**CHIEF FINANCIAL  
OFFICER REPORT**

Chair Best-Baker introduced the Chief Financial Officer report.

- Financial & Statistical Reports:
  - CEO DelRossi presented the financial & statistical report. Discussion ensued.

**Motion by:** Ted Gardner

**Seconded by:** David McCoy Barrett

**Passed 5-0 vote**

- New CFO (4/15/2024) – Mr. DelRossi reported that the new CFO's original start has been pushed to 4/29/2024 due to the background check taking a little longer than expected.
- Standard & Poor's Review – Mr. DelRossi reported that he just met with the Standard & Poor's review team in a formal meeting, we usually meet with them quarterly throughout the year. Mr. DelRossi reported that they are very pleased with our recovery so far.
- Audit (Siemens' Bonds) – Mr. DelRossi reported that we meet with Siemens about every six weeks to provide and update on our recovery plan, they are very pleased with the financial progress NIHD has been compared to last year's financial situation.
- Revenue Cycle – Self Pay – Mr. DelRossi reported that NIHD is currently working on implementing a new process to collect patient payments after insurance payments are collect. This new self-pay process on campus will provide security and support to our community and patients.

**CHIEF OF STAFF  
REPORT**

Chair Best-Baker called attention to the Chief of Staff report.

**POLICIES**

Dr. Sierra Bourne provided an overview of the policies/procedures.

1. Standardized Protocol – General Policy for the Physician Assistant
2. Employee Health NIHD Workforce Onboarding Policy
3. Employee Health NIHD Workforce Tuberculosis Surveillance Program
4. Infection Control Policy Perinatal

Discussion ensued.

**Motion by:** Mary Mae Kilpatrick

**Seconded by:** David McCoy Barrett

**Passed 5-0 vote**

MEDICAL STAFF  
APPOINTMENTS 2024-  
2025

Dr. Sierra Bourne provided an overview of the 2024-2025 Medical Staff Appointments:

1. John Avery Neal, DO (pediatrics) – Courtesy Staff
2. Rami-James Assadi, MD (neurology) – Telemedicine Staff
3. Rajeshwary Swamidurai, MD (anesthesiology) – Active Staff

**Motion by:** Mary Mae Kilpatrick

**Seconded by:** Jean Turner

**Passed 5-0 vote**

MEDICAL STAFF  
REAPPOINTMENT OF  
CALENDAR YEAR 2024

Dr. Sierra Bourne brought attention to the Medical Staff Reappointments:

1. Amy Saft, CRNA (nurse anesthesia)

**Motion by:** Ted Gardner

**Seconded by:** Mary Mae Kilpatrick

**Passed 5-0 vote**

MEDICAL EXECUTIVE  
COMMITTEE REPORT

Dr. Sierra Bourne provided the Medical Executive Committee meeting report.

Discussion ensued.

CONSENT AGENDA

Chair Best-Baker called attention to the consent agenda that contained the following items.

- *February 21, 2024 Regular Board Meeting Minutes*
- *CMO Report*
- *Department Reports*
- *CEO Credit Card Statements*
- *Approval of Policies and Procedures:*
  - *Practitioner Re-Entry Policy*
  - *Medical Staff Department Policy – Radiology*
  - *Password Policy*

Discussion ensued. Chair Best-Baker requested that all Department reports be removed from the Consent Agenda

**Motion by:** Jean Turner

**Seconded by:** Ted Gardner

**Passed 5-0 vote**

GENERAL INFORMATION  
FROM BOARD MEMBERS

Chair Best-Baker called for information from Board Members.

Discussion ensued.

ADJOURNMENT

Adjournment at 07:01 p.m.

\_\_\_\_\_  
Melissa Best-Baker, Northern Inyo Healthcare  
District, Chair

Attest:

\_\_\_\_\_  
Ted Gardner, Northern Inyo Healthcare District,  
Secretary

**CALL TO ORDER**                      The meeting was called to order at 9:00 a.m. by Chair Melissa Best-Baker, Northern Inyo Healthcare District (NIHD) Board Chair.

**PRESENT**                                Melissa Best-Baker, Chair  
 Jean Turner, Vice Chair  
 Ted Gardner, Secretary  
 David McCoy Barrett, Treasurer  
 Mary Mae Kilpatrick, Member at Large  
 Stephen DelRossi, MSA, Chief Executive Officer  
 Allison Partridge RN, MSN, Chief Operations Officer / Chief Nursing Officer  
 Adam Hawkins, DO, Chief Medical Officer  
 Alison Murray, MBA HRM, SHRM-CP, Chief Human Resources Officer

**OPPORTUNITY FOR PUBLIC COMMENT**                      Chair Best-Baker reported that at this time, members of the audience may speak only on items listed on the Notice for this meeting. Public comments shall be received at the beginning of the meeting and are limited to three minutes per speaker, with a total time limit of thirty minutes for all public comment unless otherwise modified by the Chair. The Board is prohibited from generally discussing or taking action on items not included on the Notice for this meeting. Public comments on agenda items should be made at the time each item is considered.

There were no comments from the public.

**STRATEGIC PLANNING MEETING - DRAFT**

**VALUES:**

- **Respect:** Unwavering support for employees and providers
  - Engagement Survey
  - Turnover
  - Diversity, Equity and Inclusion (DEI) Management Plan
  - Leadership Rounding to address team issues and concerns
  - Union Negotiations
  - Leadership Training (monthly)
  - Retention Rate

Discussion ensued.

- **Compassion:** Leading with empathy to preserve dignity
  - Press Ganey / HCAPS: Patient experience Top Box Data
  - Patient Rounding – Clinical leaders will regularly round with patients to address any concerns in real time.
  - Customer Service Training (in person role-play)

Discussion ensued.

- **Stewardship:** Mindful use of resources
  - Seismic 2030 NPC5 Compliance
  - Flex Budget

- Finance Key Performance Indicator's (KPI's) to be defined

Discussion ensued.

- **Excellence**: Pursuit of excellence in quality and safety
  - Reduce Occurrence of CLABSI, CAUTI, SSI
  - Quality Projects
  - High Reliability Organization
  - Health Equity and Social Determinants of Health
  - Cyber Security

Discussion ensued.

- **Accountability**: Reliable access to exceptional care
  - Readily Accessible Care
  - Community Health Needs Assessment (2025)
  - Service Lines
  - Promote Interoperability
  - Mental Health
  - Business Development

Discussion ensued.

ADJOURNMENT

Adjournment at 01:27 p.m.

\_\_\_\_\_  
Melissa Best-Baker, Northern Inyo Healthcare  
District, Chair

Attest:

\_\_\_\_\_  
Ted Gardner, Northern Inyo Healthcare District,  
Secretary





NORTHERN INYO HEALTHCARE DISTRICT

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

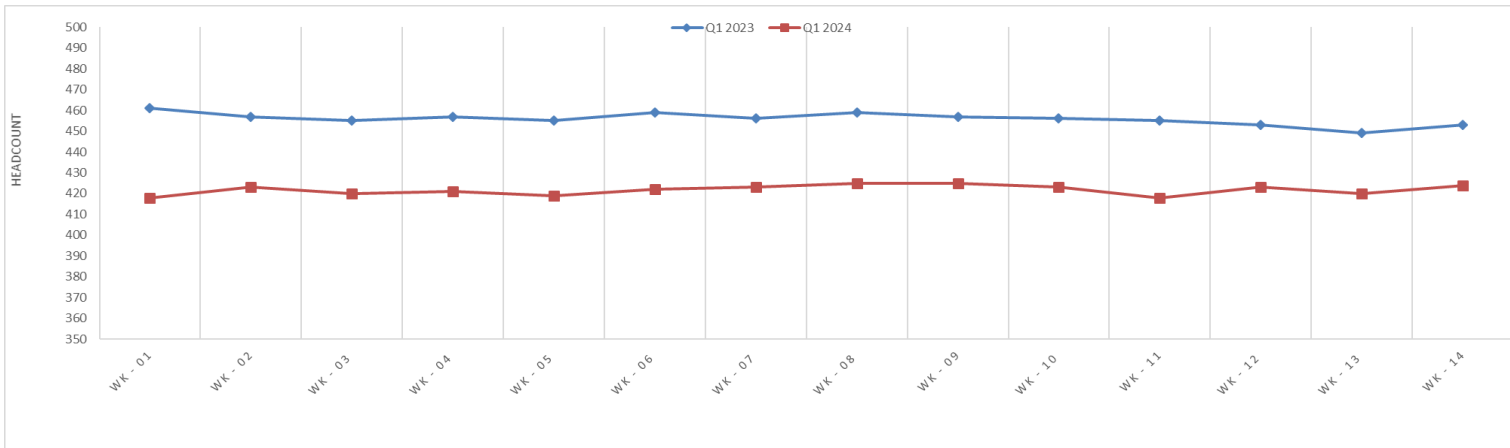
150 Pioneer Lane  
Bishop, California 93514  
(760) 873-5811

DATE: April 2024  
TO: Board of Directors  
Northern Inyo Healthcare District  
FROM: CHRO Board Report  
Alison Murray, MBA HRM, SHRM-CP  
RE: Department Update

### REPORT DETAIL

#### Human Resources (HR) Highlights

Year to date we have 424 employees, plus 25 contractor/travelers at Northern Inyo Healthcare District.



We processed 32 separations; 26 were District employees and the remaining six were contractors/travelers who finished their assignment with us.

Recruitment

Year to date we have filled 26 positions as of end of March, including a long-term recruitment for a Physical Therapist and three new Perinatal RNs which had been posted for 12 plus months.



Housing continues to be an ongoing struggle for those that are hired or relocating to Bishop for either a permanent or a temporary position. Our Recruiter actively does community outreach for housing options for new hires and travelers within our area. In addition, the department maintains a binder of local housing listings for people to contact.

Orientation

We moved from Zoom (offsite) to in-person orientation in January of this year. We continuously look for opportunities with our partners throughout the District to make the onboarding experience for our new hires the best it can be. Each member of the HR team interacts with our new hires, whether for information sharing such as benefit guidance, training such as workplace violence, or general orientation. The Executive Team does in-person introductions to all new hires bi-weekly. Many departments such as Maintenance, Compliance, Employee Health/Infection Prevention, Emergency Services and others assist with orienting new team members and make all feel welcome. We have been creating workflows in partnership with Information Technology Services to streamline systems access for our new hires.

Engagement Survey

Our annual Engagement Survey launched February 26, 2024 and ran for four weeks, closing on March 24, 2024. We had 276 respondents including members of our Medical Staff. Each year we look at key drivers for engagement including job satisfaction, wellbeing/safety, and culture. HR will be collaborating with department leaders to create strategic plans with goals to address the results with their teams. They will be reviewing results at the department level but also discussing over-all District results as well.

BETA Healthcare Group (BETA) Workplace Violence (WPV) Domain Work

We have actively been working with our BETA Partners, liability and workers’ compensation insurance provider, on improving our plan for workplace violence planning and prevention. This has been a yearlong process as we have worked through each step with our BETA partners. Through the domain work, we have collaborated internally with our Facilities Director,

Emergency Services Leaders, Employee Health Team, Compliance and others to complete a thorough review of our WPV plan, training program, response procedures and sister plans.

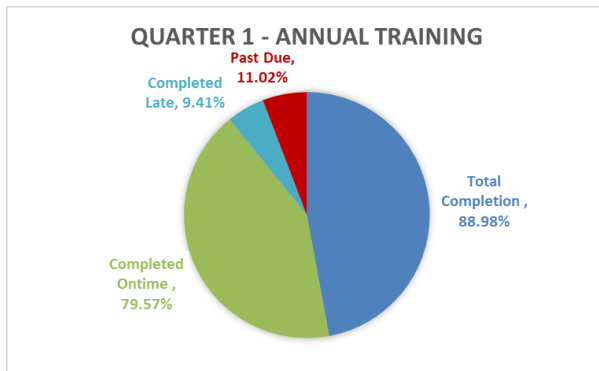
Employee of the Month

Congratulations to the following employees who received Employee of the Month during the first quarter of 2024:

- January 2024 – Anna Lavelle, RHC Medical Assistant
- February 2024 – Aaron Pause, Junior Network Systems Analyst
- March 2024 – Danna Whitehouse, Acute-Subacute CNA

Annual Regulatory Assignment for 2024 have been assigned first quarter modules were to be completed March 2024 –

Regulatory Assignments include trainings related to HIPAA, Patient Rights, Workplace Safety, Infection Control, Diversity and Cultural Competence. Trainings vary depending on area of work and level of patient contact a team member would provide in addition to regulatory requirements for specific areas.



Departments with 100% completion rate for Quarter 1 -

- Central Supply
- Dietitian
- Facilities
- Human Resources
- Infection Control/Employee Health
- Maintenance
- Med Staff Admin
- Medical Records
- Nursing Supervisor
- Pediatric Office
- Project Management
- Strategic Communications
- Security
- Surgery
- Utilization Review/Social Services

### Leadership Training

In November of 2023, the Healthcare District began assigning monthly leadership training to all leaders within the District. Each month leaders are assigned modules within our learning management system that cover topics such as: Emotional Intelligence, Communication, Fundamentals of Management, New Employee Onboarding, Staff Retention, Handling Conflict and Cultivating Relationships. Throughout the year, we will continue to look for learning opportunities to invest in our leaders, including incorporating live training sessions with subject matter experts in fields such as finance and human resources.

### Training Updates

We have been working closely with Employee Health, Rehabilitation, and our Nursing Clinical Staff Educators on safe patient handling compliance and training including a review of past and current training practices for all clinical areas. In addition, we have begun our regulatory required annual hands on workplace violence training, for most of our departments within the District.

### Benefits/LOA

As of end of March, we have 34 FMLA cases, 19 of which are for intermittent leave. Reasons vary for personal, medical and family leave throughout the District. Every January, Human Resources performs an audit on all of the medical accommodations we have on file. To date, we have verified and validated 10 accommodations, which can include receiving updated medical certifications from physicians. From January through March, we have 22 retirement distribution requests. Finally, HR has completed the annual retirement file audits to update the annual reports that are distributed to employees regarding the retirement investments.



April 2024 Statement

Open Date: 03/06/2024 Closing Date: 04/03/2024

U.S. Bank Business Platinum Card

NORTHERN INYO HOSPITA  
STEPHEN DELROSSI (CPN [REDACTED])

Account: [REDACTED]

Cardmember Service 1-866-485-4545  
BUS 30 USB 678 3

<b>New Balance</b>	<b>\$939.79</b>
<b>Minimum Payment Due</b>	<b>\$10.00</b>
<b>Payment Due Date</b>	<b>05/01/2024</b>

Activity Summary		
Previous Balance	+	\$736.42
Payments	-	\$736.42 <sup>CR</sup>
Other Credits		\$0.00
Purchases	+	\$939.79
Balance Transfers		\$0.00
Advances		\$0.00
Other Debits		\$0.00
Fees Charged		\$0.00
Interest Charged		\$0.00
<b>New Balance</b>	<b>=</b>	<b>\$939.79</b>
<b>Past Due</b>		<b>\$0.00</b>
<b>Minimum Payment Due</b>		<b>\$10.00</b>
Credit Line		\$37,500.00
Available Credit		\$36,560.21
Days in Billing Period		29

Payment Options:



Mail payment coupon with a check



Pay online at usbank.com



Pay by phone 1-866-485-4545



Pay at your local U.S. Bank branch

Please detach and send coupon with check payable to: U.S. Bank

CPN [REDACTED]



24-Hour Cardmember Service: [REDACTED]

- to pay by phone
- to change your address

[REDACTED]

NORTHERN INYO HOSPITA  
STEPHEN DELROSSI  
150 PIONEER LN  
BISHOP CA 93514-2556



Account Number	[REDACTED]
Payment Due Date	5/01/2024
New Balance	\$939.79
Minimum Payment Due	\$10.00

Amount Enclosed \$ \_\_\_\_\_

U.S. Bank

P.O. Box 790408  
St. Louis, MO 63179-0408





April 2024 Statement 03/06/2024 - 04/03/2024

Page 2 of 3

NORTHERN INYO HOSPITA  
STEPHEN DELROSSI (CPN [REDACTED])

Cardmember Service ([REDACTED])

**Important Messages**

Paying Interest: You have a 24 to 30 day interest-free period for Purchases provided you have paid your previous balance in full by the Payment Due Date shown on your monthly Account statement. In order to avoid additional INTEREST CHARGES on Purchases, you must pay your new balance in full by the Payment Due Date shown on the front of your monthly Account statement.

There is no interest-free period for transactions that post to the Account as Advances or Balance Transfers except as provided in any Offer Materials. Those transactions are subject to interest from the date they post to the Account until the date they are paid in full.

Skip the mailbox. Switch to e-statements and securely access your statements online. Get started at [usbank.com/login](https://usbank.com/login).

**Transactions**

**Payments and Other Credits**

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
03/19	03/19	[REDACTED]	PAYMENT THANK YOU	\$736.42CR	_____
<b>TOTAL THIS PERIOD</b>				<b>\$736.42CR</b>	

**Purchases and Other Debits**

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
03/15	03/13	[REDACTED]	MARRIOTT BURBANK A/P BURBANK CA FOR 01 NIGHTS [REDACTED] CHA - Legislation CEO Travel (2 toal)	\$364.90	_____
03/15	03/13	[REDACTED]	MARRIOTT BURBANK A/P BURBANK CA FOR 01 NIGHTS [REDACTED]	\$6.00	_____
03/21	03/20	[REDACTED]	SMART AND FINAL [REDACTED] BISHOP CA [REDACTED] Staff Birthday Celebration	\$48.22	_____
03/21	03/20	[REDACTED]	SQ *LOONEY BEAN OF BIS Bishop CA [REDACTED] Strategic Plan-Special	\$58.72	_____
03/22	03/21	[REDACTED]	ERICK SCHATTS BAKKERY BISHOP CA [REDACTED] Meeting (2 total)	\$62.79	_____
04/02	04/01	[REDACTED]	FACEBK [REDACTED] [REDACTED] CA [REDACTED] Advertising	\$399.16	_____
<b>TOTAL THIS PERIOD</b>				<b>\$939.79</b>	

2024 Totals Year-to-Date	
Total Fees Charged in 2024	\$78.00
Total Interest Charged in 2024	\$255.74

**Company Approval** (This area for use by your company)

Signature/Approval: \_\_\_\_\_

Accounting Code: \_\_\_\_\_

Continued on Next Page



April 2024 Statement 03/06/2024 - 04/03/2024

Page 3 of 3

NORTHERN INYO HOSPITA  
STEPHEN DELROSSI (CPN [REDACTED])

Cardmember Service ( [REDACTED])

### Interest Charge Calculation

Your Annual Percentage Rate (APR) is the annual interest rate on your account.

\*\*APR for current and future transactions.

Balance Type	Balance By Type	Balance Subject to Interest Rate	Variable	Interest Charge	Annual Percentage Rate	Expires with Statement
**BALANCE TRANSFER	\$0.00	\$0.00	YES	\$0.00	24.24%	
**PURCHASES	\$939.79	\$0.00	YES	\$0.00	24.24%	
**ADVANCES	\$0.00	\$0.00	YES	\$0.00	29.99%	

### Contact Us

Phone

Voice: 1-866-485-4545  
TDD: 1-888-352-6455  
Fax: 1-866-807-9053

Questions

Cardmember Service  
P.O. Box 6353  
Fargo, ND 58125-6353



Mail payment coupon with a check

U.S. Bank  
P.O. Box 790408  
St. Louis, MO 63179-0408



Online

usbank.com

End of Statement

NORTHERN INYO HOSPITA

## Time to update your email? Check your usbank.com profile

Dont miss out on exclusive offers and important updates. Simply provide your current email address and opt into marketing, then enjoy all the benefits of your U.S. Bank account.

You may change your email marketing preferences at any time in the Privacy section of usbank.com. Note that confidential, personal or financial information will never be sent or requested in an email from U.S. Bank.



## NORTHERN INYO HEALTHCARE DISTRICT CLINICAL POLICY AND PROCEDURE

Title: Medical Staff Department Policy - Hospital Medicine		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Hospitalist Practitioners		
Date Last Modified: 03/15/2022	Last Review Date: 03/27/2024	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/22/2021	

### **PURPOSE:**

To delineate clear expectations for practitioners in the Department of Hospital Medicine at Northern Inyo Healthcare District (NIHD).

### **POLICY:**

All practitioners granted privileges in the Department of Hospital Medicine will adhere to the following procedures.

### **PROCEDURE:**

1. Admissions and Consults
  - a. Any admission or consultation called to the Physician will become the responsibility of that Physician. If the admission or consult is called to Physician during the final 60 minutes of their shift AND the admission along with uncompleted work from his/her shift would significantly prevent the Physician from completing their shift in a reasonable amount of time, the Physician may choose to hand-off the admission or other work to the oncoming hospitalist, within reason. This decision must be made in mutual agreement with the Emergency Department (ED) physician AND the Physician must make every effort to not slow throughput in the ED or delay patient care. Exceptions to the hand-off would be if the admission or consultation is an ICU patient, critically ill, requires time sensitive testing or treatment, or there are more than one other pending admission(s) in the ED.
2. Credentialing:
  - a. Physician practitioners in the Department of Hospital Medicine must be board certified or board eligible by the American Board of Family Medicine or the American Board of Internal Medicine and are strongly encouraged to be members of the Society of Hospital Medicine.
3. Emergencies/Codes:
  - a. Physician shall respond to in-house emergencies in the same manner as other members of the Medical Staff of Northern Inyo Hospital. If physician is not in house, he/she is expected to return to the hospital within 20 minutes.
4. In-House Coverage
  - a. Physicians performing Hospitalist Services are not required to be in house at all times however, they are generally expected to be in house from 8 am to 5 pm if not longer for a full census. It is the expectation that day shift hospitalist will be fully prepared (have seen all patients and reviewed all charts) for the morning Multidisciplinary Team meeting and will fully participate in the discussion of each patient presented. Night shift Physician is encouraged but not required to



stay in-house and utilize the hospitalist call room especially if the Emergency Department is busy, the census is full or there is a critically ill or concerning patient(s). If Physician is off-campus, they are still expected to answer all calls, enter their own orders and return to the hospital for patient care within twenty (20) minutes. At any point in time, Hospitalist Director or Chief of Inpatient Medicine may request a revocation of off-campus privileges and may request Physician to provide in-house coverage for the entirety of their 12 hour shift.

5. Response time
  - a. Physician shall respond to NIHD Emergency Department or other NIHD staff requests within twenty (20) minutes of call. If the request is for an admission or consultation, a reasonable goal is to see the patient within 20 minutes so as to formulate a plan and disposition. If the Physician is otherwise preoccupied with patient care that takes a higher precedence such as a critically ill patient, Physician will discuss with ED physician or other NIHD staff to let them know when they can reasonably expect to see the patient. Every effort should be made to see the patient, determine disposition and have orders in one (1) hour after admission request.
6. Focused Professional Practice Evaluation (FPPE):
  - a. Practitioners new to NIHD will be expected to complete FPPE as per policy. Hospitalists sign out to each other at the start/end of each shift so multiple charts are reviewed on an ongoing basis. Verbal sign outs are the standard (email sign outs are acceptable but the exception) and feedback is given in real time. Peer review results and Unusual Occurrence Reports are incorporated into FPPE as appropriate.
7. Ongoing Professional Practice Evaluation (OPPE):
  - a. Practitioners will be expected to participate in all requirements of OPPE as per medical staff policy. Hospitalists sign out to each other at the start/end of each shift so multiple charts are reviewed on an ongoing basis. Verbal sign outs are the standard (email sign outs are acceptable but the exception) and feedback is given in real time. Peer review results and Unusual Occurrence Reports are incorporated into OPPE as appropriate.
8. Peer Review:
  - a. All inpatient charts identified by critical indicators will be peer reviewed by the Chief of Inpatient Medicine or delegated practitioner. Selected cases will be reviewed at the Inpatient Medicine committee at its next scheduled meeting. Records are confidential and will be kept by the Medical Staff Office.
9. Re-Entry:
  - a. Hospitalist practitioners may be eligible for re-entry per policy.
10. Services Provided
  - a. Physician should address and/or manage, within the scope of their training and responsibility, all internal medicine issues, as requested for all patients admitted to NIHD. Physician should also provide consultation and management services to patients as requested by NIHD Medical Staff members, visiting Specialist Physicians, the Emergency Department, and other departments as appropriate.

#### **REFERENCES:**

1. N/A

#### **RECORD RETENTION AND DESTRUCTION:**

1. Life of policy, plus 6 years

**CROSS REFERENCED POLICIES AND PROCEDURES:**

1. Northern Inyo Healthcare District Medical Staff Bylaws
2. *Focused and Ongoing Professional Practice Evaluation Policy*
3. *Practitioner Re-Entry Policy*
4. *InQuiseek – Referral Policy*

Supersedes: v.1 Medical Staff Department Policy - Hospital Medicine
---