Northern Inyo Healthcare District

Board Meetings

March 20, 2024 Regular Board of Directors Meeting

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AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

March 20, 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=TDlIWXRuWjE4T1Y2YVFWbnF2aGk5UT09
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.

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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. NIHD Board of Directors General Election Information Presentation – Patty Dickson, Compliance Officer

B. District Board Resolution 24-02, Election Consolidation *(Board will consider the approval of this resolution*)

C. Board Self-Assessment

D. Chief Executive Officer Report *(Board will receive this report)*

   a. Strategic Plan
   b. Women's Services collaboration with Southern Inyo Healthcare District
   c. Preliminary discussions with Toiyabe dialysis/Connor Wiles, M.D.
   d. Update on Ridgecrest
   e. Women's Clinic – OB/GYN

E. Chief Financial Officer Report

   a. Financial & Statistical Reports *(Board will consider the approval of these reports*)
   b. New CFO (4/15/2024)
   c. Standard & Poor's Review
   d. Audit (Siemens' Bonds)
   e. Revenue Cycle – Self Pay

F. Chief of Staff Report, Sierra Bourne MD:

   a. Policies (*Board will consider the approval of these Policies and 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
   b. Medical Staff Appointments 2024-2025 *(Action item)*
      1. John Avery Neal, DO (pediatrics) – Courtesy Staff
      2. Rami-James Assadi, MD (neurology) – Telemedicine Staff
      3. Rajeshwary Swamidurai, MD (anesthesiology) – Active Staff
   c. Medical Staff Reappointment for Calendar Year 2024 (*Action item*)
      1. Amy Saft, CRNA (nurse anesthesia)
   d. Medical Executive Committee Report *(Board will receive this report)*

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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 February 21, 2024 Regular Board Meeting

B. CMO Report

C. Department Reports

D. CEO Credit Card Statements

E. Approval of Policies and Procedures

   a. Practitioner Re-Entry Policy

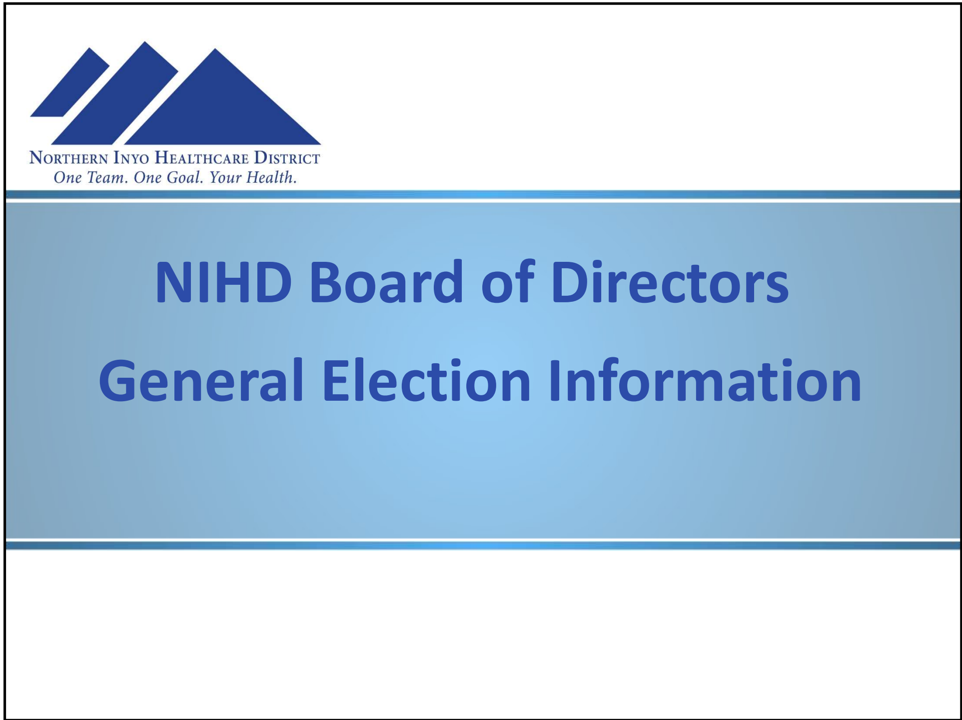
   b. Medical Staff Department Policy – Radiology

   c. Password Policy

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

G. Adjournment

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


Northern Inyo Healthcare District
One Team. One Goal. Your Health.
NIHD Board of Directors
General Election Information

Northern Inyo Healthcare District
One Team. One Goal. Your Health.
District Zones
1
•McCoy Barrett
2
•Turner
3
•Gardner
4
•Kilpatrick
5
•Best-Baker

2024 General Election

Zone 1 – 4 year term

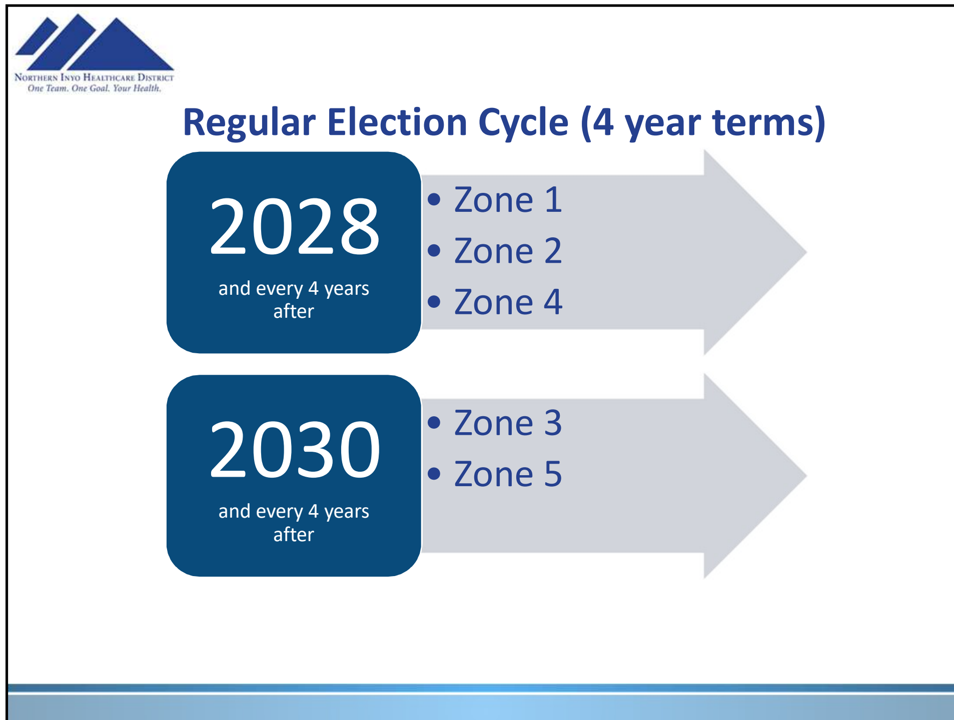
Zone 3 – 2 year term

Zone 4 – 4 year term

2026 General Election

Zone 2 – 2 year term

Zone 5 – 5 year term



Northern Inyo Healthcare District

One Team. One Goal. Your Health.

Patty Dickson, Compliance Officer

760 – 873 - 2022

Patty.Dickson@NIH.org

NORTHERN INYO HEALTHCARE DISTRICT
DISTRICT BOARD RESOLUTION 24-02
REQUESTING CONSOLIDATION OF ELECTION

WHEREAS, it is necessary that three (3) directors be elected to the Board of Directors of Northern Inyo Healthcare District, one each from Zones I (4 year term), Zone III (2 year term), and Zone IV (4 year term) of said District; and

WHEREAS, by the Board of Directors of Northern Inyo Healthcare District that it request that the Board of Supervisors of the County of Inyo, State of California, consolidate said election of directors with the Statewide election to be held of November 5, 2024; and

NOW THEREFORE, BE IT RESOLVED, the District Chief Executive Officer be, and is herby directed to file copies of this Resolution with said Board of Supervisors of the County of Inyo, State of California, and the County Clerk-Recorder, Registrar of Voters of said County.

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

PASSED, APPROVED, AND ADOPTED by the Northern Inyo Healthcare District this 20th day of March 2024 by the following vote:

AYES: _______

NOES: _______

ABSTAIN: _______

ABSENT: _______

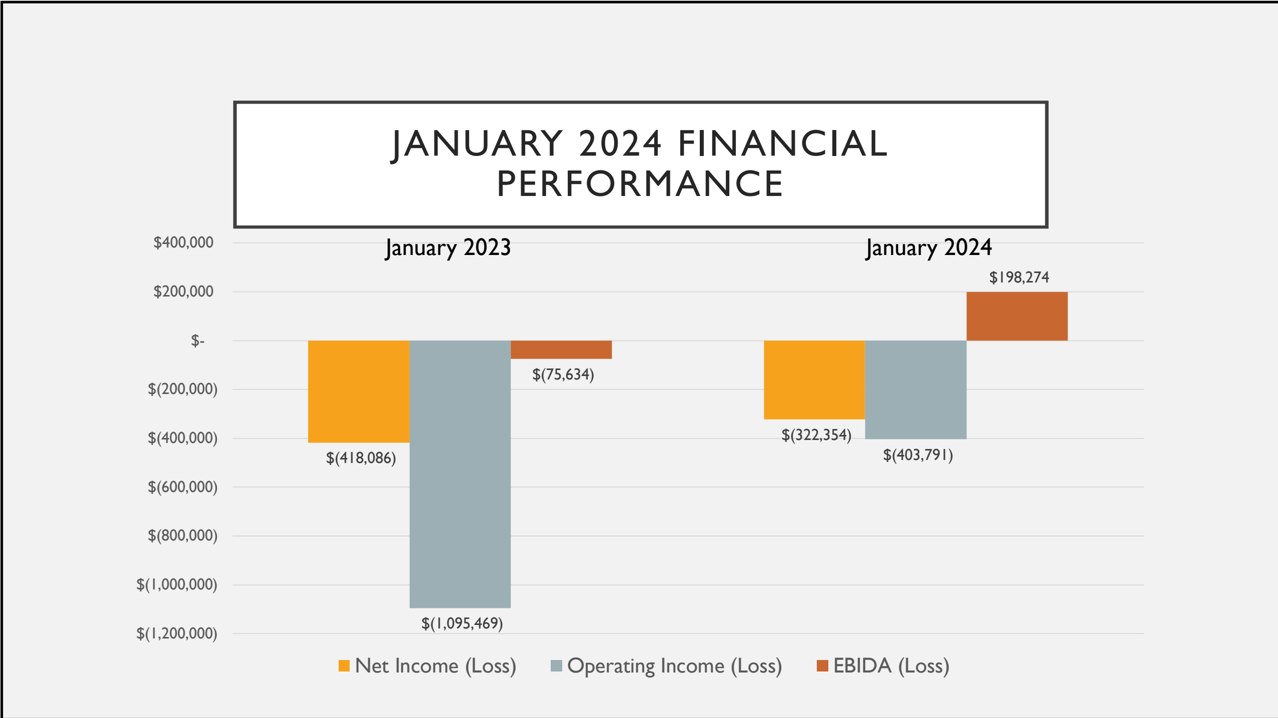
By: ____________________________________
Melissa Best-Baker, Chair of the Board
Northern Inyo Healthcare District

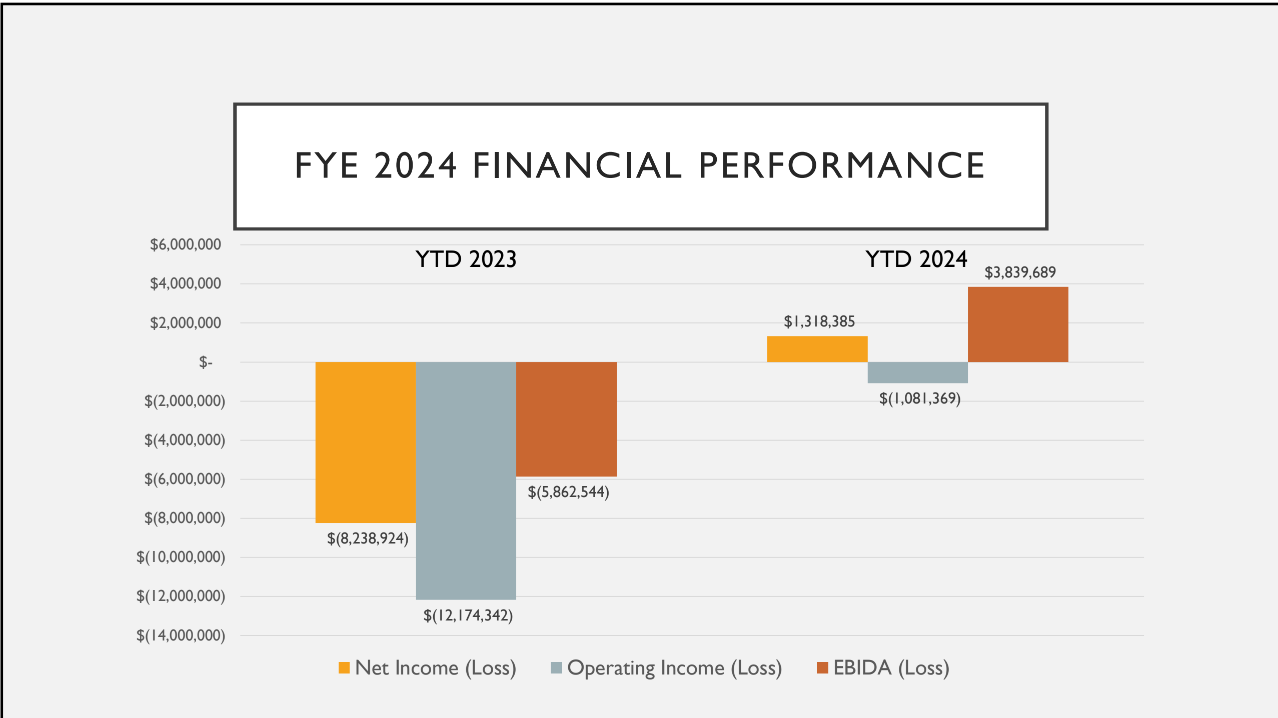
ATTEST: ______________________________________
Clerk of the Board
Northern Inyo Healthcare District

NIHD FINANCIAL UPDATE

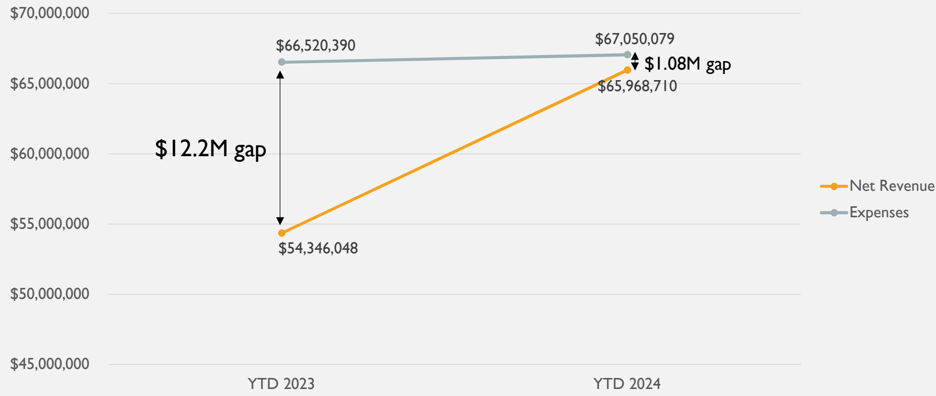
January 2024

INCOME

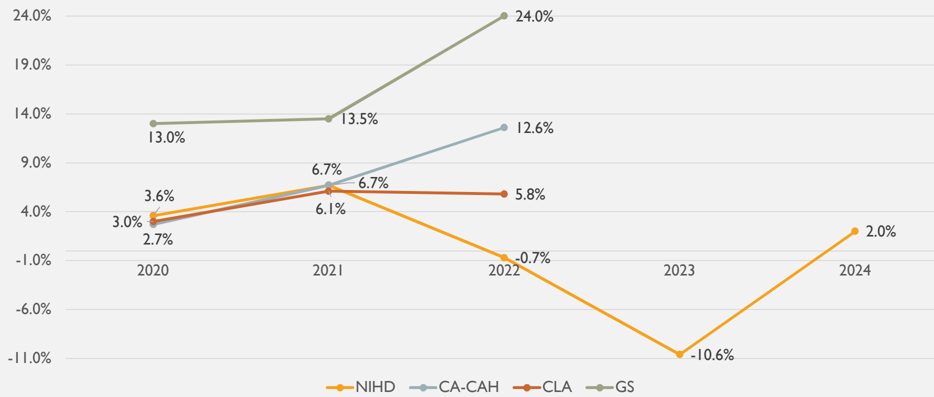

JANUARY 2024 FINANCIAL PERFORMANCE
January 2023
January 2024
$400,000
$200,000
$-
$(200,000)
$(400,000)
$(600,000)
$(800,000)
$(1,000,000)
$(1,200,000)
$(418,086)
$(1,095,469)
$(75,634)
$(322,354)
$(403,791)
$198,274
Net Income (Loss)
Operating Income (Loss)
EBIDA (Loss)


FYE 2024 FINANCIAL PERFORMANCE
YTD 2023
YTD 2024
$6,000,000
$4,000,000
$2,000,000
$-
$(2,000,000)
$(4,000,000)
$(6,000,000)
$(8,000,000)
$(10,000,000)
$(12,000,000)
$(14,000,000)
$(8,238,924)
$(12,174,342)
$(5,862,544)
$1,318,385
$(1,081,369)
$3,839,689
Net Income (Loss)
Operating Income (Loss)
EBIDA (Loss)

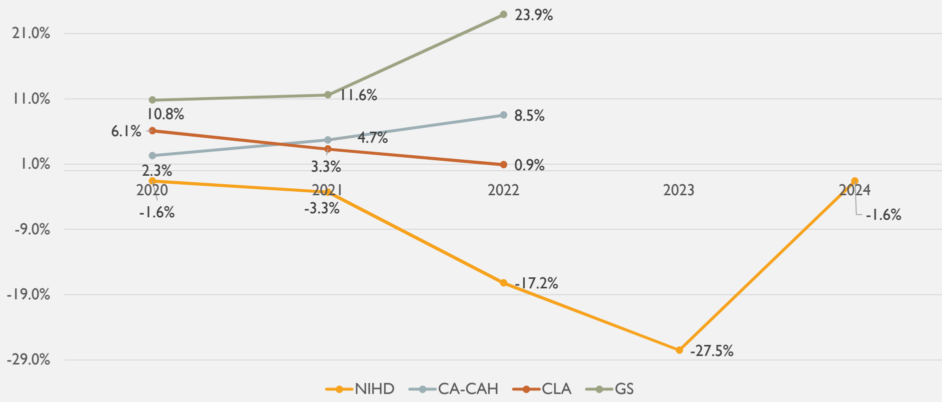
YTD OPERATING INCOME (LOSS) PERFORMANCE



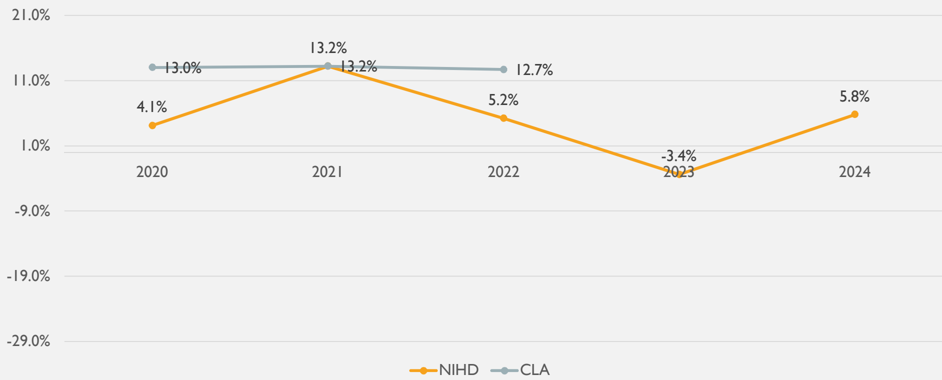
NET PROFIT MARGIN



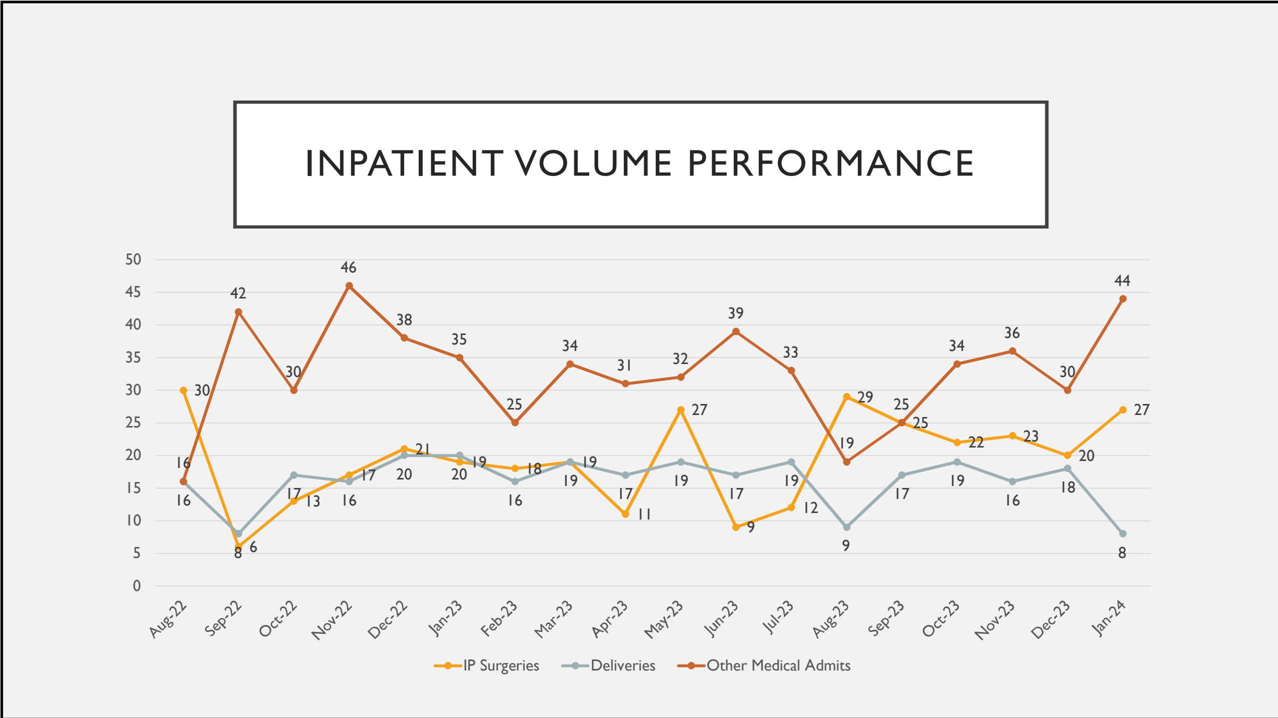
OPERATING MARGIN



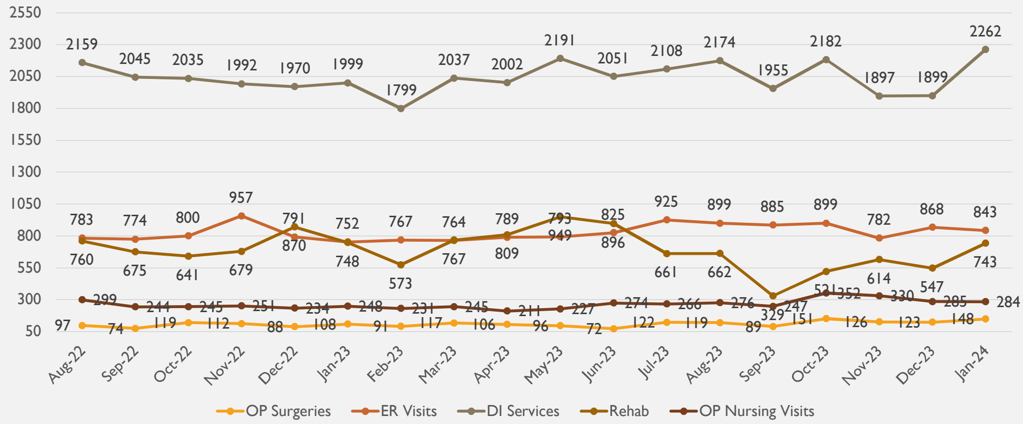
EBIDA MARGIN



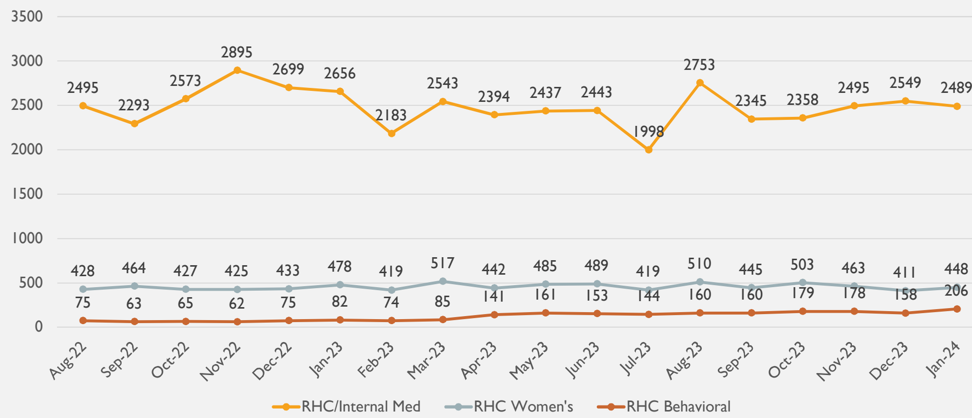
VOLUMES



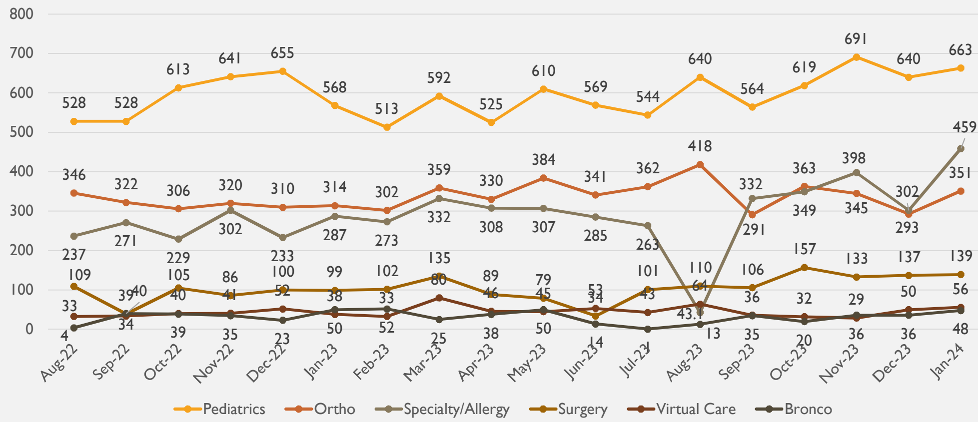
OUTPATIENT VOLUME PERFORMANCE



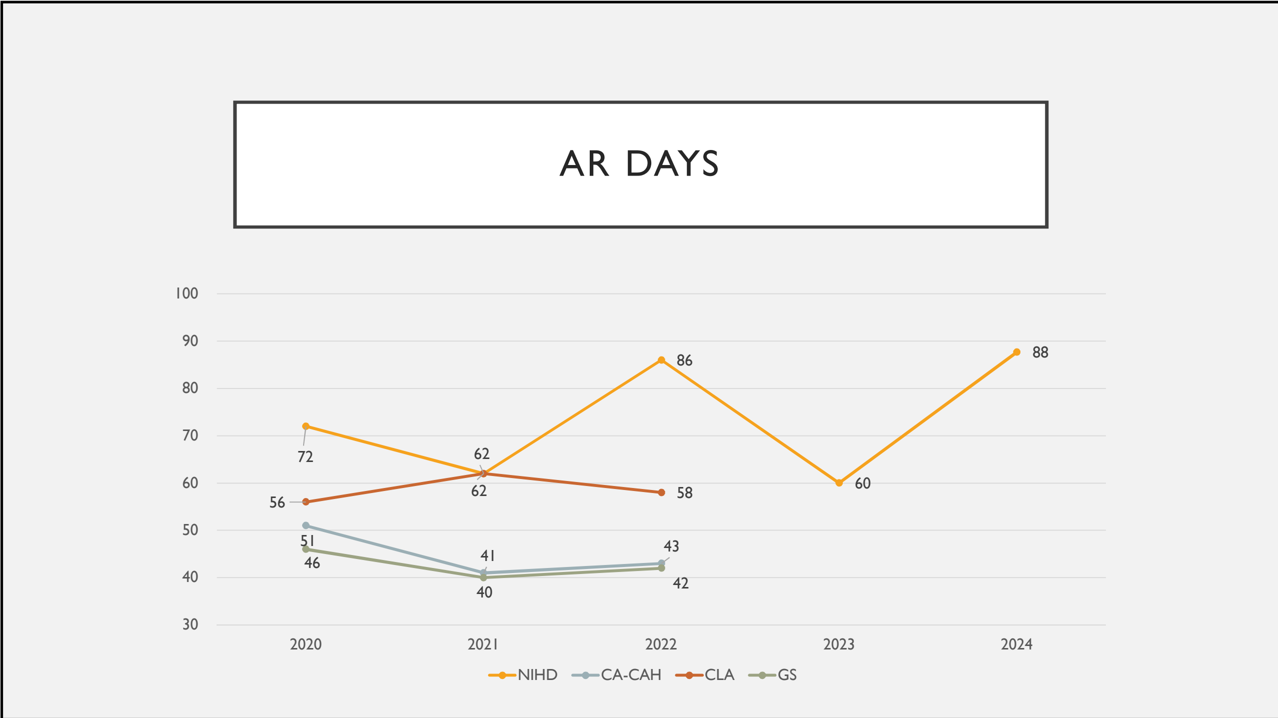
RHC VOLUME PERFORMANCE

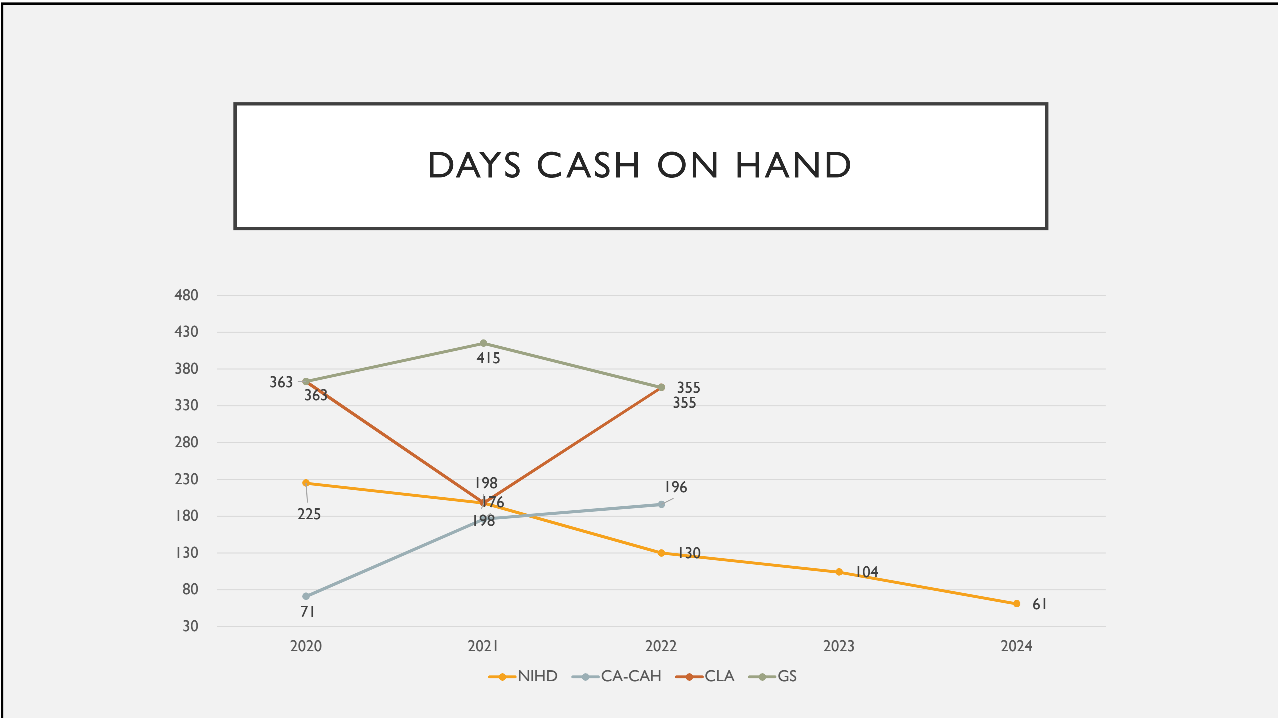


CLINIC VOLUME PERFORMANCE

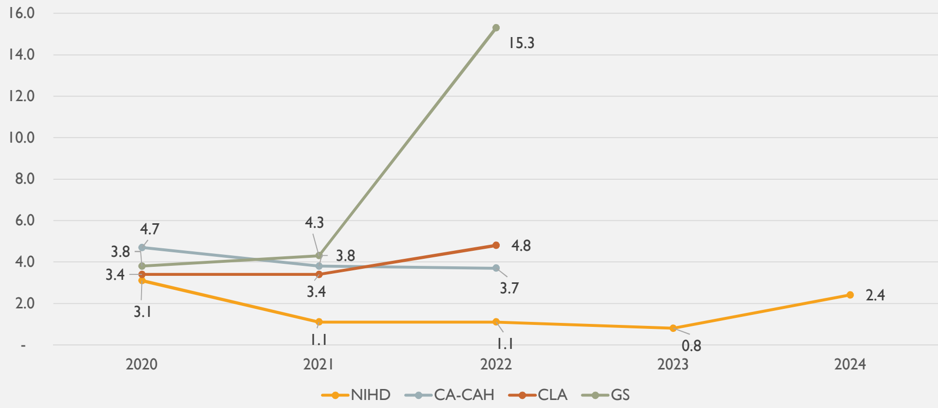


KEY PERFORMANCE INDICATORS

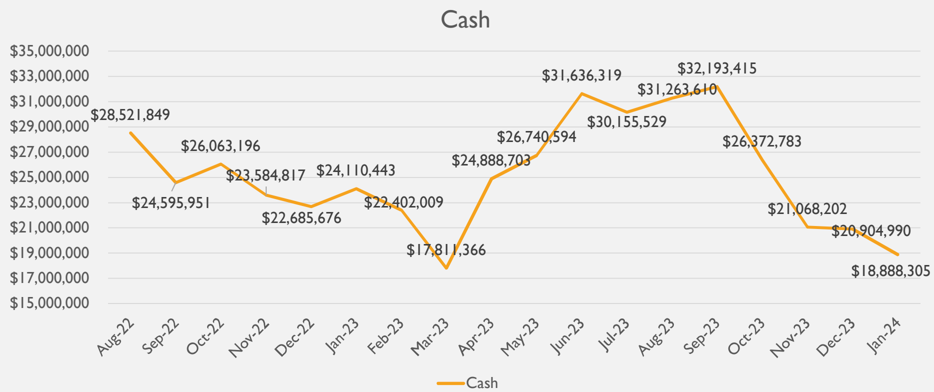

AR DAYS
100
90
80
70
60
50
40
30
2020
2021
2022
2023
2024
72
62
86
60
88
56
62
58
51
41
43
46
40
42
NIHD
CA-CAH
CLA
GS


DAYS CASH ON HAND
480
430
380
330
280
230
180
130
80
30
2020
2021
2022
2023
2024
363
363
415
355
355
198
176
198
196
225
130
104
61
71
NIHD
CA-CAH
CLA
GS

DEBT SERVICE COVERAGE RATIO



UNRESTRICTED FUNDS



WAGE COSTS

YTD 2023	YTD 2023	YTD 2024	% Change
Total Paid FTEs	434	376	-14%
Salaries, Wages, Benefits (SWB) Expense	$34.2M	$32.2M	7%
Employed Average Hourly Rate	$42.61	$52.74	24%
Benefits % of Wages	56%	49%	-7%

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2024

	7/31/2023	7/31/2022	8/31/2023	8/31/2022	9/30/2023	9/30/2022	10/31/2023	10/31/2022	11/30/2023	11/30/2022	12/31/2023	12/31/2022	1/31/2024	1/31/2023	2024 YTD	2023 YTD	PYM Change	PYTD Change
Gross Patient Service Revenue																		
Inpatient Patient Revenue	3,306,704	3,986,305	3,728,137	3,395,933	3,530,592	1,938,350	3,277,300	2,813,064	3,424,188	3,474,955	3,205,729	3,417,547	4,415,671	3,898,882	24,888,321	22,925,035	516,789	1,963,286
Outpatient Revenue	13,693,264	11,474,649	14,800,302	12,619,549	12,209,645	11,643,340	14,790,086	12,337,627	12,912,788	12,582,796	13,872,841	11,309,707	14,723,154	11,943,811	97,002,080	83,911,479	2,779,343	13,090,601
Clinic Revenue	1,274,341	1,112,050	1,721,328	1,281,637	1,455,030	1,298,041	1,599,317	1,312,937	1,643,491	1,616,268	1,672,912	1,602,344	1,668,331	1,552,193	11,034,750	9,775,470	116,138	1,259,280
Gross Patient Service Revenue	18,274,309	16,573,004	20,249,767	17,297,119	17,195,267	14,879,730	19,666,703	16,463,628	17,980,468	17,674,019	18,751,482	16,329,598	20,807,156	17,394,886	132,925,151	116,611,984	3,412,270	16,313,168
Deductions from Revenue																		
Contractual Adjustments	(8,174,338)	(6,172,708)	(9,375,676)	(7,321,120)	(4,068,387)	(6,082,559)	(9,911,289)	(9,137,803)	(8,433,073)	(8,553,896)	(8,812,993)	(8,204,159)	(9,802,285)	(7,536,311)	(58,578,040)	(53,008,558)	(2,265,974)	(5,569,483)
Bad Debt	(1,040,036)	(1,834,762)	(917,527)	(831,081)	(625,969)	(1,268,812)	(421,557)	589,809	(957,743)	(134,138)	(20,311)	(2,354,124)	(1,227,065)	(687,018)	(5,210,207)	(6,520,125)	(540,047)	1,309,918
A/R Writeoffs	(330,815)	(378,045)	(718,732)	(717,468)	(784,171)	(739,907)	(289,298)	(325,216)	(295,322)	(338,106)	(350,060)	(344,283)	(402,752)	(380,030)	(3,171,149)	(3,223,053)	(22,722)	51,905
Other Deductions from Revenue	-	497,912	-	(67,000)	-	-	-	950	-	17,166	-	410	-	-	-	449,438	-	(449,438)
Deductions from Revenue	(9,545,189)	(7,887,603)	(11,011,935)	(8,936,670)	(5,478,527)	(8,091,278)	(10,622,143)	(8,872,259)	(9,686,138)	(9,008,974)	(9,183,363)	(10,902,156)	(11,432,101)	(8,603,358)	(66,959,396)	(62,302,298)	(2,828,743)	(4,657,098)
Other Patient Revenue																		
Incentive Income	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Oper Rev - Rehab Thera Serv	1,387	5,303	-	4,367	-	4,346	-	10,361	-	7,875	1,568	3,545	-	566	2,955	36,362	(566)	(33,408)
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	1,387	5,303	-	4,367	-	4,346	-	10,361	-	7,875	1,568	3,545	-	566	2,955	36,362	(566)	(33,408)
Net Patient Service Revenue	**8,730,507**	**8,690,703**	**9,237,833**	**8,364,816**	**11,716,740**	**6,792,798**	**9,044,559**	**7,601,730**	**8,294,330**	**8,672,921**	**9,569,687**	**5,430,987**	**9,375,055**	**8,792,094**	**65,968,710**	**54,346,048**	**582,961**	**11,622,662**
CNR%	**48%**	**52%**	**46%**	**48%**	**68%**	**46%**	**46%**	**46%**	**46%**	**49%**	**51%**	**33%**	**45%**	**51%**	**50%**	**47%**	**-5%**	**3%**
Cost of Services - Direct																		
Salaries and Wages	2,446,627	2,175,027	2,580,857	2,269,022	3,511,439	2,195,439	2,804,438	2,179,142	2,694,788	2,262,511	2,811,390	2,158,750	2,783,144	2,338,917	19,632,682	15,578,807	444,227	4,053,875
Benefits	1,776,636	2,008,070	1,244,252	1,759,698	1,284,353	1,801,034	1,679,949	1,669,695	1,536,819	1,754,398	1,069,389	1,064,181	1,093,886	1,867,561	9,685,285	11,924,638	(773,675)	(2,239,353)
Professional Fees	1,751,172	1,381,538	1,919,787	1,438,889	1,825,852	1,650,775	1,442,077	1,797,498	1,875,536	1,963,643	1,648,663	1,652,265	1,923,173	1,652,745	12,386,260	11,537,353	270,428	848,907
Contract Labor	225,464	655,016	572,961	622,813	657,327	1,451,288	278,108	1,024,423	263,663	1,493,476	422,431	(20,338)	379,756	1,001,828	2,799,710	6,228,506	(622,072)	(3,428,796)
Pharmacy	392,685	211,326	655,955	671,932	379,562	54,166	283,643	136,557	434,409	596,330	468,935	268,920	373,723	360,384	2,988,912	2,299,614	13,339	689,298
Medical Supplies	393,315	315,752	608,302	290,221	375,431	578,033	690,604	366,356	421,832	474,848	340,164	448,838	785,869	476,757	3,615,518	2,950,805	309,112	664,713
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	136,392	107,979	129,805	230,353	8,890	220,408	273,794	183,047	(1,122)	146,908	168,118	54,304	150,509	126,194	866,385	1,069,192	24,315	(202,807)
Other Direct Expenses	620,496	546,374	659,948	667,228	569,841	808,934	664,293	572,765	695,124	793,341	585,553	471,021	839,875	598,990	4,635,130	4,458,655	240,884	176,476
Total Cost of Services - Direct	7,742,787	7,401,082	8,371,866	7,950,156	8,612,694	8,760,076	8,116,905	7,929,482	7,921,050	9,485,455	7,514,645	6,097,940	8,329,935	8,423,377	56,609,882	56,047,569	(93,442)	562,313
General and Administrative Overhead																		
Salaries and Wages	441,653	360,265	419,843	365,276	541,249	370,478	445,153	381,872	431,997	373,439	491,917	373,193	468,569	401,590	3,240,381	2,626,113	66,979	614,269
Benefits	320,415	356,264	178,697	312,157	226,122	316,570	275,400	1,160,994	267,702	302,169	182,190	(788,291)	154,751	262,752	1,605,276	1,922,615	(108,000)	(317,339)
Professional Fees	243,596	535,217	233,758	190,076	667,309	318,029	(5,392)	265,196	124,043	274,630	139,099	191,161	139,446	291,948	1,541,857	2,066,257	(152,502)	(524,400)
Contract Labor	72,918	30,218	56,818	52,224	43,254	92,958	93,075	57,021	(52,500)	156,142	86,055	(102,132)	4,050	(25,859)	303,670	260,572	29,909	43,098
Depreciation and Amortization	324,565	318,087	324,565	332,153	326,475	334,828	324,565	362,317	356,176	346,018	344,330	340,523	520,628	342,452	2,521,304	2,376,379	178,176	144,924
Other Administative Expenses	175,162	79,314	196,334	164,310	128,953	199,538	176,006	119,767	233,094	314,165	156,693	152,489	161,466	191,302	1,227,708	1,220,885	(29,836)	6,823
Total General and Administrative Overhead	1,578,308	1,679,363	1,410,015	1,416,196	1,933,362	1,632,402	1,308,807	2,347,167	1,360,512	1,766,564	1,400,284	166,944	1,448,910	1,464,185	10,440,197	10,472,821	(15,275)	(32,624)
Total Expenses	**9,321,095**	**9,080,446**	**9,781,881**	**9,366,352**	**10,546,056**	**10,392,477**	**9,425,712**	**10,276,649**	**9,281,562**	**11,252,019**	**8,914,928.18**	**6,264,884**	**9,778,846**	**9,887,562**	**67,050,079**	**66,520,390**	**(108,717)**	**529,689**
Financing Expense	180,370	183,196	178,594	182,350	177,359	180,796	179,095	182,190	182,866	178,894	180,113	183,171	180,628	180,418	1,259,024	1,271,015	211	(11,991)
Financing Income	228,125	64,203	228,125	431,229	228,125	247,716	228,125	247,716	228,125	247,716	228,125	247,716	228,125	247,716	1,596,872	1,734,010	(19,591)	(137,139)
Investment Income	60,924	74,115	52,333	23,389	61,899	(18,154)	158,200	99,582	324,800	16,704	59,633	50,390	(186,959)	124,884	530,832	370,911	(311,843)	159,921
Miscellaneous Income	140,406	484,508	292,643	(364,949)	72,221	146,486	185,286	10,519	381,083	68,632	238,538	2,271,115	220,899	485,200	1,531,075	3,101,511	(264,301)	(1,570,436)
Net Income (Change in Financial Position)	**(341,503)**	**49,888**	**(149,542)**	**(1,094,218)**	**1,355,571**	**(3,404,427)**	**11,363**	**(2,499,292)**	**(236,090)**	**(2,424,941)**	**1,000,942**	**1,552,152**	**(322,354)**	**(418,086)**	**1,318,385**	**(8,238,924)**	**95,732**	**9,557,309**
Operating Income	(590,588)	(389,742)	(544,049)	(1,001,537)	1,170,684	(3,599,679)	(381,153)	(2,674,919)	(987,232)	(2,579,099)	654,759	(833,897)	(403,791)	(1,095,469)	(1,081,369)	(12,174,342)	691,678	11,092,972
EBITDA	(16,938)	367,974	175,023	(762,065)	1,682,046	(3,069,599)	335,928	(2,136,975)	120,086	(2,078,923)	1,345,271	1,892,676	198,274	(75,634)	3,839,689	(5,862,544)	273,907	9,702,234
Net Profit Margin	-3.9%	0.6%	-1.6%	-13.1%	11.6%	-50.1%	0.1%	-32.9%	-2.8%	-28.0%	10.5%	28.6%	-3.4%	-4.8%	2.0%	-15.2%	1.3%	17.2%
Operating Margin	-6.8%	-4.5%	-5.9%	-12.0%	10.0%	-53.0%	-4.2%	-35.2%	-11.9%	-29.7%	6.8%	-15.4%	-4.3%	-12.5%	-1.6%	-22.4%	8.2%	20.8%
EBITDA Margin	-0.2%	4.2%	1.9%	-9.1%	14.4%	-45.2%	3.7%	-28.1%	1.4%	-24.0%	14.1%	34.8%	2.1%	-0.9%	5.8%	-10.8%	3.0%	83.5%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2024

	PY Balances	7/31/2023	7/31/2022	8/31/2023	8/31/2022	9/30/2023	9/30/2022	10/31/2023	10/31/2022	11/30/2023	11/30/2022	12/31/2023	12/31/2022	1/31/2024	1/31/2023	MOM Change
Assets																
Current Assets																
Cash and Liquid Capital	17,558,072	19,768,284	8,260,905	18,008,863	9,033,146	18,771,541	7,095,805	15,130,616	8,362,653	9,784,681	7,944,312	9,536,326	7,573,136	8,555,307	9,828,615	(1,273,308)
Short Term Investments	10,497,077	10,513,789	24,254,218	10,555,533	24,248,339	10,555,533	21,741,818	10,658,191	21,873,055	8,158,191	19,367,377	10,810,616	16,815,916	10,332,998	16,922,335	(6,589,337)
PMA Partnership	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	14,932,580	13,605,084	22,573,731	13,668,526	22,319,458	15,119,591	22,244,291	18,412,645	19,941,094	20,460,545	20,904,497	20,452,310	17,300,274	20,997,993	14,758,093	6,239,900
Other Receivables	3,244,845	66,067	3,628,324	321,629	3,799,364	794,581	4,862,660	1,149,410	5,032,262	2,837,260	5,272,009	3,258,427	9,949,468	6,140,920	8,454,896	(2,313,976)
Inventory	5,159,474	5,120,179	3,116,641	5,099,597	3,111,028	5,155,489	3,075,988	5,210,947	3,071,145	5,211,962	3,077,236	5,159,051	3,037,613	5,161,688	3,039,453	2,122,235
Prepaid Expenses	1,793,630	2,321,465	1,466,831	2,821,462	1,431,968	2,326,052	1,332,692	2,377,751	1,027,946	2,269,168	1,389,372	1,773,403	1,341,558	1,707,730	1,268,913	438,817
Total Current Assets	**53,185,677**	**51,394,868**	**63,300,650**	**50,475,610**	**63,943,304**	**52,722,787**	**60,353,254**	**52,939,560**	**59,308,155**	**48,721,807**	**57,954,804**	**50,990,133**	**56,017,967**	**52,896,636**	**54,272,305**	**(1,375,669)**
Assets Limited as to Use																
Internally Designated for Capital Acquisitions	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Short Term - Restricted	1,466,355	1,466,418	2,044,212	1,466,541	2,044,299	1,466,663	2,044,383	1,466,789	1,327,387	1,466,910	182,493	1,467,036	182,501	1,467,164	162,508	1,304,656
Limited Use Assets																-
LAIF - DC Pension Board Restricted	798,218	870,163	747,613	828,419	753,493	828,419	760,014	828,417	714,585	828,417	720,262	175,992	771,724	-	774,348	(774,348)
Other Patient Revenue	15,684,846	13,076,830	19,296,858	13,076,830	19,296,858	13,076,830	19,296,858	13,076,830	19,296,858	13,076,830	19,296,858	13,076,830	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		573,097		573,097		573,097		573,097		573,097
Total Limited Use Assets	17,056,161	14,520,090	20,044,471	14,478,346	20,050,351	14,478,346	20,056,872	14,478,344	20,011,443	14,478,344	20,017,120	13,825,919	20,068,582	16,257,943	20,071,206	(3,813,263)
Revenue Bonds Held by a Trustee	1,078,187	918,195	1,105,984	912,490	1,100,247	752,501	1,090,633	746,796	1,085,089	760,392	1,079,366	754,688	1,092,945	1,057,556	1,087,201	(29,645)
Total Assets Limited as to Use	**19,600,703**	**16,904,704**	**23,194,667**	**16,857,378**	**23,194,897**	**16,697,511**	**23,191,888**	**16,691,929**	**22,423,918**	**16,705,646**	**21,278,979**	**16,047,643**	**21,344,028**	**18,782,662**	**21,320,914**	**(2,538,252)**
Long Term Assets																
Long Term Investment	2,767,655	2,776,508	2,274,959	2,783,284	2,777,201	2,790,423	2,741,517	2,797,561	2,731,432	3,057,305	2,729,926	1,318,315	2,745,703	1,831,405	2,749,221	(917,816)
Fixed Assets, Net of Depreciation	85,078,613	76,634,301	76,799,479	77,178,241	76,624,374	76,854,908	76,931,213	77,103,154	76,624,362	77,109,988	76,617,819	76,904,399	76,714,369	85,031,471	76,561,422	8,470,050
Total Long Term Assets	**87,846,268**	**79,410,810**	**79,074,438**	**79,961,526**	**79,401,575**	**79,645,331**	**79,672,730**	**79,900,715**	**79,355,794**	**80,167,293**	**79,347,746**	**78,222,714**	**79,460,072**	**86,862,876**	**79,310,643**	**7,552,234**
Total Assets	**160,632,647**	**147,710,381**	**165,569,755**	**147,294,513**	**166,539,776**	**149,065,629**	**163,217,871**	**149,532,205**	**161,087,867**	**145,594,746**	**158,581,528**	**145,260,490**	**156,822,066**	**158,542,174**	**154,903,862**	**3,638,313**
Liabilities																
Current Liabilities																
Current Maturities of Long-Term Debt	12,139,814	825,158	2,575,534	798,370	2,549,958	801,314	2,524,301	655,101	2,053,565	676,353	1,405,934	1,339,056	1,381,851	11,675,726	953,873	10,721,853
Accounts Payable	5,088,334	7,062,903	5,058,837	6,750,705	6,469,871	6,935,344	6,569,826	6,819,778	6,512,022	5,370,018	8,025,682	6,383,025	6,121,299	4,881,333	6,181,858	(1,300,525)
Accrued Payroll and Related	8,318,121	11,742,012	6,269,082	11,656,151	7,183,582	12,664,513	6,976,334	12,669,463	7,087,285	8,534,376	7,256,024	6,924,804	7,039,248	6,556,620	5,708,653	847,967
Accrued Interest and Sales Tax	92,441	169,971	145,639	244,123	252,061	96,606	321,777	166,957	126,986	240,254	17,172	94,216	94,617	164,562	168,763	(4,200)
Notes Payable	1,532,689	1,633,708	2,133,708	1,633,708	2,133,708	1,633,708	2,133,708	1,633,708	2,133,708	1,633,708	2,133,708	1,633,708	2,133,708	1,532,689	2,133,708	(601,019)
Unearned Revenue	(4,542)	(4,542)	1,160,535	(4,542)	468,063	(4,542)	468,063	(4,542)	468,063	(4,542)	468,063	(4,542)	129,191	(4,542)	29,191	(33,733)
Due to 3rd Party Payors	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	693,247	-
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension	1,942,292	1,873,995	2,146,080	1,873,995	2,146,080	1,873,995	2,146,080	1,873,995	2,146,080	1,873,995	2,146,080	1,861,577	2,146,080	1,927,805	2,146,080	(218,275)
Total Current Liabilities	**29,802,396**	**23,996,452**	**20,182,661**	**23,645,757**	**21,896,570**	**24,694,185**	**21,833,337**	**24,507,707**	**21,220,955**	**19,017,409**	**22,145,909**	**18,925,091**	**19,739,240**	**27,427,440**	**18,015,372**	**9,412,068**
Long Term Liabilities																
Long Term Debt	30,305,060	33,455,530	33,455,947	33,455,530	33,455,947	32,730,530	33,455,947	32,730,530	33,455,947	31,715,530	32,310,948	30,380,530	33,053,530	28,565,060	33,455,530	(4,890,470)
Bond Premium	203,263	200,126	237,771	196,989	234,634	193,852	231,497	190,715	228,359	187,578	225,222	184,441	222,085	181,303	218,948	(37,645)
Accreted Interest	16,540,170	17,218,877	16,820,264	17,314,009	16,915,399	17,409,141	17,010,533	17,504,273	17,105,668	17,599,405	17,200,803	17,694,537	16,553,354	17,206,094	16,648,086	558,008
Other Non-Current Liability - Pension	47,257,663	47,257,663	47,950,740	47,257,663	47,950,740	47,257,663	47,950,740	47,257,663	48,813,068	47,257,663	48,813,068	47,257,663	47,821,876	47,257,663	47,821,876	(564,213)
Total Long Term Liabilities	**94,306,156**	**98,132,196**	**98,464,722**	**98,224,191**	**98,556,720**	**97,591,186**	**98,648,717**	**97,683,181**	**99,603,043**	**96,760,176**	**98,550,041**	**95,517,170**	**97,650,846**	**93,210,120**	**98,144,440**	**(4,934,320)**
Suspense Liabilities	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Uncategorized Liabilities	44,693	44,693	451,476	36,944	709,722	36,944	763,396	68,644	790,738	107,118	837,281	107,118	831,523	106,018	561,672	(455,654)
Total Liabilities	**124,153,245**	**122,173,341**	**119,098,859**	**121,906,892**	**121,163,011**	**122,322,315**	**121,245,449**	**122,259,532**	**121,614,735**	**115,884,703**	**121,533,231**	**114,549,379**	**118,221,609**	**120,743,579**	**116,721,484**	**4,022,095**
Fund Balance																
Fund Balance	45,515,489	23,268,194	43,831,306	23,268,194	43,831,306	23,268,194	43,831,306	23,786,064	43,831,306	26,459,404	43,831,306	26,459,404	43,831,306	35,013,048	43,831,306	(8,818,259)
Temporarily Restricted	1,466,354	2,610,349	2,589,701	2,610,472	2,589,789	2,610,594	2,589,873	2,610,720	2,589,875	2,610,841	2,589,981	2,610,967	2,589,989	1,467,163	2,589,995	(1,122,833)
Net Income	(10,502,442)	(341,503)	49,888	(491,045)	(1,044,330)	864,526	(4,448,757)	875,889	(6,948,049)	639,798	(9,372,990)	1,640,740	(7,820,838)	1,318,385	(8,238,924)	9,557,309
Total Fund Balance	**36,479,402**	**25,537,040**	**46,470,896**	**25,387,621**	**45,376,765**	**26,743,313**	**41,972,422**	**27,272,672**	**39,473,131**	**29,710,043**	**37,048,297**	**30,711,111**	**38,600,457**	**37,798,596**	**38,182,378**	**(383,782)**
Liabilities + Fund Balance	**160,632,647**	**147,710,381**	**165,569,755**	**147,294,513**	**166,539,776**	**149,065,629**	**163,217,871**	**149,532,205**	**161,087,867**	**145,594,746**	**158,581,528**	**145,260,490**	**156,822,066**	**158,542,174**	**154,903,862**	**3,638,312**
(Decline)/Gain		(12,922,266)	(1,743,492)	(415,868)	970,022	1,771,115	(3,321,905)	466,576	(2,130,005)	(3,937,458)	(2,506,339)	(334,256)	(1,759,462)	13,281,684	(1,918,204)	15,199,889
	(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		
Numerator:	HOSPITAL FUND ONLY	
Excess of revenues over expense	$ 1,318,385	7 months of earnings
+ Depreciation Expense	2,521,304	
+ Interest Expense	1,259,024	
Less GO Property Tax revenue	967,072	
Less GO Interest Expense	303,247	
"Income available for debt service" *(definition per 2010 and 2013 and 2021 Indenture)*	**$ 3,828,395**	
Denominator:		
Supplemental Indenture of Trust)		
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	
Total **Maximum Annual Debt Service**	**$ 2,722,009**	Full year of debt
	1,587,839	YTD debt
Ratio: (numerator / denominator)	2.41	YTD debt service coverage
Required Debt Service Coverage Ratio:	1.10	
In Compliance? (Y/N)	No	

Unrestricted Funds and Days Cash on Hand	
	HOSPITAL FUND ONLY
Cash and Investments-current	$ 18,888,305
Cash and Investments-non current	1,831,405
Sub-total	20,719,710
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	(1,057,556)
Building and Nursing Fund	(1,467,164)
Total Unrestricted Funds	**$ 18,194,991**
Total Operating Expenses	$ 67,050,079
Less Depreciation	2,521,304
Net Expenses	64,528,775
Average Daily Operating Expense	$ 300,134
Days Cash on Hand	61

Key Financial Performance Indicators	Industry Benchmark	Jan-23	Jun-23	FYE 2023 Average	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Variance to Prior Month	Variance to FYE 2023 Average	Variance to Prior Year Month	Variance to Benchmark	Reduction Target	Comment
Volume																	
Admits	41	74	83	68	64	57	67	75	75	68	79	11	11	5	38		Mammoth monthly average in 2022 per HCAI
Deliveries	n/a	20	17	17	19	9	17	19	16	18	8	(10)	(9)	(12)	n/a		
Adjusted Patient Days	n/a	1,102	1,105	984	951	945	862	1,272	940	969	1,009	40	25	(93)	n/a		
Total Surgeries	153	127	81	120	134	148	114	173	149	143	175	32	55	48	22		Mammoth monthly average in 2022 per HCAI
ER Visits	659	753	851	810	925	899	885	899	782	868	843	(25)	33	90	184		Mammoth monthly average in 2022 per HCAI
RHC and Clinic Visits	n/a	4,572	4,381	4,353	3,875	5,099	4,314	4,619	4,768	4,576	4,859	283	506	287	n/a		
Diagnostic Imaging Services	n/a	1,999	2,051	2,020	2,108	2,174	1,955	2,182	1,897	1,899	2,262	363	242	263	n/a		
Rehab Services	n/a	748	896	762	661	662	329	521	614	547	743	196	(19)	(5)	n/a		
AR & Income																	
Gross AR (Cerner only)	n/a	$ 52,158,604	$ 50,668,396	$ 53,638,580	$ 51,928,721	$ 50,613,728	$ 51,259,303	$ 53,295,391	$ 52,529,762	$ 53,913,830	$ 56,381,675	$ 2,467,844	$ 2,743,095	$ 4,223,071	n/a		
AR > 90 Days	$ 7,688,895.45	$ 25,648,706	$ 25,752,910	$ 23,440,542	$ 23,660,417	$ 23,784,037	$ 23,867,624	$ 23,888,672	$ 26,596,663	$ 26,961,876	$ 27,771,536	$ 809,660	$ 4,330,994	$ 2,122,830	$ 20,082,641	(20,082,641)	15% of gross AR is benchmark
AR % > 90 Days	15%	51.15%	51.55%	45.3%	45.84%	46.59%	46.19%	44.50%	50.23%	50.78%	50.04%	-0.7%	4.7%	-1.1%	35.0%		Industry average
AR Days	43.00	89.81	89.78	91.35	90.52	85.93	84.50	86.92	87.85	86.28	90.02	3.74	(1.33) $	0	47.02		California CAH
Net AR	n/a	$ 14,758,093	$ 9,351,360	$ 17,800,084	$ 13,605,084	$ 13,668,526	$ 15,119,591	$ 18,412,645	$ 20,460,545	$ 20,452,310	$ 20,997,993	$ 545,683	$ 3,197,909	$ 6,239,900	n/a		
Net AR % of Gross	n/a	28.3%	18.5%	33.1%	26.2%	27.0%	29.5%	34.5%	39.0%	37.9%	37.2%	-0.7%	4.2%	8.9%	n/a		
Gross Patient Revenue/Calendar Day	n/a	$ 561,125	$ 543,011	$ 546,652	$ 589,494	$ 653,218	$ 573,176	$ 634,410	$ 599,349	$ 604,887	$ 671,199	$ 66,312	$ 124,547	$ 110,073	n/a		
Net Patient Revenue/Calendar Day	n/a	$ 283,616	$ 198,702	$ 243,317	$ 281,629	$ 297,995	$ 390,558	$ 291,760	$ 276,478	$ 308,700	$ 302,421	$ (6,278)	$ 59,104	$ 18,805	n/a		
Net Patient Revenue/APD	n/a	$ 7,978	$ 5,395	$ 7,622	$ 9,180	$ 9,775	$ 13,593	$ 7,111	$ 8,824	$ 9,876	$ 9,291	$ (584)	$ 1,669	$ 1,313	n/a		
Wages																	
Wages	n/a	$ 2,946,758	$ 5,954,820	$ 3,281,173	$ 3,246,211	$ 3,393,123	$ 4,052,687	$ 3,249,591	$ 3,126,785	$ 3,303,307	$ 3,251,713	$ (51,594)	$ (29,460)	$ 304,956	n/a		
Employed paid FTEs	n/a	385.06	364.62	384.63	365.27	357.51	351.58	352.89	350.57	346.65	346.54	(0.11)	(38.09)	(38.52)	n/a	-10%	
Employed Average Hourly Rate	$ 38.00	$ 43.20	$ 95.27	$ 48.51	$ 50.17	$ 53.58	$ 67.24	$ 51.98	$ 52.03	$ 53.79	$ 52.97	$ (0.82)	$ 4.46	$ 9.77	$ 14.97		According to California Hospital Association data
Benefits	n/a	$ 1,924,062	$ 1,610,167	$ 1,907,194	$ 1,782,070	$ 1,030,526	$ 1,510,474	$ 1,955,349	$ 1,804,521	$ 1,251,579	$ 1,248,638	$ (2,941)	$ (658,556)	$ (675,424)	n/a		
Benefits % of Wages	30%	65.3%	27.0%	58.7%	54.9%	30.4%	37.3%	60.2%	57.7%	37.9%	38.4%	0.5%	-20.3%	-26.9%	8.4%	(151,569)	Industry average
Contract Labor	n/a	$ 975,969	$ 803,281	$ 808,284	$ 493,990	$ 629,779	$ 700,581	$ 371,183	$ 211,163	$ 508,486	$ 383,806	$ (124,680)	$ (424,478)	$ (592,163)	n/a		
Contract Labor Paid FTEs	n/a	36.45	39.55	40.27	30.74	21.10	18.33	22.14	21.61	22.52	21.60	(0.92)	(18.67)	(14.85)	n/a		
Total Paid FTEs	n/a	421.51	404.17	424.90	396.01	378.61	369.91	375.03	372.18	369.17	368.14	(1.03)	(56.76)	(53.37)	n/a		
Contract Labor Average Hourly Rate	$ 81.04	$ 151.15	$ 118.48	$ 112.84	$ 90.72	$ 168.49	$ 222.95	$ 94.64	$ 57.00	$ 127.46	$ 100.31	$ (27.16)	$ (12.53)	$ (50.84)	$ 19.27	$ (73,758)	Per zip recruiter as of August 2023 for California, higher range is benchmark
Total Salaries, Wages, & Benefits	n/a	$ 5,846,788	$ 8,368,268	$ 5,996,651	$ 5,522,271	$ 5,053,428	$ 6,263,742	$ 5,576,123	$ 5,142,469	$ 5,063,372	$ 4,884,157	$ (179,215)	$ (1,112,494)	$ (962,631)	n/a		
SWB% of NR	50%	66.5%	140.4%	79.8%	63.3%	54.7%	53.5%	61.7%	62.0%	61.0%	52.1%	-8.9%	-27.7%	-14.4%	$ 0	$ (278,529)	Per Becker Healthcare, max should be 50%
SWB/APD	2,613	$ 5,306	$ 7,573	$ 5,912	$ 5,807	$ 5,348	$ 7,267	$ 4,384	$ 5,471	$ 5,225	$ 4,841	$ (385)	$ (1,072)	$ (465)	$ 2,228	$ (6,698)	Industry average
SWB % of total expenses	50%	64.4%	92.2%	66.0%	58.7%	51.7%	59.4%	59.2%	55.4%	56.8%	49.9%	-6.9%	-16.1%	-14.4%	0%	$ 4,801	Industry average
Physician Spend																	
Physician Expenses	n/a	$ 1,366,533	$ 1,428,974	$ 1,400,634	$ 1,369,822	$ 1,536,032	$ 1,424,804	$ 1,432,267	$ 1,713,978	$ 1,416,488	$ 1,099,861	$ (316,627)	$ (300,773)	$ (266,672)	n/a		
Physician expenses/APD	n/a	$ 1,240	$ 1,293	$ 1,451	$ 1,440	$ 1,625	$ 1,653	$ 1,126	$ 1,823	$ 1,462	$ 1,090	$ (372)	$ (361)	$ (150)	n/a		
Supplies																	
Supply Expenses	n/a	$ 837,141	$ (985,032)	$ 544,557	$ 786,000	$ 1,264,257	$ 754,993	$ 974,247	$ 856,240	$ 809,100	$ 1,159,592	$ 350,492	$ 615,035	$ 322,451	n/a		
Supply expenses/APD		$ 760	$ (891)	$ 579	$ 826	$ 1,338	$ 876	$ 766	$ 911	$ 835	$ 1,149	$ 314	$ 571	$ 390	n/a		
Other Expenses																	
Other Expenses	n/a	$ 1,029,983	$ 268,236	$ 1,138,604	$ 1,724,605	$ 1,928,164	$ 2,102,517	$ 1,443,075	$ 1,568,875	$ 1,625,968	$ 2,635,236	$ 1,009,268	$ 1,496,632	$ 1,605,253	n/a		
Other Expenses/APD	n/a	$ 935	$ 243	$ 1,178	$ 1,813	$ 2,040	$ 2,439	$ 1,134	$ 1,669	$ 1,678	$ 2,612	$ 934	$ 1,434	$ 1,677	n/a		
Margin																	
Net Income	n/a	$ (418,086)	$ (5,031,592)	$ (1,448,727)	$ (341,503)	$ (149,542)	$ 1,355,571	$ 11,363	$ (236,090)	$ 1,000,942	$ (322,354)	$ (1,323,296)	$ 1,126,373	$ 95,732	n/a		
Net Profit Margin	n/a	-4.8%	-84.4%	-20.8%	-3.9%	-1.6%	11.6%	0.1%	-2.8%	10.5%	-3.4%	-13.9%	17.4%	1.4%	#VALUE!		
Operating Income	n/a	$ (1,095,469)	$ (5,308,483)	$ (2,495,327)	$ (590,588)	$ (544,049)	$ 1,170,684	$ (381,153)	$ (987,232)	$ 654,759	$ (403,791)	$ (1,058,550)	$ 2,091,536	$ 691,678	n/a		
Operating Margin	2.9%	-12.5%	-89.1%	-33.0%	-6.8%	-5.9%	10.0%	-4.2%	-11.9%	6.8%	-4.3%	-11.1%	28.7%	8.2%	-7.2%		Per Kaufman Hall September Natitonal Hospital Flash
EBITDA	n/a	$ (760,538)	$ (5,370,917)	$ (1,789,289)	$ (16,938)	$ 175,023	$ 1,682,046	$ 335,928	$ 120,086	$ 1,345,271	$ 198,274	$ (1,146,997)	$ 1,987,563	$ 958,812	n/a		
EBITDA Margin	12.7%	-8.7%	-90.1%	-22.6%	0.2%	1.9%	14.4%	3.7%	1.4%	14.1%	2.1%	-12.0%	24.7%	10.8%	-10.6%		CLA critical access hospitals
Debt Service Coverage Ratio	3.70	(5.8)	(5.8)	(5.8)	0.6	1.3	3.7	3.4	4.4	2.3	2.4	0.10	8.21	8.20	(1.30)		Per bond requirement, need to be at 1.1
Cash																	
Avg Daily Disbursements	n/a	$ 318,010	$ 489,123	$ 363,636	$ 296,364	$ 490,705	$ 321,703	$ 304,199	$ 379,443	$ 264,416	$ 441,224	$ 176,808	$ 77,588	$ 123,214	n/a	$ 52,332	39%
Average Daily Cash Collections	n/a	$ 438,340	$ 482,340	$ 340,919	$ 254,229	$ 306,137	$ 255,132	$ 296,639	$ 327,103	$ 316,748	$ 337,135	$ 20,387	$ (3,784)	$ (101,204)	n/a	$ (52,332)	-28%
Average Daily Net Cash		$ 120,330	$ (6,783)	$ (22,716)	$ (42,135)	$ (184,568)	$ (66,571)	$ (7,560)	$ (52,340)	$ 52,332	$ (104,089)	$ (156,421)	$ (81,372)	$ (224,418)	n/a	$ (52,332)	-474%
Unrestricted Funds	n/a	$ 24,110,443	$ 31,636,319	$ 25,185,410	$ 30,155,529	$ 31,263,610	$ 32,193,415	$ 26,372,783	$ 21,068,202	$ 20,904,990	$ 18,888,305	$ (2,016,685)	$ (6,297,105)	$ (5,222,138)	n/a		-20%
Change of cash per balance sheet	n/a	$ 1,424,767	$ 4,895,725	$ 204,360	$ (1,480,790)	$ 1,108,081	$ 929,805	$ (5,820,632)	$ (5,304,581)	$ (163,212)	$ (2,016,685)						
Days Cash on Hand (assume no more cash is collected)	196	82	105	83	102	64	100	87	56	79	43	(36)	(40)	(40)	n/a		Per bond requirement, we need 75 minimum. Other California CAH average 196
Estimated Days Until Depleted (assumes cash continues and spend continues)		-	4,664	1,109	716	276	329	351	298	417	327	(90)	(782)	327	n/a		
Years Unit Cash Depletion		-	12.78	3.04	1.96	0.76	0.90	0.96	0.82	1.14	0.89	(0.25)	(2.14)	0.89	n/a		

Northern Inyo Healthcare District

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	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Net Income (Loss)	(322,354)	(418,086)	(1,924,067)	95,732	1,601,713	1,318,385	(8,238,924)	(11,981,519)	9,557,309	13,299,904	23%	116%	111%
Operating Income (Loss)	(403,791)	(1,095,469)	(2,213,043)	691,678	1,809,252	(1,081,369)	(12,174,342)	(15,602,511)	11,092,973	14,521,142	63%	91%	93%

Income is favorable to prior year month due to volume and reduced expenses. Income is favorable. FYE 2024, income is favorable compare to prior year due to increase volume and revenue.

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
IP Gross Revenue	4,415,671	3,898,881	3,125,052	516,790	1,290,619	24,928,060	22,924,934	20,892,126	2,003,126	4,035,934	13%	9%	19%
OP Gross Revenue	14,723,154	11,943,811	12,007,728	2,779,343	2,715,426	97,002,080	83,911,479	86,248,279	13,090,601	10,753,801	23%	16%	12%
Clinic Gross Revenue	1,668,331	1,552,193	1,419,005	116,138	249,326	11,034,750	9,775,470	8,834,413	1,259,280	2,200,337	7%	13%	25%
Net Patient Revenue	9,375,055	8,792,094	6,951,750	582,961	2,423,305	65,968,710	54,345,948	48,782,836	11,622,762	17,185,874	7%	21%	35%
Cash Net Revenue % of Gross	45%	51%	42%	-5%	3%	50%	47%	42%	3%	8%	-5%	3%	18%

Revenue is favorable to prior year due to increased volumes in several areas including surgeries, ER, RHC, and clinics. For the year

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Admits (excl. Nursery)	79	74		5		485	487		(2)		7%	0%	
IP Days	227	273		(46)		1,457	1,530		(73)		-17%	-5%	
IP Days (excl. Nursery)	216	247		(31)		1,296	1,366		(70)		-13%	-5%	
Average Daily Census	7	8		(1)		6	6		(0)		-13%	-5%	
ALOS	2.73	3.34		(0.61)		2.67	2.80		(0.13)		-18%	-5%	
Deliveries	8	20		(12)		106	114		(8)		-60%	-7%	
OP Visits	3,877	3,647		230		24,549	25,420		(871)		6%	-3%	
RHC Visits	3,143	2,816		327		21,170	18,592		2,578		12%	14%	
Rural Health Clinic Visits	2,489	2,256		233		16,786	15,077		1,709		10%	11%	
Rural Health Women Visits	448	478		(30)		3,199	3,032		167		-6%	6%	
Rural Health Behavioral Visits	206	82		124		1,185	483		702		151%	145%	
NIA Clinic Visits	1,716	1,756		(40)		10,901	11,815		(914)		-2%	-8%	
Bronco Clinic Visits	48	50		(2)		189	191		(2)		-4%	-1%	
Internal Medicine Clinic Visits	-	400		(400)		201	2,703		(2,502)				
Orthopedic Clinic Visits	351	314		37		2,423	2,219		204		12%	9%	
Pediatric & Allergy Clinic Visits	663	568		95		4,361	3,989		372		17%	9%	
Specialty Clinic Visits	459	287		172		2,534	1,794		740		60%	41%	
Surgery Clinic Visits	139	99		40		883	638		245		40%	38%	
Virtual Care Clinic Visits	56	38		18		310	281		29		47%	10%	
Surgeries IP	27	19		8		158	135		23		42%	17%	
Surgeries OP	148	108		40		878	703		175		37%	25%	
Total Surgeries	175	127		48		1,036	838		198		38%	24%	
Cardiology	-	-		-		-	-		-		#DIV/0!	#DIV/0!	
General	92	58		34		474	355		119		59%	34%	
Gynecology & Obstetrics	12	12		-		109	83		26		0%	31%	
Ophthalmology	28	26		2		177	186		(9)		8%	-5%	
Orthopedic	30	29		1		199	194		5		3%	3%	
Pediatric	-	-		-		-	1		(1)		#DIV/0!	-100%	
Podiatry	-	-		-		1	3		(2)		#DIV/0!	-67%	
Urology	13	2		11		74	16		58		550%	363%	
Diagnostic Imaging	2,262	1,999		263		14,477	14,160		317		13%	2%	
Emergency Visits	843	752		91		6,101	5,778		323		12%	6%	
ED Admits	44	35		9		221	238		(17)		26%	-7%	
ED Amits % of ED Visits	5.2%	4.7%		0.6%		3.6%	4.1%		-0.5%		12%	-12%	
Rehab	743	748		(5)		4,077	5,154		(1,077)		-1%	-21%	
Nursing Visits	284	248		36		2,040	1,782		258		15%	14%	
Observation Hours	2,726	1,738		988		14,412	12,692		1,720		57%	14%	

Admissions increased due to higher ER volume. For the year, admissions are consistent with last fiscal year. Deliveries are slightly under prior year for January and for the fiscal year. For January, RHC/internal medicine is lower but slightly higher for the fiscal year. Total surgeries are 38% higher compared to last January and 34% higher compared to last fiscal year. This is due to new physicians Dr. Wiles and Dr. Clayton Davis

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Payor mix													
Blue Cross	27.0%	25.0%		2.0%		27.6%	27.6%		0.0%				
Commercial	4.6%	8.1%		-3.5%		5.4%	6.6%		-1.2%				
Medicaid	17.6%	18.6%		-1.0%		19.3%	21.7%		-2.4%				
Medicare	45.5%	43.5%		2.0%		42.9%	39.2%		3.7%				
Self-pay	3.0%	2.3%		0.7%		3.0%	2.9%		0.1%				
Workers' Comp	2.0%	1.8%		0.2%		1.3%	1.4%		-0.1%				
Other	0.3%	0.6%		-0.3%		0.4%	0.6%		-0.2%				
DEDUCTIONS													
Contract Adjust	9,802,285	7,536,311	8,939,134	2,265,974	863,151	58,578,040	53,008,558	62,603,538	5,569,482	(4,025,498)	30%	11%	-6%
Bad Debt	1,227,065	687,018	327,510	540,047	899,555	5,210,207	6,520,125	2,294,222	(1,309,918)	2,915,985	79%	-20%	127%
Write-off	402,752	307,332	327,510	95,420	75,242	3,157,487	2,513,940	2,294,222	643,547	863,265	31%	26%	38%

Northern Inyo Healthcare District

Jan 2024 – Financial Summary

Payor mix is relatively stable and collection efforts have caused an increase in net revenue as a % of gross revenue

DENIALS

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

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
CHARITY	10,216	94,778		(84,562)	10,216	36,118	259,675		(223,557)		-89%	-86%	

Charity discounts have decreased compared to prior year.

BAD DEBT

Bad debt write offs were $804k.

CASH

Cash deficit for October was -$3.3M or $-104k/day due to IGT and Bridge loan payments of $M plus AP catch up

CENSUS

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Patient Days	227	273		(46)		1,457	1,530		(73)		-17%	-5%	
Adjusted Days	1,060	1,218		(158)		7,768	7,783		(15)		-13%	0%	
Employed Paid FTE	347	385		(39)		353	392		(38)		-10%	-10%	
Contract Paid FTE	22	36		(15)		23	43		(20)		-41%	-47%	
Total Paid FTE	368	422		(53)		376	434		(59)		-13%	-14%	
EPOB (Employee per Occupied Bed	1.55	1.57		(0)		1.75	1.94		(0)		-1%	-10%	
Adjusted EPOB	0.33	0.35		(0.0)		0.33	0.38		(0.1)		-6%	-13%	

Decline in contract FTEs and total FTEs due to RIFFs and staffing management.

SALARIES

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Per Adjust Bed Day	$ 3,068	$ 2,250		$ 818		$ 2,945	$ 2,339		$ 605		36%	26%	
Total Salaries	$ 3,251,713	$ 2,740,507	$ 3,241,506	511,206	10,207	$ 22,873,063	$ 18,204,920	$ 22,533,551	4,668,143	339,512	19%	26%	2%
Normalized Salaries (incl PTO used)	$ 3,251,713	$ 2,946,758	$ 3,241,506	304,956	10,207	$ 22,873,063	$ 20,497,129	$ 22,533,551	2,375,934	339,512	10%	12%	2%
Average Hourly Rate	$ 52.97	$ 43.20		$ 9.77		$ 52.74	$ 42.61		$ 10.12		23%	24%	
Employed Paid FTEs	346.54	385.06		(38.52)		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.

BENEFITS

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Per Adjust Bed Day	$ 1,178	$ 1,749		$ (571)		$ 1,453	$ 1,779		$ (326)		-33%	-18%	
Total Benefits	$ 1,248,638	$ 2,130,312	$ 2,036,905	$ (881,674)	(788,267)	$ 11,290,561	$ 13,847,252	$ 13,946,936	$ (2,556,691)	(2,656,375)	-41%	-18%	-19%
Benefits % of Wages	38%	78%	63%	-39%		49%	76%	62%	-27%		-51%	-35%	
Pension Expense	$ 542,170	$ 841,111	$ 826,842	$ (298,941)	(284,672)	$ 3,162,882	$ 5,956,078	$ 5,531,871	$ (2,793,196)	(2,368,989)	-36%	-47%	-43%
MDV Expense	$ 279,164	$ 583,782	$ 557,158	$ (304,618)	(277,994)	$ 6,007,599	$ 3,746,504	$ 3,848,733	$ 2,261,095	2,158,866	-52%	60%	56%
Payroll Taxes & WC insurance	$ 379,553	$ 299,203	$ 340,774	$ 80,350	38,779	$ 2,221,760	$ 1,912,767	$ 2,402,470	$ 308,993	(180,710)	27%	16%	
PTO Incurred	$ -	$ 206,251	$ -	$ (206,251)	-	$ -	$ 2,292,209	$ 2,069,479	$ (2,292,209)	(2,069,479)	-100%	-100%	
PTO Accrued	$ 47,751	$ 196,375	$ 298,058	$ (148,624)	(250,307)	$ (109,143)	$ (245,599)		$ 136,456	$ (109,143)	-76%	-56%	
Reimbursements	$ -	$ -	$ -	$ -	-	$ 3,021	$ 1,437	$ -	$ 1,584	$ 3,021	#DIV/0!	110%	
Sick	$ -	$ 2,354	$ 14,075	$ (2,354)	(14,075)	$ 4,442	$ 173,701	$ 94,383	$ (169,259)	$ (89,941)	-100%	-97%	
Other	$ -	$ 1,237	$ -	$ (1,237)	-	$ -	$ 10,156	$ -	$ (10,156)	-	-100%	-100%	
Normalized Benefits	$ 1,248,638	$ 1,924,062	$ 2,036,905	$ (675,424)		$ 11,290,561	$ 11,555,043	$ 11,877,457	$ (264,482)	$ (586,896)	-35%	-2%	-5%
Normalized Benefits % of Wages	38%	65%	63%	-27%		49%	56%	53%			-41%	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.

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Salaries, Wages & Benefits	$ 4,500,351	$ 4,870,819	$ 5,278,411	$ (370,468)	(778,060)	$ 34,163,624	$ 32,052,172	$ 34,411,008	$ 2,111,452	$ (247,384)	-8%	7%	-1%
SWB/APD	$ 4,246	$ 3,999		$ 247		$ 4,398	$ 4,118		$ 280		6%	7%	

Total SWB for November were consistent with prior year. Wage increases offset decreases in pension benefits. Total YTD SWB is over 3% due to an increase in MDV expenses.

PROFESSIONAL FEES

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Per Adjust Bed Day	$ 2,308	$ 2,398		$ (90)	2,308	$ 2,193	$ 2,582	$ -	$ (389)	$ 2,193	-4%	-15%	
Total Physician Fee	$ 1,466,380	$ 1,289,298	$ 1,041,863	$ 177,082	424,517	$ 9,960,949	$ 9,100,177	$ 7,236,026	$ 860,772	$ 2,724,923	14%	9%	38%
Total Contract Labor	$ 383,806	$ 975,969	$ 418,094	$ (592,163)	(34,288)	$ 3,103,380	$ 6,489,077	$ 3,002,613	$ (3,385,697)	$ 100,767	-61%	-52%	3%
Total Other Pro-Fees	$ 596,239	$ 655,396	$ 583,908	$ (59,157)	$ 12,331	$ 3,967,169	$ 4,503,434	$ 4,136,782	$ (536,265)	$ (169,613)	-9%	-12%	-4%
Total Professional Fees	$ 2,446,425	$ 2,920,663	$ 2,043,865	$ (474,238)	402,560	$ 17,031,498	$ 20,092,688	$ 14,375,421	$ (3,061,190)	$ 2,656,077	-16%	-15%	18%
Contract Paid FTEs	21.60	36.45		(14.85)		22.60	42.90		(20.30)		-41%	-47%	
Physician Fee per Adjust Bed Day	1,383	1,059		325		$ 1,282	1,169		113				

Physician expense increase due to anesthesia expenses, 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 $3.4M.

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
PHARMACY													
Per Adjust Bed Day	$ 353	$ 296		$ 57		$ 385	$ 295		$ 89		19%	30%	
Total Rx Expense	$ 373,723	$ 360,384	$ 368,461	$ 13,339	5,262	$ 2,988,912	$ 2,299,614	$ 2,519,688	$ 689,298	$ 469,224	4%	30%	19%

Supplies are higher due to volume. YTD supplies are relatively flat to prior year.

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
MEDICAL SUPPLIES													
Per Adjust Bed Day	$ 741	$ 391		$ 350		$ 465	$ 379		$ 86		89%	23%	
Total Medical Supplies	$ 785,869	$ 476,757	$ 376,028	$ 309,112	409,841	$ 3,615,518	$ 2,950,805	$ 2,603,908	$ 664,713	$ 1,011,610	65%	23%	39%

Supplies are higher for the month and year due to higher volume.

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
EHR SYSTEM													
Per Adjust Bed Day	$ 142	$ 104		$ 38		$ 112	$ 137		$ (26)		37%	-19%	
Total EHR Expense	$ 150,509	$ 126,194	$ 151,595	$ 24,315	(1,086)	$ 866,385	$ 1,069,192	$ 1,061,165	$ (202,807)	$ (194,780)	19%	-19%	-18%

YTD is under last year due to prior year invoicing backlog paid in prior year

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
OTHER EXPENSE													
Per Adjust Bed Day	$ 945	$ 649		$ 296		$ 755	$ 730		$ 25		46%	3%	
Total Other	$ 1,001,340	$ 790,292	$ 587,270	$ 211,048	414,070	$ 5,862,839	$ 5,679,540	$ 4,761,049	$ 183,299	$ 1,101,790	27%	3%	23%

For the month and the year, utilities and insurance increased compared to prior year.

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
DEPRECIATION AND AMORTIZATION													
Per Adjust Bed Day	$ 491	$ 281		$ 210		$ 325	$ 305		$ 19		75%	6%	
Total Depreciation and Amortization	$ 520,628	$ 342,452	$ 369,093	$ 178,176	151,535	$ 2,521,304	$ 2,376,379	$ 2,583,630	$ 144,925	$ (62,326)	52%	6%	-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.

	CY MONTH	PY MONTH	BUDGET	PY Variance	Budget Variance	YTD	PY YTD	BUDGET	PY Variance	Budget Variance	MOM % Variance	YOY % Variance	YTD Budget % Variance
Total Expenses	$ 9,778,845	$ 9,887,561	$ 9,174,723	$ (108,716)	604,122	$ 67,050,080	$ 66,520,390	$ 64,385,348	$ 529,690	2,664,732	-1%	1%	4%

For the year, expenses are down overall due to less contract labor.

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: March 5, 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. *Standardized Protocol – General Policy for the Physician Assistant*
   2. *Employee Health NIHD Workforce Onboarding*
   3. *Employee Health NIHD Workforce Tuberculosis Surveillance Program*
   4. *Infection Control Policy Perinatal*

B. Medical Staff Appointments 2024-2025 (*action item*)
   1. John Avery Neal, DO (*pediatrics*) – Courtesy Staff
   2. Rami-James Assadi, MD (*neurology*) – Telemedicine Staff
   3. Rajeshwary Swamidurai, MD (*anesthesiology*) – Active Staff

C. Medical Staff Reappointment for Calendar Year 2024 (*action item*)
   1. Amy Saft, CRNA (*nurse anesthesia*)

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

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROTOCOL

Title: Standardized Protocol - General Policy for the Physician Assistant		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Physician Assistants		
Date Last Modified: 03/06/2024	Last Review Date: No Review Date	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/20/2019	

PURPOSE:

To outline the general policy for the development of standardized protocols and the evaluation of those authorized to perform the standardized protocol functions, as promulgated by the guidelines of the Medical Board of California and the Physician Assistant Board.

DEFINITIONS:

1. **Physician Assistant (PA)** is licensed by the State of California Department of Consumer Affairs and possesses preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards.

POLICY:

1. Development and Review of Standardized Protocols
    a. All Physician Assistant Protocols are developed collaboratively and approved by the Northern Inyo Healthcare District (NIHD) Interdisciplinary Practice Committee (IDPC) and must conform to guidelines as specified in Title 16, Chapter 7.7, section 3502.
    b. All Physician Assistant Protocols will be kept in a manual (either hardcopy or electronic) that includes date and signature of the Physician Assistant who is approved under the protocol and the Physician Supervisor(s).
    c. All Physician Assistant Protocols are to be reviewed biennially by the PA(s), Chiefs of Service, and by the IDPC. Standardized protocols will be updated as practice changes.
    d. All changes or additions to the Protocols are to be approved by the IDPC. All Protocols approved by the IDPC will be sent to the Medical Staff Executive Committee and, if so approved, to the NIHD Board of Directors.
2. Setting of Practice:
    a. Northern Inyo Healthcare District (NIHD) and affiliated locations, as appropriate for specialty.
3. Scope of Practice
    a. The PA may perform the following functions within his/her specialty area and consistent with their experience and credentialing: assessment, management, and treatment of episodic illness, chronic illness, contraception, certifying disability, and the common functions of health promotion, and general evaluation of health status (including but not limited to ordering

laboratory procedures, x-rays, and physical therapies as well as recommending diets, and referring to specialty services when indicated).

b. Protocol functions, such as prescribing medications, are to be performed at an approved setting of practice. Consulting Supervising Physician(s) will be available to the PA(s) in person, by electronic means or by phone.

c. Physician consultation is to be obtained under the following circumstances:
    i. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
    ii. Acute decompensation of patient situation.
    iii. Problem which is not resolving as anticipated.
    iv. History, physical, or lab finding inconsistent with the clinical picture.
    v. Upon request of patient, nurse, supervising physician, or upon request of the PA.

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

e. Supervision of Medical Assistants
    i. A PA may provide supervision of the medical assistant, although the supervising physician is ultimately responsible for the patient's treatment and care.

4. Qualifications and Evaluations

a. Each Physician Assistant performing PA Protocol functions must have a current California Physician Assistant license, be a graduate of an approved Physician Assistant program, and have current certification as a Physician Assistant by the California Physician Assistant Committee and the Department of Consumer Affairs.

b. Evaluation of PA's competence in performance of Protocol functions will be done in the following manner:
    i. <u>Initial</u>: Within the initial focused professional practice evaluation (FPPE) period the Supervising Physician(s) will evaluate performance via direct observation, consultations and chart review/co-signature and provide feedback to the interim PA. Input from other physicians and colleagues will be utilized. Recommendations to move from interim status to full status once the FPPE has been satisfactorily completed will be considered as per the Medical Staff policy. Nurse Manager(s) along with the Medical Director(s) and Supervising Physician(s) will provide feedback utilizing performance evaluation based upon the PA job description.
    ii. <u>Routine</u>: frequency in accordance with the Medical Staff Ongoing Professional Practice Evaluation (OPPE) policy.
    iii. <u>Follow-up</u>: areas requiring increased proficiency, as determined by the initial or routine evaluation, will be reevaluated by the supervising physician(s) at appropriate intervals until an acceptable skill level is achieved.

c. The scope of supervision for the performance of the functions referred to in this area shall include chart review as required by law.

d. Further requirements shall be regular continuing education in primary care or other relevant medical care, including reading of appropriate journals and new text books, attending conferences sponsored by hospitals, professional societies, and teaching institutions equaling as many hours as required by the Physician Assistant Board.

i. A record of continuing education must be submitted to the Medical Staff Office every other year at re-credentialing.

5. Protocols
   a. The protocols developed for use by the Physician Assistant are designed to describe the steps of medical care for given patient situations.

REFERENCES:

1. Physician Assistant Practice Act. Business and Professions Code, Division 2, Chapter 7.7. Revised January 1, 2020 (SB 697)
2. UpToDate-evidence-based, Physician-authorized clinical decision support resource
3. (2021) Title 16, California Code of Regulations, Sections 1399.540, 1399.544, 1399.546
4. Laws and Regulations Relating to the Practice of Physician Assistants. Issued May 2018.
5. (2021) Title 16, California Code of Regulations, Chapter 7.7, Section 3502.
6. (2021) Title 16, California Code of Regulations, Section 1366. Additional Technical Support Services.

ATTACHMENTS:

1. List of Authorized Physician Assistants and Supervising Physicians

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.5 Standardized Protocol - General Policy for the Physician Assistant

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Employee Health NIHD Workforce Onboarding Policy		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: District Wide		
Date Last Modified: 03/06/2024	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 09/18/2019	

PURPOSE:

Health screening for the Northern Inyo Healthcare District (NIHD) workforce occurs to ensure the worker is able to perform in the position offered and a plan has been developed for necessary documentation of immunity against specific diseases throughout the working relationship. The workforce reduces the personal risk of infection and the spread of vaccine-preventable infections by receiving/offered recommended vaccines, lab titers and Tuberculosis (TB) screening.

POLICY:

1. The NIHD workforce Health Screening is arranged by the Employee Health (EH) Department in collaboration with Human Resources (HR), Medical Staff Administration, the Rural Health Clinic (RHC), and Department Leadership.
2. The Health Screening begins after the employee has accepted the position and background has cleared.
3. Immunization monitoring and TB screening is an ongoing process that continues throughout the working relationship. All vaccination and TB monitoring policies will be consistent with federal, state, and local guidelines.
4. The scope of this policy, unless otherwise noted, applies to all health care workers (HCW's) at Northern Inyo Healthcare District (NIHD). Recommendations within this policy are in accordance with the:
    - United States Center for Disease Control and Prevention (CDC) guidelines for Immunization of Health-Care Personnel
    - California Division of Occupational Safety and Health Association (CAL/OSHA)
    - California Department of Public Health (CDPH)

DEFINITIONS

1. **Employee:** NIHD payroll employee
2. **Workforce:** Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.
3. **Volunteer and Auxiliary:** Active members that are in contact with patients and their families on campus.
4. **Shadower:** Observing a health care role, but not physically involved in any care.

PROCEDURE:

1. Employee Health will inform the workforce member that health-screening requirements need to be completed prior to start date.
2. Human Resources and Medical Staff Administration will provide Employee Health with names, date of birth, and contact information of all new workers who have signed an NIHD contract, or other agreement. Their support is critical to success in acquiring the new worker's childhood and career vaccines from prior employers, clinics, and hospitals, as well as completing a physical exam. It is preferred this process begins at a minimum of two weeks prior to start date.
3. A Shadower is not cleared by Employee Health as they are observing and not in direct contact with patients.
4. To clear a new hire through the Employee Health the nursing team must be able to do the following:
   a. Review prior TB Screening, immunization records, and titers
   b. Develop a plan with the new employee to meet onboarding requirements
   c. The Health History and Physical Exam is completed as defined in this policy.
   d. Once completed, an employee health team member will send an email to HR or Medical Staff Administration, stating the worker is cleared by Employee Health.

5. **New Hire Health History and Physical Exam**
   a. The New Hire Health History and Physical Exam includes documentation of the following:
      i. Health History
      ii. Physical Exam
      iii. Allergies including latex
      iv. Whisper test or Audiometry
      v. Audiometry is required if failed whisper test.
      vi. Failed Audiometry requires a referral to Audiologist
      vii. Vision Test: Visual Acuity with correction if applicable
      viii. Color vision: Ishihara 14 plates with color failure identification
      ix. Infectious Disease Exposure Screening
   b. The New Hire Health History and Physical Exam is required for all prospective NIHD payroll employees and all contracted/traveler workers. Providers (permanent and locums), students, and volunteers are NOT required to complete a physical exam, whisper test, vision test, nor color vision test.
   c. Contracted 100% remote workers, never on site, are only required to complete the physical exam with whisper test, visual acuity, and Ishihara color screening. If the contract agreement changes that the worker is requested to come onto campus, the worker and their Manager/Director are responsible to ensure the worker has completed and been cleared by employee health for all employee health workforce requirements of vaccinations, titers, and Tuberculosis (TB) testing before arriving on campus. The process may take up to 2 weeks to complete.
   d. The physical exam will be completed prior to the first day of employment. For employees on payroll, Employee Health will coordinate the physical exam with RHC, and schedule immunizations, lab testing, and onboarding paper work with Laboratory Services, Patient Access Services, and HR. Contracted workers are responsible for completing their own health requirements prior to start date.
   e. If an NIHD worker returns within six months of separation, the prior Health History and Physical is acceptable. Employee Health staff will review prior immunization records, TB screening, and fit testing to ensure the worker meets currents requirements for their new position. If any requirement has expired, it will be completed and brought into compliance, prior to their new position start date.
   f. Documentation of the following must be included:

If the worker does not pass any section of the physical, Employee Health will inform HR. Human Resources will arrange an accommodation meeting with the manager and other key stakeholders. Human Resources will contact the worker with the outcome plan.

6. **Volunteers**

   Volunteer Health Screening Requirements are limited to the following:

   a. Tdap once at or after age 11
   b. Influenza immunization annually
   c. TB screening per policy

7. **Drug Screening**

   Drug Screening is required of Contractors and Travelers prior to start date. New NIHD employees, providers (permanent or locums), students, and volunteers will not be required to drug screen as an onboarding process.

8. **Tuberculosis (Tb) Screening**

   a. TB Screening includes completion of a TB and a Risk and Symptom Screening Questionnaire and testing and is required of all NIHD workforce who will be on the NIHD campus at any time.
   b. NIHD will accept documentation of a QuantiFERON Gold (QFT), T Spot or Tuberculin Skin Test (TST), and the NIHD TB Risk and Symptom Screening Questionnaire on this timeline:
      i. **Employees of NIHD:** will be tested during the Employee Health onboarding process. Expired tests results for employees returning less than 6 months, must be completed prior to start date.
      ii. **Providers, permanent and locums:** test results are accepted within 90 days of start date, or ordered by Employee Health and scheduled by Medical Staff Office, to be completed on or before start date.
      iii. **Students**: may provide documentation within 12 months of rotation start date. A new Risk Factor, since the test date, will require a repeat current test (i.e. travel for more than 30 days since last test).
      iv. **Contracted workers**: test results are accepted within 90 days of start date
   c. An initial baseline QFT is preferred as the most efficient and accurate initial documentation regardless of BCG vaccine or past TST positives. A TST 2- step is an alternative option if the worker has not had a BCG vaccine and has not had a documented TST within the last 12 months, and is able to complete the first step prior to their start date.
   d. Employee Health orders/provides the TB testing at no cost for Employees, providers, volunteers. Students and contracted travelers must provide the results as described above.
   e. New workers with a history of a positive TB test.
      i. Submit documentation of the positive test and a chest x-ray report dated after the conversion. The x-ray does not need to be repeated unless documentation is lacking, or they are symptomatic, or immunocompromised. If a QFT is not documented, it will be drawn to confirm positivity, and determine serial monitoring method (testing every 2 years or questionnaire annually).
      ii. This worker needs to complete a Risk and Symptom Screening Questionnaire upon hire and annually. No further testing is needed.
      iii. If the worker has not been treated for latent TB, the Employee Health Nurse will educate on latent TB and follow up care. Provider follow up is at the discretion of the worker.
   f. Please reference Employee Health NIHD Workforce Tuberculosis Surveillance Program Policy for serial testing intervals, and procedure for positive results (TB Conversion).

9. **Immunizations**

   a. Employee Health vaccine screening, monitoring and administering is limited to the following: Influenza, MMR, Varicella, Tdap, Hepatitis B, Meningococcal ACWY, Meningococcal B, and QFT

or TB Skin Tests. If the worker requests other vaccinations, they will be directed to contact their primary care practitioner.

b. Initial immunization screening is required of all workers prior to their start date.
c. Annual Influenza vaccinations will be managed by the Employee Health Department in collaboration with Infection Prevention, Pharmacy and all department leaders.
d. A signed consent with screening questionnaire or vaccine declination will be completed for all immunizations.
e. Employee Health Standing Orders for Vaccine administration to workers are based on the CDC/ACIP Recommendations retrieved from www.immunize.org. They will be approved by the Employee Health Medical Director annually using the CDC/ACIP order templates. The signed Standing Orders will be available in the Employee Health Office.
f. **Employee Health Immunizations**
   i. **Influenza**
      1. Applies to all NIHD workforce on campus during the influenza season.
      2. Annually, during each flu season, one dose of influenza vaccine is required if there is no documentation for that season or a signed declination.
      3. Refer to Health Care Worker (HCW) Influenza Vaccination policy and procedure
   ii. **Measles (Rubeola), Mumps, Rubella (MMR)**
      1. Applies to all workers on campus: except volunteers and auxiliary.
      2. Documentation of 2 MMR vaccines, minimum of 28 days apart, or positive qualitative IgG titer results for each, anytime in the past. If immunity or vaccination history is undocumented, an IgG titer will be drawn for Rubella, Rubeola, and Mumps. Historical evidence of Rubella, Rubeola, and Mumps immunity via laboratory documentation of IgG Titers is accepted.
      3. In routine testing (not related to exposure) if the worker has 2 documented measles and mumps containing vaccines and has inadvertently been tested demonstrating negative or equivocal titer results for measles or mumps, it is not recommended that they receive additional doses. Such persons should be considered to have acceptable evidence of measles and mumps immunity. If there is one documented MMR, and the Measles of Mumps titer is non-immune, offer one additional MMR to be considered immune. If there is no documentation of any MMR, and the Measles or Mumps titer is non-immune the worker will be offered two MMR vaccines, with a minimum of 28 days apart to be considered immune. If the worker declines the vaccine, a declination must be signed. Repeat testing is not needed after vaccination.
      4. In routing testing (not related to exposure) if the worker has 1 documented Rubella containing vaccines and has inadvertently been tested demonstrating negative or equivocal titer results for Rubella, it is not recommended that they receive additional doses. Such persons should be considered to have acceptable evidence of rubella immunity. If there is no documentation of vaccines and the Rubella titer testing is non-immune the worker will be offered one MMR vaccine to be considered immune. If the worker declines the vaccine, a declination must be signed. Repeat testing is not needed after vaccination.
   iii. **Varicella (chickenpox)**
      1. Applies to all workers on campus: except volunteers and auxiliary.
      2. Documentation of 2 Varicella vaccines, minimum 28 days apart, OR positive qualitative IgG titer results anytime in the past. Only doses of varicella vaccines for which written documentation of the date of administration is presented should be considered valid. Persons who lack documentation of adequate vaccination or other evidence of immunity should be vaccinated. Documented receipt of 2 doses of varicella vaccines supercedes results of subsequent serologic testing. Therefore, serologic testing for immunity is not necessary for persons who

have received 2 doses of varicella vaccine (ACIP). Documented history of disease alone does not guarantee immunity. NIHD requires an IgG Varicella titer. If the titer is nonimmune, documentation of 2 varicella vaccine Standing Orders will be followed for booster dose or re-vaccination if the results demonstrate non-immunity or equivocal.

3. Historical evidence of Varicella immunity via laboratory documentation of IgG Titers is accepted.

iv. **Tetanus, diphtheria, pertussis (Tdap)**

1. Applies to all workers on campus, no exceptions.
2. Documentation of one dose of Tdap at or after the age of 11.
3. Booster doses would be provided by the person's primary care practitioner.

v. **Meningococcal**

1. Two types of Meningococcal vaccines are only recommended for microbiologists and lab personnel potentially plating Neisseria Meningitides.
2. A single dose of Quadrivalent (serogroup A, C, W, Y) meningococcal conjugate vaccine (Menveo or Menactra) with a booster dose every 5 years, if exposure is ongoing. This includes workers over the age of 55.
3. Serogroup B vaccine series of Bexsero (2 doses) or Trumenba (3 doses). No booster doses of serogroup b meningococcal vaccine are recommended.

vi. **Hepatitis B**

1. Required by Cal/OSHA.
2. Applies to NIHD HCW's who will be working in these departments/roles:
    - Activities Director
    - Patient Access Department
    - Biomedical
    - Case Management
    - Central Sterile Processing
    - Diagnostic Imaging Techs and Radiologists
    - Dietary
    - Environmental Services
    - Cardiopulmonary Department
    - Compliance, Laboratory
    - Language Services
    - Laundry
    - Surgical Tech's
    - Maintenance/Plant Operations
    - Nursing Staff (RN, LVN, MA, CNA)
    - Pharmacy
    - Physical Therapy
    - Occupational Therapy
    - Security
    - Social Services
    - Providers
    - Any additional roles that will require a worker to enter patient rooms.
3. Documentation of a complete series of Hepatitis B vaccines followed by a Hepatitis B Surface Antibody (HBs Ab) IgG Titer is the greatest assurance of immunity to Hepatitis B.
4. NIHD will assist the employee to attempt to obtain prior Hepatitis B vaccine documentation. Historical laboratory documentation of a qualitative reactive Hepatitis B surface antibody

(HBs-Ab) titer is accepted following a complete Hepatitis B vaccine series. If documentation of a complete series is lacking, CDC recommends to complete the series of Hepatitis B vaccines if records cannot be located. A titer alone is not recommended unless there is documentation of a full series of Hepatitis B vaccines. This is because, anti-HBs has only been deemed a correlate of protection when following a complete series.

a. For manufacturer interchangeability, dosing schedule, and revaccination for non immune HBs Ab titer (< 10mIU/ml) reference NIHD Employee Health Standing Orders for Administering Hepatitis B Vaccine to Adults in the Employee Health Office. Postvaccination serologic testing should be completed using a method that allows determination of the protective level of anti-HBs (≥10 mIU/mL).
b. If the Hepatitis B vaccine series is only partially documented, it is not necessary to restart the series because of an extended interval between doses, no matter how long; just complete the series. Heplisav is approved to complete the initial series of 3 vaccines regardless of initial dosing manufacturer. Once there is a complete series of documented Hepatitis B vaccines, ensure follow up testing for a reactive HBs Ab is documented post-final vaccination.
c. If the titer is negative after one complete series, a second series will be started. NIHD will provide one Heplisav dose followed by a HBs Ab test in 6 weeks. If the worker remains nonreactive (< 10), provide the second dose of Heplisav followed by a final HBs Ab test in 6 weeks. This completes the second series and conversion is anticipated when Heplisav is used.
d. For workers that were historically considered non-reactive/non-converting after 2 complete series of Engerix (6 doses) they should be offered a complete 2 dose series of Heplisav followed by HBs Ab testing 6 weeks after the second dose. There is a high probability of conversion with Heplisav in those that never responded to Engerix.
e. Cal OSHA requires healthcare facilities to offer Hepatitis B vaccine within 10 days of hire.
f. Cal OSHA requires a signed declination should the worker decide against Hepatitis B vaccination. The declination/acknowledgement contains the following, staff to check all that apply:
    - Due to my occupational exposure to blood or other potentially infectious materials (OPIM), I may be at risk of acquiring Hepatitis B virus (HBV) infection. NIHD employees on payroll and Providers may seek vaccination through NIHD Employee health at no charge.
    - I understand that documentation of a complete series of Hepatitis B Vaccine followed by a Hepatitis B Surface Antibody IgG Titer is the greatest assurance of immunity.
    - I believe I have received the complete Hepatitis B vaccine series but cannot show proof.
    - I decline Hepatitis B Vaccine at this time.

vii. Covid-19

1. Documentation and vaccine as required by federal, state, or local agencies. Employee Health will make attempt collect COVID-19 vaccination data on all NIHD workforce for required regulatory reporting.
2. Employees will be instructed where they can obtain COVID-19 vaccine if wanted.

10. **VACCINE DECLINATIONS**

a. NIHD strives to ensure the safety of our patients and workers through vaccinations. Should a worker decline any of the required vaccines a declination must be signed for each vaccine, acknowledging

awareness of risk. Any employee that declines vaccines may change mind and receive vaccine (s) free of charge through Employee Health Department later.
b. California law requires signed declination for refusal of vaccines to prevent aerosol transmissible diseases and Hepatitis B.

11. **EXCEPTIONS:**
   a. Vendors are not screened through Employee Health. Vendormate is used in this instance.

12. **COSTS**
   a. Required exams, immunizations, titers, and TB testing is offered at no cost to NIHD employees on payroll, providers, volunteers, and auxiliary members upon hire.
   b. Contracted workers and all students will need to meet their health requirements through a primary health care provider at their cost.
   c. Annual influenza immunization is offered to all NIHD workforce during influenza season at no cost.
   d. Ongoing TB testing is offered at no cost to all employees on payroll, providers, and volunteers.

13. **DOCUMENTATION**
   a. Documentation related to vaccinations, titers, TB screening, medical history and Physical Exam will be kept in the Employee Health files and electronic database.
   b. Historical documentation:
      i. All records require Name and Date of Birth
      ii. To ensure accuracy of lab results documentation with reference range and collection date are preferred. Documentation of titer results on formal records from Universities or Healthcare Systems will be accepted.
      iii. TB documentation of TST must include placement and result with dates.
   c. Vaccines provided by NIHD require a consent which includes a screening questions, the manufacturer, lot, expiration date, and date of published VIS that was provided. This information will be stored in the HCW's health record.

REFERENCES:

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3. CAL/OSHA, Title 8 Regulations. Section 5193. Bloodborne Pathogens. https://www.dir.ca.gov/title8/5193.html
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5. Centers for Disease Control and Prevention. Prevention and Control of Influenza with Vaccines—Recommendations of ACIP at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html
6. Centers for Disease Control and Prevention (2011). Immunization of Health-Care Personnel. Recommendations of the Advisory Committee on Immunization Practices (ACIP). Recommendations and Reports. Vol 60; No7. https://www.cdc.gov/mmwr/pdf/rr/rr6007.pdf
7. Centers for Disease Control and Prevention. Recommended Adult Immunization Schedule., United States, 2023. https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf

8. Center for Disease Control (2000). Use of Standing Orders Programs to Increase Adult Vaccination Rates: Recommendations of the ACIP. MMWR 2000/49 (No. RR-01); 15-26. https://www.cdc.gov/mmwr/preview/mmwrhtml/rr4901a2.htm
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11. OSHA Fact Sheet (2011). Hepatitis B Vaccination Protection. https://www.osha.gov/sites/default/files/publications/bbfact05.pdf
12. OSHA, Standard Number 1910.1030 App A - Hepatitis B Vaccine Declination (Mandatory) https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.1030AppA
13. California Department of Public Health (January 2020). Immunization and Immunity Testing Recommendations for California Personnel and Health Science Students. https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/Immunization/HCWIZRecs.pdf

RECORD RETENTION AND DESTRUCTION:
Employee Health Records will be maintained for 30 years after separation.

CROSS REFERENCED POLICIES AND PROCEDURES:
1. Health Care Worker (HCW) Influenza Vaccination
2. Employee Tuberculosis Surveillance Program
3. Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program
4. Bloodborne Pathogen Exposure Control Plan

Supersedes: v.3 Health Care Worker Health Screening and Maintenance Requirements

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Employee Health NIHD Workforce Tuberculosis Surveillance Program		
Owner: Manager Employee Health & Infection Control	Department: Employee Health	
Scope: NIHD		
Date Last Modified: 02/15/2024	Last Review Date: No Review Date	Version: 6
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/1994	

PURPOSE:

1. To protect employees in the workplace as well as the community, through surveillance, to prevent the spread of Mycobacterium Tuberculosis (MTB).
2. To meet regulations of Title XXII, California Division of Occupational Safety and Health Agency (Cal/OSHA), California Department of Public Health (CDPH), and Center for Disease Control and Prevention (CDC) through screening and surveillance standards of practice.

POLICY:

1. The scope of this policy-applies to all Northern Inyo Healthcare District (NIHD) workforce. There are no exceptions.
2. Tuberculosis (TB) Screening is an ongoing process that begins upon hire or contract, and continues throughout the working relationship, with mandatory screening every two years. See attached letter from James A. Richardson, MD. Health Officer Inyo County, dated 8/8/2018.
3. Screening includes a test for TB and a Risk and Symptom Screening Questionnaire.
4. Workers may request screening at any time without a reason. This includes the QuantiFERON-TB Gold plus (QFT) blood test or the Tuberculin Skin Test (TST) and a questionnaire. Their 2 year due date will be adjusted.
5. Annual workforce TB Education is required for everyone and offered by the Employee Health and Infection Prevention Departments.

DEFINITIONS:

1. **Active Tuberculosis (TB) disease (pulmonary):** People with active TB disease in their lungs have symptoms and can spread the disease through coughing and sneezing. Symptoms may include cough lasting more than 3 weeks, night sweats, weight loss, feeling ill, fever, chest pain, coughing up blood.
2. **Bacille Calmette-Guerin (BCG) Vaccine:** BCG is a vaccine to prevent TB disease. It has variable effectiveness. At this time it is not used in the United States, due to low rates of TB, however other countries with high cases of TB often give the vaccine to infants and small children. .
3. **Interferon-gamma release assay (IGRA):** IGRAs are blood tests to measure the T cell immune response to MTB. QFT and T-Spot are current available IGRA tests in the United States.
4. **Latent Tuberculosis Infection (LTBI):** People with latent TB do not have any symptoms and cannot spread TB. If they do not get treatment, however, they may develop active TB disease in the future, spread the disease to others, and feel quite ill. TB screening can detect LTBI.
5. **Mycobacterium Tuberculosis (MTB):** A bacteria that causes Tuberculosis.
6. **QuantiFERON TB Gold Plus (QFT):** A United States Food and Drug Administration (FDA) approved blood test that aids in the detection of Mycobacterium tuberculosis. It is considered more accurate

than Tuberculin Skin Test (TST) and is endorsed by the World Health Organization (WHO), preferred by the Center for Disease Control (CDC), embraced by the United Nations (UN) and International Public Policy Association (IPPA) and among the WHO's 120 essential diagnostic tests. QFT-Plus uses an interferon-gamma release assay (IGRA) to measure the T cell immune response to MTB. Unlike the TST, QFT-Plus is not affected by the BCG vaccination.

7. **Tuberculosis (TB):** An infection caused by a bacteria called Mycobacterium tuberculosis (MTB). This bacteria usually affects the lungs, but it can also affect the kidney, brain, and spine. It is spread by airborne transmission similarly to a cold or flu. Not everyone infected has symptoms. Hence, there are two TB related conditions: Active TB disease and latent TB infection (LTBI). If untreated TB can be fatal.
8. **Tuberculosis Conversion:** A change from negative to positive as indicated by TB test results, based upon current CDC or CDPH guidelines for interpretation of the TB test.
9. **Tuberculosis Screening:** Methods to evaluate active and latent TB include a symptom questionnaire, a risk questionnaire including travel history, immune suppression or close contact with a person with TB as well as a TB test (TST, QFT, or TSpot). Healthcare employers must adhere to screening regulations identified by CalOSHA, Title XXII, CDPH, and the CDC to protect employees in the workplace as well as the community.
10. **Tuberculosis Surveillance:** State and local health departments report cases of TB to the CDC. This collaboration allows the National Tuberculosis Surveillance System (NTSS) to collects information on each newly report case of TB in the United States/monitors and analyzes data on tuberculosis disease, infection and other tuberculosis –like disease. The goal is to reduce tuberculosis cases.
11. **T-Spot:** An FDA approved blood test that helps in the detection of MTB. It is comparable to the TST in the identification of workers with tuberculosis infection and is more specific than the TST for people who have received the BCG vaccine.
12. **Tuberculin Skin Test (TST):** A diagnostic aid to detect infection with mycobacterium tuberculosis. The test has been available for 120 years. The test is done by placing a small amount of TB protein (antigens) under the top layer of the skin. If someone has been exposed to mycobacterium tuberculosis the skin will react with a bump in 2-3 days. Results may be inaccurate if someone has had the BCG Vaccine.

PROCEDURE:

1. QFT is the preferred testing method. Other acceptable test results include a T-Spot or a TST.
2. Workers with TB risk factors or symptoms should inform Employee Health for testing as soon as possible.
    a. Rick Factors Include:
        i. Travel: a temporary or permanent residence of 30 days or more in a country with a high TB rate; any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe.
        ii. Immunocompromised:
            1. Current or planned immunosuppression,
            2. Human Immunodeficiency Virus (HIV) infection,
            3. Organ transplant recipient,
            4. Treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month), or other immunosuppressive medication.
        iii. Close contact with someone who has had infectious TB disease since the last TB test.
    b. Symptoms include any of the following:
        i. Bad cough lasting 3 weeks or more'

ii. Coughing blood or sputum (phlegm from deep inside the lungs)
iii. Shortness of breath
iv. Chest pains
v. Chills
vi. Weakness or fatigue
vii. Unexplained weight loss
viii. Unexplained fevers
ix. Sweating at night

3. **TB testing and live vaccines**
   a. TST or IGRA testing may be completed either on the same day as vaccination with live-virus vaccine or 4-6 weeks after the administration of the live-virus vaccine.
4. **Tuberculin Skin Testing**
   a. Reference Lippincott Procedure: Tuberculin Skin Test.
   b. TST's are placed and read by Employee Health, Infection Prevention, House Supervisor, or Rural Health Clinic (RHC) staff using NIHD TST and Questionnaire Form. *Note: RHC Medical Assistants may place a TB skin test, but not read/interpret them.*
   c. NIHD Employee Health will order a QFT for any induration of 5mm or greater.
5. **All new workforce**
   a. TB screening will take place through Employee Health during the pre-employment onboarding. NIHD provides TB testing for new workforce, to establish a baseline.
   b. NIHD will accept documentation of a QFT or T Spot or TST, and the NIHD TB Risk and Symptom Screening Questionnaire on this timeline:
      i. **Employees of NIHD:** will be tested during the Employee Health onboarding process. Expired tests results for employees returning less than 6 months, must be completed prior to start date.
      ii. **Providers, permanent and locums:** test results are accepted within 90 days of start date, or ordered by Employee Health and scheduled by Medical Staff Office, to be completed on or before start date.
      iii. **Students**: may provide documentation within 12 months of rotation start date. A new Risk Factor, since the test date, will require a repeat current test (i.e. travel for more than 30 days since last test).
      iv. **Contracted workers**: test results are accepted within 90 days of start date
   c. A worker with a history of a positive TB test.
      i. Submit documentation of the positive test and a chest x-ray report dated after the conversion. The x-ray does not need to be repeated unless documentation is lacking, or they are symptomatic, or immunocompromised.
      ii. This worker needs to complete a Risk and Symptom Screening Questionnaire upon hire and annually. No further testing is needed.
      iii. If the worker has not been treated for latent TB, the Employee Health Nurse will educate on latent TB and follow up care. Provider follow up is at the discretion of the worker.
6. **Serial TB Surveillance**
   a. The interval for serial TB testing of all NIHD workforce is at least every two years as indicated by institutional and community risk.
   b. Serial surveillance includes testing with QFT, T Spot, or TST and the completion of an individual TB Risk and Symptom Screening Questionnaire. Employee and department leader will be notified via email within 3 months before the due date.

c. **Failure to comply with mandatory screening will result in the inability to work until evidence of compliance is produced, by having documented that the QFT or T-Spot blood test has been drawn or a TST has been placed with a reading scheduled in 48-72 hours after.**
d. For workers with a positive baseline or workers who later convert to a positive, only an individual TB Risk and Symptom Screening Questionnaire is required **annually**. Answers to yes questions will be reviewed by Employee Health Nurse or Infection Prevention Nurse with the worker to determine if follow up is needed.
e. NIHD workforce may request a TB test at any time, for any reason NIHD Employee Health will order the QFT or provide the TST with the TB Risk and Symptom Screening Questionnaire. The two year due date of the serial surveillance will be reset.
f. Leave of Absence: Employees who are on a leave of absence for any reason when their screening is due, must provide proof of TB screening prior to their return or complete their screening within five days of their return.

7. **TB Conversion**
   a. If a QFT results a new positive, a second QFT will be ordered and drawn.
   b. If a TST results an induration of 5mm or greater, a QFT will be ordered.
   c. If the second test is negative it is no longer considered a conversion if there are no risk factors or symptoms.
   d. If second test is negative and there are risk factors or symptoms, will refer to Medical Director for review, and inform Inyo County Public Health Infection Prevention Registered Nurse.
   e. If the second test result is positive, the Employee Health Nurse will order a R/O TB Chest x-ray (CXR).
   f. The worker will be educated about latent TB the importance of follow-up and treatment. Copies of the two test results, CXR report, and the Risk and Symptom Screening Questionnaire will be provided to the worker to take to their provider.
   g. The Employee Health Nurse will send a completed TB California Confidential Morbidity Report (CMR) to the Inyo County Public Health.
   h. Employee Health will report conversions to Human Resources to be recorded on the OSHA 300 log.
8. **Work Restrictions**
   a. There is no restriction on employment for healthy personnel with a positive skin test and documented negative CXR, with or without treatment.
   b. Workforce personnel receiving treatment for LTBI can return to work immediately. Workers with LTBI who cannot take or do not accept a full course of treatment for LTBI should not be excluded from the workplace.
   c. Individuals with indications of active disease should not work. This will be determined, along with return to work date, by Inyo County Public Health, Human Resources, Employee Health, and NIHD Medical Director.
9. **NIHD TB Exposure**
   a. TB exposure occurs when an unprotected worker is exposed to a confirmed or suspected case of pulmonary, laryngeal, and or pleural TB with a cavitary lesion on chest radiograph, and or positive Acid-Fast Bacilli (AFB) sputum smear or positive Nucleic Acid Amplification Test (NAAT).
   b. TB exposure, duration and intensity, is determined by Inyo County Public Health and NIHD Medical Director.
   c. Workforce personnel with a previous negative TB test result should be tested immediately and re-tested 8-10 weeks after the last known exposure. For consistency, the same type of TB test (e.g., TB blood test or TB skin test) should be used upon hire (i.e., pre-placement) and for any follow up testing.

d. Workforce personnel with a documented history of a positive TB test result do not need to be re-tested after exposure to TB. They should complete the NIHD TB Risk and Symptom Screening Questionnaire and if they have symptoms of TB, should be evaluated for TB disease.
e. Educate the exposed worker to monitor their health for symptoms of TB infection particularly for the first ten days following known exposure and call their primary care and employee health department immediately if they develop any illness signs or symptoms. Most of the signs and symptoms of TB overlap with those of other respiratory illnesses.
f. Employee Health will provide all test results, CXR results and completed questionnaires to the worker with a recommendation to see their primary care physician or NIHD RHC provider for medical evaluation and TB case management.

10. **TB Case Management:** A TB Consultation Service for Medical Providers is available through *UCSF Tuberculosis Warmline*, brochure attached with contact information.
11. **Responsibility of Treatment**
    a. Follow up and treatment of reactors/converters is to be managed by the workers personal physician.
    b. If TB infection occurred as a result of employment at NIHD, with an identified source patient, the worker will contact Human Resources to discuss Workman's Compensation eligibility.
12. **Standing Orders** for NIHD workforce TB lab testing and CXR are stored in the Employee Health Office, signed by the current Medical Director, ordered by the Employee Health Nurse and/or Infection Prevention Nurse per this policy.
13. **Education** will be provided to all NIHD workforce upon hire and annually through the Learning Management System.

REFERENCES:

1. California Code of Regulations, Title 22, Division 5, Chapter 1. 70723 (b) (3) p. 804.1 70723. Employee Health Examinations and Health Records. https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/California-TB-Testing-Regulations.aspx
2. California Tuberculosis Controllers Association. Healthcare Personnel (HCP) TB Screening Resources. https://ctca.org/guidelines/healthcarepersonnel/
3. California Department of Public Health. (8/16/2019). AFL 19-28 Updated Centers for Disease Control Tuberculosis Screening Recommendations for Health Care Personnel and Nationwide Shortage of Tuberculin Skin Test Antigens. https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-19-28.aspx
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6. Cal/OSHA – title 8 Regulation. Section 7(h) Aerosol Transmissible Disease 5199. https://www.dir.ca.gov/titles/5199.html Retrieved 10/4/2023.
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13. Curry International Tuberculosis Center/UCSF Tuberculosis Warmline. 2024. https://www.currytbcenter.ucsf.edu/sites/default/files/2023-06/Warmline%20Brochure_2023_San%20Francisco%20IDC.pdf
14. Sosa LE, Njie GJ, Lobato MN et al. (2019). Tuberculosis Screening, Testing, and Treatment of U.S, Healthcare Personnel: Recommendations from the National Tuberculosis Controllers Association and the CDC. MMWR May 17, 2019; 68(19) 439-443. https://www.cdc.gov/mmwr/volumes/68/wr/mm6819a3.htm
15. Thanassi, W.; Behrman, A.; Reves, R; et al. (2020). Tuberculosis Screening, Testing, and Treatment of US Health Care Personnel: ACOEM and NTCA Joint Task Force on Implementation of the 2019 MMWR Recommendations. Journal of Occupational and Environmental Medicine 62(7):p e355-e369, July 2020. |

RECORD RETENTION AND DESTRUCTION:
Employee Health Records will be maintained for 30 years after separation.

CROSS-REFERENCE POLICIES AND PROCEDURES:
1. Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program Tuberculosis Exposure Control Plan Employee Health NIHD Workforce Onboarding
2. Tuberculosis Exposure Control Plan
3. Lippincott Procedure. Tuberculin Skin Test

Supersedes: v.5 Employee Tuberculosis Surveillance Program

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Infection Control Policy Perinatal		
Owner: PERINATAL NURSE MANAGER	Department: Perinatal	
Scope: Perinatal Services		
Date Last Modified: 08/24/2023	Last Review Date: 08/24/2023	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 12/14/2016	

PURPOSE:
To provide a clean, healthy and safe environment for patients and staff on the Perinatal Unit.

POLICY:
Standard Precautions provide the same high level of precautions for all patients, including newborns.
General Infection Control Policies, stressing the importance of aseptic technique, apply and are followed on the Perinatal Unit.

PROCEDURE:

1. Gowns, gloves and face shields are recommended for Providers at all deliveries. Gloves and face shields are recommended for nursing and respiratory staff at all deliveries.
2. Conditions requiring Contact Precautions (presence of stool incontinence, draining wounds, uncontrolled secretions, RSV), Droplet Precautions (respiratory viruses –influenza, parainfluenza virus, adenovirus), or Airborne Precautions (COVID-19,measles, chicken pox, disseminated herpes zoster) shall be instituted as indicated For suspicion of TB, refer to the Aerosolized Transmissible Disease Plan.
3. The nursery is a restricted area and visitors should be minimized to protect the newborn.
4. Children under the age of 14 are not allowed on the Perinatal Unit. Siblings of the newborn are exempt from this restriction and are allowed and encouraged to visit. All visitors should be screened for infections; any visitor, child or adult, showing signs of illness will be discouraged from visiting.
5. A newborn must be handled with Standard Precautions until its first bath has been performed. Thereafter there is a potential to transmit viruses via oral secretions. If any transmission occurs, the nurse is required to change into clean scrubs.
6. Each baby's supplies and instruments are stocked individually, including twins, who should be treated as individuals.
7. Babies born out of the hospital shall be handled according to Standard Precautions. Institute Transmission-based Precautions if applicable.
8. Barriers indicated under Standard Precautions are adequate for diarrhea or open draining lesions of newborns.
9. Perinatal HCWs (extra staff) may float or be assigned to care for patients on other hospital units; performing hand hygiene and observing Standard Precautions prevents transmission of infections.
10. Patients with a history of or a current multidrug resistant organism follow NIHD Multi-drug Resistant (MDRO) Control Plan.
11. Point of Use instrument cleaning will be performed for all vaginal deliveries following manufactures instructions. .

DOCUMENTATION:
As needed in documenting routine care.

REFERENCES:

1. Guideline for care and cleaning of surgical instruments. In: *Guidelines for Perioperative Practice*. AORN, Denver: CO; 2023:407-446.

Cross-Reference Polices

1. Aerosolized Transmissible Disease Exposure Plan/Respiratory Protection Program
2. Multidrug Resistant Organism (MDRO) Control Plan

Supersedes: N/A

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 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, Chief Human Resources Officer Sierra Bourne, MD, Chief of Staff *(Via Zoom)*
ABSENT	David McCoy Barrett, Treasurer
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

RESOLUTION 24-01, NEW NAMED FIUCIARIES OF PENSION PLAN(S)	Chair Best-Baker called attention to District Board Resolution 24-01, New Named Fiduciaries of Pension Plan(s). Discussion ensued. Alison Partridge recommend we add new executive position Chief Human Resources Officer to the Resolution. Discussion ensued and the Board agreed to approve this resolution with the updated to add new Chief Human Resources positon. **Motion by**: Mary Mae Kilpatrick **Seconded by**: Ted Gardner **Passed 4-0 vote**
PHARMACY / INFUSION PROJECT PRESENTATION	Chair Best-Baker introduced Scott Hooker and called attention to the Pharmacy / Infusion Project Presentation. Scott Hooker introduced Colombo Construction representative Louis

Varga. Discussion ensued, and the Board agreed to approve the request of additional funding for the Pharmacy / Infusion Project.

Motion by: Mary Mae Kilpatrick
Seconded by: Jean Turner
Passed 4-0 vote

GOVERNANCE COMMITTEE (G.C.) REPORT

Chair Melissa Best-Baker called the attention to the Governance Committee (G.C.) report.

Vice Chair Jean Turner reported on behalf of the Governance Committee. Vice Chair Turner expressed her appreciate for all the work from NIHD staff and Board G.C. member David McCoy-Barrett for all the Governance Committee work being done this year. Vice Chair Turner reported the updates and recommendations discussed and approved to bring to the full Board by the Governance Committee. Discussion ensued. Vice Chair Turner concluded that all the recommendation are action items following this report.

BOARD APPROVAL OF AMENDED BYLAWS

Chair Best-Baker called attention to the Bylaws and the recommended updates brought forth by the Governance Committee. Discussion ensued.

Motion by: Mary Mae Kilpatrick
Seconded by: Ted Gardner
Passed 4-0 vote

APPROVAL OF GOVERNANCE COMMITTEE CHARTER & WORKPLAN

Chair Best-Baker called attention to the G.C. Charter and Workplan. Discussion ensued.

Motion by: Ted Gardner
Seconded by: Mary Mae Kilpatrick
Passed 4-0 vote

APPROVAL OF BOARD CALEDNAR OF TIME SENSITIVE BUSINESS

Chair Best-Baker called attention to the updated Calendar of Time Sensitive Business. Discussion ensued.

Motion by: Ted Gardner
Seconded by: Mary Mae Kilpatrick
Passed 4-0 vote

REVIEW OF BOARD'S CODE OF CONDUCT

Chair Best-Baker called attention to the Board's Code of Conduct for its annual review. The Board did not have any comments or updates.

Motion by: Ted Gardner
Seconded by: Mary Mae Kilpatrick
Passed 4-0 vote

CHIEF EXECUTIVE OFFICER REPORT

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

- Brown Act Handbook – Information item for the Board on Brown

Act updates.

- Strategic Planning – Mr. DelRossi reported that he is planning a Special Board meeting for Strategic Planning in March, and our executive team is currently meeting weekly to prepare.
- Expanded Cardiology – Mr. DelRossi reported that we continue to work with Dr. Rowan to offer expanded services to match our community demand. Dr. Rowan is now offering insertion of Loop Recorder devices through PACU/Infusion. Dr. Rowan will provide a healthy lifestyle talk at the end of February and will also go over what cardiac services are being offered at NIHD.
- Neurosurgeon – Mr. DelRossi reported that we are currently in negotiations with a Neurosurgeon who is fellowship trained in skull base and spine therapies and surgery. He will be starting as a clinic provider, but plans to expand services to include minimally invasive outpatient surgeries in the future.

CHIEF FINANCIAL OFFICER REPORT

Chair Best-Baker introduced the Chief Financial Officer report.

- Financial & Statistical Reports:
    - Andrea Mossman presented the financial & statistical report. Discussion ensued.

Motion by: Jean Turner
Seconded by: Ted Gardner
Passed 4-0 vote

- New CFO - Mr. DelRossi reported that the new CFO's start date was pushed to April
- Financial Audit – Mr. DelRossi reported that the Audit should be completed the end of February and will provide an update at the regular March Board meeting.

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. Credentialing – da Vinci Robotic Surgery
2. Newborn Blood Glucose Monitoring
3. Nitrous Oxide Use in the Intrapartum / Immediate Postpartum Period
4. Nursing Care of the Laboring Patient Receiving Regional Analgesia
5. Standards of Patient Care in the Perinatal Unit

Discussion ensued.

Motion by: Jean Turner
Seconded by: Mary Mae Kilpatrick
Passed 4-0 vote

MEDICAL STAFF APPOINTMENTS 2024-2025

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

1. Naomi Lawrence – Reid, MD (pediatrics) – Courtesy Staff
2. Rachel Chamberlain, DO (OB/GYN) – Active Staff

ADDITIONAL PRIVILEGES

Dr. Sierra Bourne brought attention to the additional privilege:

1. Christopher Rowan, MD (Cardiology) – request for privileges to perform loop recorder insertions.

CARDIOLOGY PRIVILEGE FORM UPDATE

Dr. Sierra Bourne presented the updated form:

1. Addition of Invasive Cardiology Privilege Cluster

Motion by: Jean Turner to approve agenda items b., c., and d. under the Chief of Staff report as presented.
Seconded by: Mary Mae Kilpatrick
Passed 4-0 vote

MEDICAL EXECUTIVE COMMITTEE REPORT

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

Discussion ensued.

CONSENT AGENDA

Chair Kilpatrick called attention to the consent agenda that contained the following items.

- *January 17, 2024 Regular Board Meeting Minutes*
- *January 31, 2024 Special Board Meeting Minutes*
- *COO/CNO Report*
- *Annual Compliance Report*
- *Department Reports*
- *CEO Credit Card Statements*
- *Approval of Policies and Procedures:*
  - *Workforce Social Media*
  - *340B Hospital / Outpatient Clinic Administered Drugs Policy and Procedure*
  - *Medical Staff Department Policy – Anesthesia*
  - *Billing and Collections*
  - *Teleconference Recordings, Retention and Destruction of Board Meetings*

Discussion ensued.

Motion by: Jean Turner
Seconded by: Ted Gardner

	Passed 4-0 vote
GENERAL INFORMATION FROM BOARD MEMBERS	Chair Kilpatrick called for information from Board Members. Discussion ensued.
ADJOURNMENT	Adjournment at 06:59 p.m.

____
Melissa Best-Baker, Northern Inyo Healthcare District, Chair

Attest: ____________________________________
Ted Gardner, Northern Inyo Healthcare District, Secretary

Northern Inyo Healthcare District
www.nih.org

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

Date: 03/08/2024
To: Board of Directors
From: J. Adam Hawkins, DO Chief Medical Officer
Re: Bi-Monthly CMO report

Medical Staff Department update

Project Updates:

- Women's Health:
    - As access to reliable women's healthcare, both regionally and nationally, continues to dwindle I am very proud to be a part of a team who is not only interested in maintaining our program, but actively engaged in projects that will allow for growth. According to a recent Becker's Healthcare article, between 2011 and 2021, 267 rural hospitals nationwide have dropped obstetrics services, representing nearly a quarter of America's rural obstetric units. Supporting our Women's Health program is an operational and moral imperative for our entire executive team. Here are a few updates:
        - We will provide our first Saturday Women's clinic on March 9th, 2024. This will allow working patient's access to care that they otherwise would not be able to accommodate with their schedules. It will also allow women from outside of the Bishop area to commit the necessary time to drive up to Bishop to see our providers.
        - We welcomed a new OB/GYN to the department at the beginning of this month, Dr. Rachael Chamberlain. Being able to attract skilled and compassionate providers to our Women's Health department is a pivotal aspect of ensuring this departments success. We are very pleased to welcome Dr. Chamberlain to our team!
        - The Women's Health providers and the NIHD leadership teams continue to engage our regional partners to ensure the women of the Eastern Sierra have access to the care they deserve. We are in continued dialogue with our partners at Mammoth Hospital, Southern Inyo Healthcare District, and Ridgecrest Regional Hospital to see how we can extend care to their women in need while still caring for our patient's locally.
- Oncology / City of Hope
    - NIHD partners with City of Hope and their Lancaster team to allow our patient's to receive their chemotherapy infusions locally. To once again highlight the headwinds rural hospitals in America face, Becker's Healthcare reported that between 2014 and 2022, 382 rural hospitals stopped providing chemotherapy services. Many of these treatments require frequent infusions and can leave patient's feeling extremely fatigued and ill. As you can imagine, having to undergo such a trying experience while

commuting many hours to Southern California would be a monumental hardship for our patients. That is why we prioritize our relationship with our oncology partners at City of Hope. We were fortunate enough to host many members of their team, including their Medical Director of Oncology, on our campus March 8th. We have a great relationship and continue to engage in frequent meetings to keep the program up and running for our patient's.

- Cardiology:
    - We have added clinic days to Dr. Rowan's schedule which has reduced patient wait times to 4 – 5 weeks. This is a striking improvement to the long wait times we were facing in my last report. This is a testament to the hard work of our clinic leadership, patient access employees, and Dr. Rowan's commitment to providing reliable cardiology services to the patients of our community.
    - Dr. Rowan provided an excellent and comprehensive Healthy Lifestyles Talk (https://www.youtube.com/watch?v=nEpXqFFkiLk) this past month. If you did not get a chance to attend the talk I encourage you to watch the recording at the link posted above!
    - Echocardiography Program: As I mentioned in my last report, 2023 was the single busiest year in our programs history. 2024 started strong. January and February recorded some of the highest volume months in the history of our program! I want to reiterate how fortunate NIHD is to have skilled echo sonographers that set the standard for excellence in the Eastern Sierra. We anticipate ongoing, thoughtful growth in this department.
    - Our Loop Recorder program is live! Dr. Rowan implanted NIHD's first ever loop recorder this quarter.
    - Pacemaker clinic: The first pacemaker clinic will be held March 22nd! This is a fantastic service that will allow patient's with pacemakers in our community to be able to stay in our community for chronic maintenance of their implanted device.
- Plastic Surgery
    - The virtual component of Dr. Plank's practice has been a success and a win for our patient's. We continue to assess the community need for Plastic Surgery and Dermatology services and are hopeful for ongoing expanded clinic availability in the near future.

Physician Recruitment update:

- Anesthesia: Dr. Ted Rasoumoff and his newly formed physician group has assumed responsibility for staffing our anesthesia department. We are already experiencing a more stabilize and financially sustainable staffing model. Dr. Rasoumoff has been an amazing partner and has already recruited a few new providers who are considering providing NIHD with full-time anesthesia coverage. I look forward to providing continued good news in the near future.

Quality Department update

- The Quality Department continue to work on finalizing QIP data for reporting year 2023 (Performance Year 6). As of now 6 out of 12 measures' data has been validated with several measures over-reaching targets! We are confident that we will be able to successfully report on the maximum 12 measures, although validation continues before we are able to submit. There is a dashboard on the Intranet with our most up to date data.
- We have attested to the maximum number of metrics to report on for QIP in 2024 (Performance Year 7). Improvement projects are ongoing in the clinics and other areas. Particularly we continue work to improve performance on cervical cancer screening and depression screening.
- New workflows have been rolled out in our inpatient departments to capture newly required information on Social Determinants of Health.

Dietary Department

- We recently hired a new per diem dietician who will provide this department with needed operational flexibility. Our full-time dietician, Kalina Gardner and our long-term partner and per diem dietician, Denice Hynd have gone above and beyond for the past year to make sure that this department is always staffed. I am very excited to be able to offer them additional support.

Rehab Department

- The Rehabilitation Department completed its official move from the old mobile clinic to their new space in the Pioneer Building. NIHD held an Open House last month which was well attended by patients, partnering local healthcare leadership such as Toiyabe's CEO and COO, as well as many of our providers and community members. Most importantly, this move was completed without any appointments having to be cancelled. This is thanks to dedicated work from our Rehab team, facilities team, IT, and infection control.
- Physical Therapy: We continue to be fully staffed. We also just hired a new full-time PT who will be relocating to Bishop!
- Occupational Therapy: One of our local, full-time therapists, Monica Jones, submitted a research paper to a scholarly journal, Occupational Therapy in Mental Health, highlighting her clinical work providing cognitive behavioral therapy. We are very proud of Monica and are very fortunate to have her providing care to our patients.

Reference:
https://www.beckershospitalreview.com/finance/50-of-rural-hospitals-are-operating-in-the-red-7-things-to-know.html?origin=CFOE&utm_source=CFOE&utm_medium=email&utm_content=newsletter&oly_enc_id=7365B1063234D5L

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

150 Pioneer Lane
Bishop, California 93514

(760) 873-5811

DATE: March 2024

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Jannalyn Lawrence, Outpatient Clinics

RE: Department Update

REPORT DETAIL

NEW BUSINESS

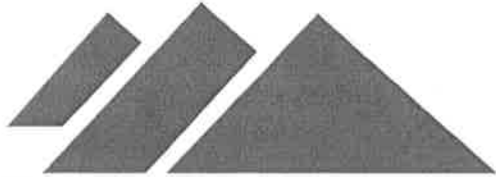
1. Continued expansion of Specialty Services: Anticipating the arrival of Dr. Hanna and Dr. Thunder in the next couple of months.

2. Women's Clinic continues to see increased volume with recent closure of Ridgecrest L&D. Our schedules have been full and we are adding Saturday clinic starting 3/9. This will allow an opportunity for patients to receive prenatal care outside the workweek, hopefully lessening the burden for moms who work Monday-Friday and/or have to travel significant distance for appointments. We will be hiring a second Certified Nurse Midwife to help handle clinic volume and provide support up on the labor and delivery unit.

3. In an effort to expand access to primary care and contribute to the reduction of the District's financial burden, we are making some operational changes to RHC provider schedules. The primary care providers will soon work consistent hours 8am-5pm, and their templates will be adjusted to accommodate additional appointments. These changes are part of a collaborative effort between providers and leadership, and we anticipate the impact on our community will be positive.

OLD BUSINESS

None



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

150 Pioneer Lane
Bishop, CA 93514

(760) 873-5811

DATE: March 2024

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Greg Bissonette, Foundation Executive Director/Grant Writer

RE: Department Update

REPORT DETAIL

FOUNDATION

The Foundation went dark for the month of January as there was no new business to address. February's meeting saw the Foundation donate $130 to the District for CAREshuttle repairs. There was no other action taken by the board at this meeting.

GRANT WRITING

Multiple grants were submitted during January and February. The SHIP grant was submitted to cover some of the costs associated with UASI's physician/provider documentation audit. The CARE grant was also submitted to help offset some of the RSM consulting fees associated with the daily charge reconciliation project. The SHIP grant will be around $12,000 and the CARE grant is for $15,000. The CARE program was also offering a conference stipend for $1,500 and that is supporting the Quality Team to attend the i2i conference. i2i is a quality reporting software platform the District uses, in conjunction with Cerner, to pull specific quality data for the State QIP program.

150 Pioneer Lane
Bishop, California 93514
(760) 873-5811 Ext. 3415

DATE: March 2024

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Barbara Laughon, Manager, *Marketing, Communications, & Strategy*

RE: Department Update

REPORT DETAIL

COMMUNITY OUTREACH

Community events: Participating in upcoming events including National Nutrition Month with the County of Inyo (3/14); ESCA Blue Ribbon Walk & Run (3/16); Bronco Pride Night at BUHS (4/23); SIHD's Health and Community Fair (5/4); and potentially Toiyabe's Cancer Survivorship event in June. Also working on a memorial plaque for the late Dr. John Ungersma.

Healthy Lifestyle Talks: Cardiology talk held Feb. 22, with Dr. Christopher Rowan, hosted by CMO Dr. Adam Hawkins. Video available on NIHD YouTube Channel. March spotlights Colorectal Cancer Awareness with Drs. Robbin Cromer-Tyler and Connor Wiles on March 28, 5:30 p.m. via Zoom. Working on an in-person skin care series with Dr. Stacey Brown and on gut biome Zoom session with Kalina Gardiner, RDN, and Elizabeth Haun, FNP-BC. Thanks to Dr. Hawkins for ongoing support.

Podcast: Elizabeth Haun recorded sessions on diabetes and menopause. Dr. Clayton Davis has committed; recording date TBD. Future segments to cover hospitalist program, new neurosurgeons, and segments on behavioral health.

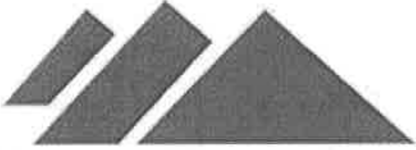
MARKETING

Social Media & Digital Ads: Increased content on LinkedIn, resulting in significant growth in impressions (up by 160%) and interactions (up by 101%). Engagement rate stable at 6.29%, attracting decision-makers and experienced professionals. In Digital Ads, NIHD reached 15,240 people with a click-through rate of 2.58%. Focused reach areas around Bishop, including Ridgecrest and Tonopah, with an uptick in Ridgecrest numbers but not as much with Tonopah. Will review and adjust as needed.

Ridgecrest: Spotlighted OB team in *The Daily Independent* with large ad March 1, 8 and 22.

COMMUNICATIONS

Internal: Employee Town Halls: Thursdays, March 28 and April 25, 8:30 a.m. via Zoom.
External: Community Town Hall scheduled for Thursday, April 25, 5:30 p.m. via Zoom webinar.



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

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

DATE: March 2024

TO: Board of Directors
Northern Inyo Healthcare District

FROM: CEO Board Report
Tanya De Leo, Patient Access

RE: Department Update

REPORT DETAIL

NEW BUSINESS

Auth & Referral will be adding 3 additional team members due to the increase in referrals being submitted by providers and with the additional addition of providers to the district. The 3 additional team members will be stationed in specific clinics, which will allow for more efficient and timely processing.

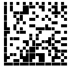
Patient access will be looking at adding additional team members in areas of high volume patient check-in, we will be reviewing areas.

OLD BUSINESS

None

March 2024 Statement
Open Date: 02/06/2024 Closing Date: 03/05/2024

Account:



U.S. Bank Business Platinum Card
NORTHERN INYO HOSPITA STEPHEN DELROSSI

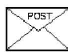
Cardmember Service 1-866-485-4545

New Balance	**$736.42**
Minimum Payment Due	**$10.00**
Payment Due Date	**04/01/2024**

Activity Summary

Previous Balance	+	$3,187.71
Payments	-	$3,187.71CR
Other Credits		$0.00
Purchases	+	$736.42
Balance Transfers		$0.00
Advances		$0.00
Other Debits		$0.00
Fees Charged		$0.00
Interest Charged		$0.00
New Balance	=	**$736.42**
Past Due		**$0.00**
Minimum Payment Due		**$10.00**
Credit Line		$37,500.00
Available Credit		$36,763.58
Days in Billing Period		29

Payment Options:



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Pay at your local U.S. Bank branch

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

24-Hour Cardmember Service: 1-866-485-4545

. to pay by phone
. to change your address

Account Number	
Payment Due Date	4/01/2024
New Balance	$736.42
Minimum Payment Due	$10.00

Amount Enclosed $________________

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

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

NORTHERN INYO HOSPITA STEPHEN DELROSSI

Cardmember Service 1-866-485-4545

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.

Transactions

Payments and Other Credits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
02/21	02/21	ET	PAYMENT THANK YOU	$3,187.71CR	
			TOTAL THIS PERIOD	**$3,187.71CR**	

Purchases and Other Debits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
02/22	02/21	0669	CHA CAHHS Registration - Finance & Reimbursement	$295.00	
02/26	02/25	0190	AMZN Mktp US*RW1XA32L2 Amzn.com/bill WA Hospital Week	$32.60	
02/27	02/27	9064	WF WAYFAIR2763424877 MA Administration Support	$24.55	
03/01	02/29	7074	FACEBK 4PS2S28KU2 CA Advertisement	$384.27	
			TOTAL THIS PERIOD	**$736.42**	

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: ______________

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	$736.42	$0.00	YES	$0.00	24.24%	
**ADVANCES	$0.00	$0.00	YES	$0.00	29.99%	

Continued on Next Page

NORTHERN INYO HOSPITA STEPHEN DELROSSI

Cardmember Service 1-866-485-4545

Contact Us

Phone	Questions	Mail payment coupon with a check	Online
Voice: 1-866-485-4545 TDD: 1-888-352-6455 Fax: 1-866-807-9053	Cardmember Service P.O. Box 6353 Fargo, ND 58125-6353	U.S. Bank P.O. Box 790408 St. Louis, MO 63179-0408	usbank.com

End of Statement

NORTHERN INYO HOSPITA

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Scan the above QR code with your phones camera.

Or log in to usbank.com to get started.

*Required information includes legal name, date of birth and Social Security number for each employee you would like to add to your account. Additional employee card fees may apply. Please refer to your Cardmember Agreement for details.

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Practitioner Re-Entry Policy		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Medical Staff Privileged Practitioners		
Date Last Modified: 12/17/2021	Last Review Date: 02/16/2024	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/18/2020	

PURPOSE:
To enable a practitioner, under certain circumstances, to return to clinical practice after an extended period of clinical inactivity while ensuring the high standard of patient care expected at Northern Inyo Healthcare District (NIHD).

DEFINITIONS:
1. **Full Re-entry:** Defined by the American Medical Association as "return to clinical practice for which one has been trained, certified or licensed after an extended period of clinical inactivity not resulting from discipline or impairment". For the purposes of this policy an extended period is further defined as greater than or equal to 2 years and no more than 5 years.
2. **Partial Re-entry:** Process of resuming a portion of clinical practice for which an actively practicing clinical practitioner has been previously trained, certified or licensed but is not currently able to qualify for privileges due to inactivity in that area of practice.

POLICY FOR FULL RE-ENTRY:
1. To qualify for full re-entry, the applicant must meet the following requirements:
    a. Meet the definition of full re-entry above.
    b. Abide by state medical board re-entry rules or recommendations, if any.
    c. Abide by any re-entry policy of the relevant specialty board(s), if any.
    d. Abide by malpractice insurance policy for practitioner re-entry, if any.
    e. Have evidence of recent continuing medical education in accordance with current medical staff standards.
    f. Be board certified.
    g. Meet all other qualifications for credentialing as per the medical staff bylaws.
2. A potential applicant who has been out of clinical practice for more than 5 years will not qualify for re-entry but may apply for medical staff membership after completion of a full standardized re-entry program or an equivalent program adequate to prove current competency.
3. The full re-entry plan requirements are as follows:
    a. Re-entry plan may include a full standardized re-entry program, re-entry evaluation with a standardized re-entry program, specific skills proctoring at a teaching facility or other appropriate facility (e.g. robotic surgery, Neonatal Intensive Care Unit (NICU) for neonatal care, high volume of deliveries to resume obstetrical privileges, etc.) shadowing/proctoring within our organization, or an appropriate combination thereof at the discretion of the relevant department and/or credentialing committee.

b. The re-entry plan will identify a mentor to oversee the re-entry process. The mentor must have sufficient time and experience and be a member of the medical staff in good standing.
c. The re-entry plan will include a Focused Practice Performance Evaluation (FPPE) for documentation of the re-entry process completed by the identified mentor. The FPPE plan will be individualized to each applicant, but will be no less than the minimum requirements for initial FPPE plans normally used by the department.
d. The re-entry plan will be agreed upon by the applicant, the relevant department(s) and the credentialing committee.
e. The length and scope of the re-entry plan will account for the type of practice/procedures privileges requested, previous level of training/experience, Maintenance of Certification (MOC) status, and any relevant interim activities. The expected length and scope of the re-entry plan will be included in the initial plan but may be extended by the applicant or the department upon recommendation of the mentor if more time is deemed necessary to show competency.
f. Any practitioner who practices in a field in which the volume of patients at NIHD makes re-entry proctoring impractical to complete within a reasonable amount of time will be required to complete a full standardized re-entry program or an equivalent program at the discretion of the relevant department and/or credentialing committee.

POLICY FOR PARTIAL RE-ENTRY:

1. A practitioner who is currently in clinical practice but unable to prove current competency/recent experience for some portion of core privileges may be eligible for a partial re-entry plan.
2. The partial re-entry plan requirements are as follows:
    a. A partial re-entry plan may include specific skills proctoring at a teaching facility or other appropriate facility (e.g. robotic surgery, NICU for neonatal care, high volume of deliveries to resume OB privileges, etc.) shadowing/proctoring within our organization or an appropriate combination thereof at the discretion of the relevant department and/or credentialing committee.
    b. The partial re-entry plan will be agreed upon by the applicant, the relevant department(s) and the credentialing committee.
    c. The length and scope of the partial re-entry plan will account for the type of practice/procedures privileges requested, previous level of training/experience, MOC status, and any relevant interim activities.
    d. The partial re-entry plan will identify a mentor to oversee the re-entry process. The mentor must have sufficient time and experience and be a member of the medical staff in good standing.
    e. The partial re-entry plan will include a FPPE for documentation of the re-entry process completed by the identified mentor.
    f. Once the agreed upon partial reentry plan has been completed the practitioner may be released from FPPE for the appropriate additional clinical privileges.

PROCEDURE:

1. A practitioner who qualifies for full or partial re-entry as stated above may complete an application for medical staff or Advanced Practice Provider staff membership with the medical staff office as per the NIHD bylaws.
2. Once the application is otherwise complete, a re-entry plan will be required in lieu of current competencies/recent experience. An example re-entry plan is included in Attachment 1.

3. The re-entry plan must be agreed upon by the applicant, the relevant department(s) and the credentialing committee before the application process can proceed. NIHD medical staff will attempt to complete this process in a timely manner.
4. If a re-entry plan cannot be agreed upon, the application will be deemed incomplete and can be withdrawn without penalty.
5. The re-entering practitioner will be responsible for any cost incurred from the re-entry plan unless otherwise agreed upon by NIHD administration/ board at the recommendation of the department and or credentialing committee.
6. Once a re-entry plan is agreed upon the application process can proceed as per current bylaws.

REFERENCES:

1. American Medical Association. Resources for physicians returning to clinical practice. https://www.ama-assn.org/practice-management/career-development/resources-physicians-returning-clinical-practice
2. Community Memorial Health System. "Medical Staff Re-entry Plan." Policy and procedure. Revised 10/4/2016.
3. National Association of Medical Staff Services. "Back in the Saddle Again: Credentialing Conundrums Surrounding the Reentry Physician." Educational Conference and Exhibition. 9/20/2016.
4. State Medical Licensure Requirements and Statistics. "Physician Re-entry." 2013.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

CROSS REFERENCED POLICIES AND PROCEDURES:

1. N/A

Supersedes: v.1 Practitioner Re-Entry Policy

ATTACHMENT 1

SAMPLE RE-ENTRY TO PRACTICE PLAN

Name: ____

Clinical Experience:

Specialty: ____

Time Spent in Clinical Practice: ____

Date and Location of Last Clinical Practice: ____________________________________

Reason for Leaving Clinical Practice: ____

Intended Clinical Practice:

Intended Practice Setting and Location: _______________________________________

Special Privileges requested: ____

Description of How I Maintained Competency After Leaving Clinical Practice

____

____

____

____

____

____

Maintenance of Certificate status: ____

Applicable Medical Board status including most recent test date: _____________________

Continuing Medical Education within last 2 years: __________________________________

Plan for Obtaining Re-entry Education and Clinical Competency

Refresher Course(s)/ Mini-Residency Offered by a Medical School or Other Formal Program:

____

Mentorship/Preceptorship:

Name/Medical Specialty of Mentor/Preceptor: ____

Number of Work Days/Hours per Week: ____

Total hours of patient care expected: ____

Total number of procedures expected (if applicable): __________________________________

Method of Direct Supervision and Review of Clinical Care: (e.g. The mentor shall participate in the care of each patient to the degree necessary to be personally responsible for the care rendered, to be able to certify to the quality of such care, and to provide prompt meaningful feedback and guidance)____

____

____

____

____

Frequency of Written Reports to Department/Credentialing committee: ________________

Content of Written Reports to the Department/Credentialing committee: (e.g. Practice activities, hours, workload, functioning, knowledge, skills, general professionalism, any deficiencies, and overall ability to practice safely and competently. Minimum must be equivalent to department FPPE standard):

____

____

____

____

Signatures: ______________________________________ (applicant)

______________________________________ (department chair(s))

______________________________________ (credentials committee)

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Medical Staff Department Policy - Radiology		
Owner: MEDICAL STAFF DIRECTOR	Department: Medical Staff	
Scope: Physicians Privileged in Radiology		
Date Last Modified: 02/23/2024	Last Review Date: 02/21/2024	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/16/2022	

PURPOSE: To delineate clear expectations for physicians in the Department of Radiology within Northern Inyo Healthcare District (NIHD).

POLICY: All physicians (radiologists) granted privileges in the Department of Radiology will adhere to the following procedures.

PROCEDURE:

1. Patient Care Responsibilities
   a. Patient care services, including call, on-site hours, and procedures are to be provided in accordance with the applicable contract(s) for services.
2. Documentation:
   a. Radiology reports will be completed timely as further outlined in the *DI – Timely Performance Standards – Hospital Based Patients* policy.
   b. The radiologist, or radiologist's designee, shall communicate critical results to the ordering provider within 1 hour of determining the results of the test as per the *DI – Timeliness for Critical Results* policy.
   c. Informed consent is to be obtained by the physician and properly documented for applicable procedures as described in the *Informed Consent – Practitioner's Responsibility* policy.
   d. Verbal and/or phone orders are to be authenticated within 48 hours as per the *Verbal and/or Phone Medical Staff Practitioner Orders* policy.
3. Credentialing:
   a. Physicians in the Department of Radiology must be board certified or board eligible by the American Board of Radiology.
   b. Radiologists applying for privileges in breast imaging must meeting Mammography Quality Standards Act (MQSA) requirements.
4. Meeting Attendance:
   a. Radiologists are to attend meetings of the Medical Staff per Medical Staff Bylaws requirements.
5. Focused Professional Practice Evaluation (FPPE):
   a. Radiologists new to NIHD will be expected to complete FPPE as per policy and as recommended at the time of privileging.
6. Ongoing Professional Practice Evaluation (OPPE):
   a. Practitioners will be expected to participate in all requirements of OPPE as per Medical Staff policy.

7. Peer Review:

  a. Five percent of interpretations will be randomly selected for peer review on an ongoing basis.
  b. All charts identified by critical indicators will be peer reviewed by the Chief of Radiology or designee. Critical indicator lists are reviewed by the Department of Radiology on an annual basis.
  c. Selected cases will be reviewed at the Radiology Services committee at its next scheduled meeting. Records are confidential and will be kept by the Medical Staff Office.
8. Re-Entry:
  a. Applicants to the Department of Radiology may be eligible for Re-entry as per policy.

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. DI - Timely Performance Standards
3. DI Timeliness for Critical Results*
4. Informed Consent Policy - Practitioner's Responsibility
5. Verbal and/or Phone Medical Staff Practitioner Orders
6. Focused and Ongoing Professional Practice Evaluation
7. Practitioner Re-Entry Policy

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY

Title: Password Policy		
Owner: ITS Director - CISO	Department: Information Technology	
Scope: District Wide		
Date Last Modified: 09/22/2022	Last Review Date: 02/22/2024	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/01/2004	

PURPOSE:
Passwords are an important aspect of computer security. They are the front line of protection for user accounts. A poorly chosen password may result in the compromise of NIHD's entire network. As such, all NIHD workforce members including but not limited to- employees, members of the Board of Directors, contractors and vendors with access to NIHD systems are responsible for taking the appropriate steps, as outlined below, to select and secure their passwords.

The purpose of this policy is as follows:

1. To establish a standard for creation of strong passwords
2. To establish a standard for the protection of those passwords
3. To establish a standard for the frequency of change of those passwords.

POLICY:

1. All passwords must be changed every 60 days.
2. Password history will remember the last 24 passwords that cannot be reused.
3. Accounts will be locked out after 8 failed attempts to prevent password spraying attempts.
4. Passwords must not be inserted into email messages or other forms of electronic communication.
5. All user-level and system-level passwords must conform to the guidelines described below.
   a. Password must contain a minimum of 12 characters and maximum of 15 characters
   b. Passwords must contain a combination of capital and lowercase letters, numbers and symbols
   c. Passwords should not contain easily recognizable words (i.e. Bishop, Inyo, NIH)
   d. ***Password exception for DMS***– Passwords can **only** contain capital or lowercase and not in combination. Example – "TgAgm487&" the password would have to be "tgagm4878&" or" TGAGM4878&"
6. Passwords are not to be shared with anyone, including administrative assistants.
7. If a password is suspected to have been compromised, report the incident immediately to the Information Technology Services Department or the District Information Security Officer.
8. NIHD workforce members cannot use the same password for NIHD accounts as they use for other non-NIHD access (e.g., personal ISP account, shopping sites, benefits, etc.).
   a.) If an employee's NIHD account(s) is compromised the ITS department will then investigate the public password breaches to verify that an employee's password(s) are not in the public domain.
   b.) During an investigation of a security breach an employee may be asked - do you use the same password for any other accounts whether private or public?

9. NIHD workforce members cannot use the "Remember Password" feature of applications (e.g., Internet, Outlook OWA, etc.).

REFERENCES:

1. HIPAA Security - Security Awareness and Training Standard 164.308(a)(5)(ii)(D)
   NIST SP: 800-118, 800-12, 800-82 Rev 2, 800-53 Rev 4, 800-63-2, 800-66 4.5.3
2. The Joint Commission (CAMCAH Manual) Jan. 2022; Standard IM.02.01.03 EP 1.

RECORD RETENTION AND DESTRUCTION: N/A

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Computer Screen Lock Policy
2. Information Security and Data Integrity
3. Confidentiality
4. Computer Screen Lock Policy

Supersedes: v.3 Password Policy