Northern Inyo Healthcare District

Board Meetings

October 16, 2024 Regular Board of Directors Meeting

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

AGENDA
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING

October 16, 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 meets 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.

Board Member David McCoy Barrett will attend from 61 Yorkville Ave, Toronto, ON MSR 3V6 Canada via Zoom.

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1. Call to Order at 5:30 p.m.
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 comments 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. COO/CNO Report – *(information item)*
    b. Chief Executive Officer Report *(Board will receive this report)*

i. Strategic Plan
ii. CHRO and CFO updates
iii. Update on conferences and public appearances
iv. Lunch and learn training

c. Chief Financial Officer Report
   i. Financial & Statistical Reports (*Board will consider the approval of these reports)*
   ii. Recruitment for new revenue cycle director
   iii. Preparation for audit and cost update

d. Chief of Staff Reports, Sierra Bourne MD
   i. Medical Staff Appointments 2024-2025 (*action item*)
      1. Sharita Nagaraj, MD (general surgery) – Courtesy Staff
      2. William Pace, MD (interventional radiology) – Courtesy Staff
      3. Jonathan Hester, MD (breast imaging) – Courtesy Staff
      4. Thomas Powierza, MD (interventional radiology/neuroradiology) – Courtesy Staff
   ii. Medical Staff Appointments 2024-2025 – Proxy Credentialing (*action item*)
      1. *As per the approved credentialing and privileging agreements, and as outlined by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon the Distant-Site entity's credentialing and privileging decisions.*
      2. Jeremiah Bell, MD (neurology) – Telemedicine Staff (Sevaro)
      3. Mark Faltaous, MD (diagnostic radiology) – Telemedicine Staff (Direct Radiology)
      4. Rashmi Hande, MD (diagnostic radiology) – Telemedicine Staff (Direct Radiology)
      5. Noman Malik, MD (diagnostic radiology) – Telemedicine Staff (Direct Radiology)
   iii. Medical Executive Committee Meeting Report (*information item*)

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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 September 18, 2024 Regular Board Meeting
b. CEO Credit Card Statements
c. GASB 67 and 68 Disclosure – Northern Inyo County Local Hospital District Retirement Plan
d. Approval of Policies and Procedures
    i. Aveed™ (testosterone undecanoate) Risk Evaluations and Mitigation Strategies (REMS) program
    ii. Bloodborne Pathogen Exposure Control Plan
    iii. Credentialing Healthcare Practitioners in the Event of a Disaster *(no changes made)*
    iv. Discharge Instructions Emergency Department
    v. Evaluation of Pregnant Patients in the Emergency Department
    vi. Medical Staff Department Policy – Radiology
    vii. Medical Staff Professional Conduct Policy *(no changes made)*
    viii. Pediatric and Newborn Consultation Requirements *(no changes made)*
    ix. Safely Surrendered Baby Policy and Procedure
    x. Sublocade™ (Buprenorphine): Risk Evaluation and Mitigation Strategies (REMS) Program
    xi. Utility Systems Electrical and Generator Failure
    xii. Utility Systems Inventory
    xiii. Utility Systems Pneumatic Tube Failure

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5. General Information from Board Members (*Board will provide this information)*
6. Public comments on closed session items
7. Adjournment to closed session to/for:
    a. Public Employee Performance Evaluation pursuant to Government Code Section 54957(b)(1). Title: CEO Evaluation
    b. Conference with Legal Counsel – Communication from potential plaintiff threatening litigation GOV § 54956.9 (d)(2). John Brown v. Dr. Thomas K. Reid, MD, and Northern Inyo Healthcare District
8. Return to open session and report on any actions taken in closed session
9. Adjournment

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact the administration at (760) 873-2838 at least 24 hours prior to the meeting.

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

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

DATE: October 2024
TO: Board of Directors, Northern Inyo Healthcare District
FROM: Allison Partridge COO-CNO
RE: District Updates

REPORT DETAIL

The Department Leaders have contributed to this report with an overview of the ongoing work in their areas of oversight.

District-Wide Capital Project Update

Projects in the planning phase

- Flooring replacement will occur in the following areas: Pediatric Clinic, RHC Women's Clinic, Specialty Clinic, and Respiratory Therapy.
- Permanent parking at the old Rehab building site will be installed.

Acute/Subacute and ICU Updates

- The Acute/Subacute Unit currently has three open CNA positions. All other positions in the Acute/Subacute Unit are currently filled.
- We have one ICU RN position open.
- We are updating our Heparin protocol to simplify the format and ensure it is clear and easy to follow.
- We have implemented new SCD pumps through our GPO. These new pumps provide a high-quality product that yields cost savings for the District.
- The Acute/Subacute Unit has implemented Pediatric Rounds. This process involves an interdisciplinary rounding process with our Pediatricians. The rounds occur at the patient's bedside and ensure all team members, patients, and families are apprised and aligned with the care plan.

- Focused work was completed to update our referral workflow to ensure that inpatients with outpatient referrals have their appointments scheduled promptly.

Perinatal Updates

- We have four open full-time L&D RN positions, and one open per diem L&D position posted.
- My Child 6 update: We are transitioning from Senso and Tummy tags to Cutband tags. Transitioning to Cutband tags will help reduce the false alarms we have seen with the Senso tags and eliminate the risk of umbilical irritation associated with the Tummy tags.
- We have met all criteria for the Beta Perinatal Quest for Zero Tier 1 and Tier II, resulting in a 6% discount on our liability insurance with Beta.
- We have hired a traveler, Carolyn Arnold, to fill the Perinatal Manager position until January 24, 2025.
- We have two L&D RNs enrolled in classes to become certified childbirth educators. This will allow the District to continue offering Childbirth Classes to our community.
- We are currently assessing our perinatal admission workflows to ensure that our workflows are as efficient as possible for our patients and the District.

Emergency Department

- The Emergency Department is fully staffed with all positions filled.
- The Emergency Department just completed its annual skills day with 100% participation from team members.
- The Emergency Department participated in the annual multi-agency Disaster Drill on September 28. The drill was a collaboration with Inyo and Mono County. It was a great test of systems and provided the opportunity to erect our Disaster tents.

Perioperative

- The PACU is fully staffed with all positions filled.
- The OR has one open position with one traveler providing coverage until the permanent staff is secured.
- The OR will welcome Dr. Thunder in late October. He will perform total hip replacements.

Infection Prevention

Best Practices and Policy Updates

- Continuous Review and Update**:** We are actively reviewing and updating our infection prevention practices to align with national and state guidelines.
- Ongoing monthly reporting includes:
    - Infection Prevention Quality Reporting to CMS, Joint Commission, and CDPH.

- Multi-drug resistant Organisms reporting facility-wide for inpatient and emergency departments.
- Hospital-Acquired Infection Reporting.
- Antibiotic Use and Resistance Reporting for Promoting Interoperability.
- COVID-19 Healthcare Worker Vaccination Rate.

Upcoming Initiatives

Tracer Activity**:** Infection Prevention will initiate tracer activities using CDPH tracer tools to monitor adherence to infection prevention practices. These tracers will align with regulatory tracer forms and focus on Central Sterile Processing (CSP). CSP will be a key area of focus due to its importance in infection prevention, as both CDPH and The Joint Commission (TJC) emphasize. This will ensure thorough oversight and compliance with established sterilization and infection control standards.

CDPH Infection Prevention Validation 2024

- Annual CDPH Validation: The validation for Q1 was submitted. This validation focuses on:
  - Central Line-Associated Blood Stream Infections (CLABSI)
  - Methicillin-resistant Staphylococcus aureus (MRSA) Bloodstream Infections
  - Clostridium Difficile Infections (CDI)
  - Colon Surgery and Surgical Site Infections (SSI)
  - Fusion Surgeries and SSI (Note: NIHD is not performing fusion surgeries)
- External CDPH Validation Audit:
  - Selection Process: CDPH will randomly select ten facilities for the external validation audit from hospitals selected in 2022 or 2023. NIHD was selected for validation in 2022.
  - Onsite Audit: If selected, CDPH will conduct an onsite audit to evaluate our Infection Prevention processes and reporting. The review will cover 2024 Q1 & Q2 data.
  - Scope: The audit will include CLABSI, all LabID events (MRSA/VRE BSI and CDI), and SSI for three surgical procedures: Colon Surgery (COLO), Cesarean Section (CSEC), and Hysterectomy (HYST) for Q1 and Q2 2024.

CMS Reporting Requirements

- Effective November 1, 2024: CMS will require acute care and critical access hospitals to electronically report data via NHSN on:
  - Confirmed Infections: COVID-19, influenza, and RSV among hospitalized patients.

- Hospital Bed Census and Capacity: Both overall and by setting/population group.
- Limited Patient Demographic Information.
- Optional Weekly Personal Protective Equipment (PPE) current supply and ability to maintain a 3-day supply.

Employee Health

Flu Vaccination

- The NIHD flu clinic commenced on September 16, 2024, offering free flu vaccinations to all NIHD workforce throughout the flu season.

Mask Mandate

- The Inyo County Public Health Officer has mandated that all healthcare workers receive an influenza vaccine by November 1, 2024, or comply with a mask requirement through flu season.

COVID-19 Testing Changes

- Effective August 26, 2024, NIHD has closed the COVID-19 testing shed and transitioned to self-administered employee testing regarding COVID-19 return-to-work or exposure pathways. This change simplifies the process, prevents scheduling conflicts, and improves compliance and accuracy.

Ergonomics and Safety

- Assessments: Ongoing ergonomics and safety assessments are conducted with Physical Therapy and Employee Health to address departmental concerns, ensure workstation safety and comfort, and reduce the risk of musculoskeletal disorders.

Safe Patient Handling Training

- Safe patient handling safety training has been updated to meet industry standards.

Facilities Department Update

- The HVAC units are being craned off the PMA roof for the final installation of the new roof on the HCAC curbs.
- The camera system installation is complete. The new camera software system is up and running; IT is migrating cameras from the old system to the new one.
- Work is underway to prepare for the Corridor remodel of the PMA corridor (Remove planters, replace the flooring, Drywall repair, and paint).
- Ongoing collaboration continues with the Project Management Department on office moves.

Project Updates

- Pharmacy / Infusion Project

    - As of 9/6/24, the design and construction teams were onsite finalizing the work list to help with substantial completion. Colombo and Ping and Associated feel that we will be ready for the HCAI inspection in approximately three weeks. Upon successful completion of inspection, substantial completion will be achieved.
- SB 1882 Seismic
    - The signage portion of the requirements has been accepted and processed through the review process.
    - We are awaiting responses for the water and sewer portion of the project.

Cardiopulmonary (CP)

- Our Cardiopulmonary department has experienced a continued increase in patient volume and service orders since Dr. Rowan's arrival to the District. Echo-specific volume has risen by 46% compared to the previous year, with 805 echocardiograms completed at the end of August 2024, up from 550 during the same period last year. We are actively monitoring capacity across all cardiopulmonary services in response to this growing demand and are expanding resources as needed to ensure timely appointment scheduling.
- The Pulmonary Function software, ComPAS2, is scheduled for an upgrade in October. A representative from Morgan Scientific will be onsite to provide training for the pulmonary function technicians and Dr. Kamei, ensuring a smooth transition and full utilization of the updated system.
- Adam Wills, our Echocardiographer trainee is on track to achieve his Registered Diagnostic Medical Sonographer (RDMS) registry within the year. We have allocated resources to support his ongoing training and are actively exploring opportunities for him to gain experience in neonatal echocardiography.
- Liliana Castro is a recent addition to the cardiopulmonary team.
- The Respiratory Department recently sent four of our newest Respiratory Therapists to Pomona for specialized NICU training. The training was highly successful, providing valuable experience and skill development for the team.
- The Respiratory Department is now fully staffed with permanent personnel. We have also recently welcomed Summer Sheeder as a per diem Respiratory Therapist. Summer has periodically worked with our department as a traveler for six years.
- The implementation of the new fit testing workflow, where each department manages its own fit testing, is progressing smoothly.

Diagnostic Imaging (DI)

- DI's advanced Imaging Modalities (CT and MRI) have experienced a 9% increase in volume in the last 12 months and a 15% increase in the last 24 months. The DI department has experienced a 2% and a 7% increase respectively over the same periods.
- DI has successfully recruited two full-time Technologists. Luis and Talicia Rico have joined our team as full-time X-ray techs.
- DI continues to search for a full-time Mammographer. We currently have a traveler serving in this position.
- Led by our Marketing and Public Relations Department, The DI department is prepared for Breast Cancer Awareness Month and will hold four Moonlight Mammo events. These events will occur every Wednesday in October from 4 pm – 8 pm. Additional dedicated Mammography days are reserved for NIHD Employees, Toiyabe employees and patients, and Southern Inyo Healthcare District employees and patients.

Laboratory Services (Lab)

- The lab has brought in two new tabletop analyzers, allowing us to bring six moderate-volume tests in-house that were previously sent for outside testing. This transition is expected to increase testing quality, decrease turnaround time for testing, and provide a marginal increase in revenue for the District.
- The lab has had a relationship with MedPro, a long-term traveling staffing solution, for approximately four years. MedPro travelers are committed to three years of service to the organization as travelers and then are available to hire permanently within the facility. I am happy to report that three Medpro staff have completed their three-year contracts within the last six months, and we have successfully transitioned all of them to full-time permanent NIHD staff.

Northern Inyo Healthcare District

August 2024 – Financial Summary and Operational Insights

Financial Summary Insights:

1. Net Income:
For the month of August, we had a net income of $248k, a significant improvement from losses of $(150k) in the prior year month and better than budget of $(1.07M) loss; this is due to increased volume and net patient revenue. For the year, we have net income of $2.3M, a significant improvement from losses of $(491k) in prior year to date and better than budget of $(1.9M) loss.

2. Operating Income:
While the current operating income is a loss of $(78k), it's a notable improvement compared to losses of $(544k) and budget of $(1.35M). For the year, operating income is favorable by $1.38M, which has improved compared to prior year's operating loss of $(1.1M).

3. EBIDA:
EBIDA is positive at $689k, up from $17k in the prior period and better than a budgeted loss of $(707k). For the year, EBIDA is favorable by $3.2M compared to $158k last fiscal year.

4. Revenue Breakdown:
Gross Revenue: For August and the year, we increased by 5% due to increased admissions including 10 additional deliveries.
Net Patient Revenue (cash revenue): For August, we increased by 6% due to volume increase. Write-off rates were consistent to last August. For the year, we increased by 13% due to favorable payor mix and $(680k) less bad debt write-offs

Summary:
Positive Trend: There is significant progress in profitability and operational performance, especially with positive net income and EBIDA.
Operating income remains slightly negative, indicating the need for continued focus on cost control and revenue growth to achieve sustainable profitability.

Deductions Summary Insights:

1. Contract Adjustments:

For August, there was a 4% shift from self pay (reserved at 100%) to Medicaid (reserved at 85%) causing a slight decrease in contractual adjustments.

2. Bad Debt:
Bad debt was high this month at $1.9M due to an increase in AR greater than 270 days which is reserved at 100% but is $(680k) lower for the year compared to prior year.

3. Write-offs:
Denials have been reduced by $(300k) compared to last August and last fiscal year to date.

Summary:
Aged AR greater than 270 days old has declined $3.75M compared to last fiscal year.

Payor mix shifted away from Medicare and Self Pay to Blue Cross, Commerical, and Medicaid, which is also contributing to favorable cash revenue.

Northern Inyo Healthcare District

August 2024 – Financial Summary and Operational Insights

Salaries Insights:

1. Per Adjusted Bed Day / Adjusted Employee Per Occupied Bed (Adjusted EPOB):
Wages per patient has declined due to FTEs staying consistent with prior year while volume increased, meaning staffing was more efficient; adjusted EPOB reduced 30% year over year.

2. Total Salaries:
For August, total salaries are (7%) lower than budget, but 8% higher than prior year due to merit increases.
For the year, total salaries are (8%) under budget, but higher than prior year to date due to merit increases.

3. Average Hourly Rate:
Average hourly rate has increased 12% for the year due to merit increases.

Benefits Insights:

1. Total Benefits:
For August, benefits are lower than budget but higher than last August.
For the year, benefits are below budget and prior year to date due to lower insurance and other benefits.

2. Benefits % of Wages:
For the fiscal year, benefits percentage of wages was 45%, down from 59% budgeted and 60% prior year-to-date, showing an improvement in managing benefit costs relative to wages.

Total Salaries, Wages, and Benefits (SWB) Insights:

1. SWB/APD:
SWB per patient was reduced 22% year over year due to increased volume.

2. SWB % of Total Expenses:
For the year, SWB percentage total expenses was 51% compared to prior year of 49%. The goal is 50% or lower.

Contract Labor Insights:

1. Contract Labor Expense:

Contract labor expense increased due to staffing challenges in key volume growth areas including women's services, radiology, and rehababilitation.

2. Contract Labor Rates:
Contract labor rates increased overall compared to prior year due to change in departments utilizing contract labor.

3. Contract Labor FTEs:
Contract labor FTEs increased by 5.5 employees, or 21%, compared to prior year.

Summary:
Patient Volumes: Volumes increased while SWB costs increases slightly at 2% increase due to merit raises.
Labor Costs: While overall labor costs increased, it decreased significantly when adjusted for increased volume.

Efficiency: We staffedn more effectively and showed improvements in productivity throughout the district. We still need to minimize contract labor.

Other Expenses Insights:

1. Physician Expense / Adjusted Patient Day:

Physician expenses increased slightly by 2%, but was (23%) lower than prior year, when reviewing on a per patient basis.

2. Supplies:

Overall supplies decreased more than $(300k) due to lower drug costs. On a per patient basis, supplies were reduced by 28% year-to-date

3. Total expenses:

Total expenses were lower by 1% from prior year and 23% year on a per patient basis.

Northern Inyo Healthcare District

August 2024 – Financial Summary and Operational Insights

Stats Summary Insights:

1. Admits (excluding Nursery):
For the month and year, admissions increased 32% due to a higher acuity in the ER and 10 more deliveries.

2. IP Days (excluding Nursery):
Patient days increased due to additional admissions and an increase in length of stay.

3. Average Daily Census:
For the month and year, ADC increased 40%.

4. ALOS (Average Length of Stay):
For August, ALOS increased 6%; for fiscal year to date, ALOS increased 15%.

5. Deliveries:
There were 19 deliveries for the current month, an increase of 10 from prior month.

From February to September, Ridgecrest deliveries equated to 6% of total deliveries with 50% of the visits insured by Blue Cross, which pays 80% of charges.

6. Surgical Procedures:

Total surgeries increased 20% compared to last August and, for the year, increased 13% compared to prior year-to-date related to additional or expanded services.

7. Emergency Department (ED) Visits:
For August, ER visits were 9% higher and ED acuity was higher leading to an increase in ED admits.
For the year, ER visits were 4% higher and ED acuity was higher leading to an increase in ED admits.

8. DI Exams:
For August, DI exams were favorable 2% to prior year but were under prior year to date by 3%.

9. Rehab Visits:
For the month rehab visits increased 26%; rehab visits increased 20% year over year.

10. OP Infusion/Wound Care Visits:
IP Infusions, Injections, and Wound Care were higher than prior year for the month and the year.

11. Observation Hours:
Observation hours increased 5% over prior year.

12. RHC:
RHC was consistent with prior year. Women services grew 10% due to expanded hours.

13. Other Clinics:
All other clinics increased volume: specialty care 52%; surgical clinics 38%.

Northern Inyo Healthcare District

August 2024 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	**Budget**	**Variance**	**Variance %**	**Actual**	**Change**	**Change %**	**Actual**	**Budget**	**Variance**	**Variance %**	**Actual**	**Change**	**Change %**
Net Income (Loss)	248,064	(1,070,412)	1,318,476	(123%)	(149,542)	397,606	266%	2,288,726	(1,891,133)	4,179,858	221%	(491,045)	2,779,771	(566%)
Operating Income (Loss)	(77,526)	(1,355,988)	1,278,463	(94%)	(544,049)	466,523	86%	1,378,961	(2,470,561)	3,849,522	156%	(1,136,024)	2,514,985	(221%)
EBIDA (Loss)	689,172	(706,834)	1,396,006	(198%)	175,023	514,149	(294%)	3,171,167	(1,163,977)	4,335,144	372%	158,085	3,013,082	1,906%
IP Gross Revenue	3,787,918	3,664,038	123,880	3%	3,728,137	59,781	2%	7,702,860	7,244,951	457,910	6%	7,034,841	668,020	9%
OP Gross Revenue	15,612,963	15,010,563	602,400	4%	14,800,302	812,661	5%	29,257,518	29,507,045	(249,527)	(1%)	28,493,566	763,952	3%
Clinic Gross Revenue	1,782,904	1,804,337	(21,433)	(1%)	1,721,328	61,576	4%	3,361,701	3,232,662	129,039	4%	2,995,669	366,032	12%
Total Gross Revenue	**21,183,785**	**20,478,938**	**704,847**	**3%**	**20,249,767**	**934,018**	**5%**	**40,322,080**	**39,984,658**	**337,422**	**1%**	**38,524,076**	**1,798,004**	**5%**
Net Patient Revenue	**9,782,784**	**8,827,737**	**955,047**	**11%**	**9,237,833**	**544,952**	**6%**	**20,255,922**	**17,787,209**	**2,468,713**	**14%**	**17,968,339**	**2,287,583**	**13%**
Cash Net Revenue % of Gross	*46%*	*43%*	*3%*	*7%*	*46%*	*1%*	*1%*	*50%*	*44%*	*6%*	*13%*	*47%*	*4%*	*8%*
Admits (excl. Nursery)	75				57	18	32%	144				121	23	19%
IP Days	285				189	96	51%	539				386	153	40%
IP Days (excl. Nursery)	244				174	70	40%	476				346	130	37%
Average Daily Census	8				6	2.24	40%	8				6	2.09	37%
ALOS	3.25				3.05	0.19	6%	3.30				2.86	0.44	16%
Deliveries	19				9	10	111%	37				28	9	32%
OP Visits	4,659				3,644	1,015	28%	9,015				7,026	1,989	28%
Rural Health Clinic Visits	2,391				2,742	(351)	(13%)	4,357				4,550	(193)	(4%)
Rural Health Women Visits	550				510	40	8%	1,023				929	94	10%
Rural Health Behavioral Visits	186				160	26	16%	377				304	73	24%
Total RHC Visits	**3,127**				**3,412**	**(285)**	**(8%)**	**5,757**				**5,783**	**(26)**	**(0%)**
Bronco Clinic Visits	19				13	6	46%	19				14	5	36%
Internal Medicine Clinic Visits	-	N	N		11	(11)	(100%)	-	N	N	N	201	(201)	(100%)
Orthopedic Clinic Visits	426	o	o		418	8	2%	750	o	o	o	780	(30)	(4%)
Pediatric Clinic Visits	623	t	t		640	(17)	(3%)	1,188	t	t	t	1,184	4	0%
Specialty Clinic Visits	519				431	88	20%	1,052				694	358	52%
Surgery Clinic Visits	144	A	A		110	34	31%	291	A	A	A	211	80	38%
Virtual Care Clinic Visits	63	v	v		64	(1)	(2%)	120	v	v	v	107	13	12%
Total NIA Clinic Visits	**1,794**	a	a		**1,687**	**107**	**6%**	**3,420**	a	a	a	**3,191**	**229**	**7%**
IP Surgeries	24	i	i		29	(5)	(17%)	41	i	i	i	41	-	-%
OP Surgeries	153	l	l		119	34	29%	278	l	l	l	241	37	15%
Total Surgeries	**177**	a	a		**148**	**29**	**20%**	**319**	a	a	a	**282**	**37**	**13%**
Cardiology	2	b	b		-	2	100%	2	b	b	b	-	2	-%
General	87	l	l		59	28	47%	144	l	l	l	115	29	25%
Gynecology & Obstetrics	18	e	e		5	13	260%	45	e	e	e	17	28	165%
Ophthalmology	27				23	4	17%	57				56	1	2%
Orthopedic	31				46	(15)	(33%)	52				79	(27)	(34%)
Pediatric	-				-	-	-%	-				-	-	-%
Plastics	1				-	1	100%	1				-	1	-%
Podiatry	1				1	-	-%	1				1	-	-%
Urology	10				14	(4)	(29%)	17				14	3	21%
Diagnostic Image Exams	2,221				2,174	47	2%	4,159				4,282	(123)	(3%)
Emergency Visits	905				833	72	9%	1,808				1,731	77	4%
ED Admits	32				19	13	68%	66				52	14	27%
ED Admits % of ED Visits	3.5%				2.3%	1.3%	55%	3.7%				3.0%	0.6%	22%
Rehab Visits	835				662	173	26%	1,581				1,323	258	20%
OP Infusion/Wound Care Visits	781				276	505	183%	1,708				542	1,166	215%
Observation Hours	2,268				1,758	510	29%	4,017				3,811	206	5%
PAYOR MIX														
Blue Cross	20.3%				20.1%	0%	1%	23.4%				18.9%	4%	24%
Commercial	0.0%				2.6%	(3%)	(100%)	4.4%				2.6%	2%	69%
Medicaid	31.6%				15.9%	16%	99%	31.1%				15.6%	16%	100%
Medicare	44.7%	N/A	N/A		51.3%	(7%)	(13%)	37.3%	N/A	N/A	N/A	55.6%	(18%)	(33%)
Self-pay	3.4%				7.4%	(4%)	(54%)	2.1%				6.0%	(4%)	(65%)
Worker's Comp	0.0%				2.6%	(3%)	(100%)	1.7%				1.3%	0%	28%
Other	0.0%				0.0%	-%	-%	0.0%				0.0%	-%	-%

Northern Inyo Healthcare District

August 2024 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
DEDUCTIONS														
Contract Adjust	(9,097,698)	(10,300,782)	1,203,084	(12%)	(9,375,676)	277,978	(3%)	(17,896,494)	(19,544,750)	1,648,256	(8%)	(17,550,014)	(346,480)	2%
Bad Debt	(1,932,456)	(714,992)	(1,217,464)	170%	(917,527)	(1,014,929)	111%	(1,277,787)	(1,447,036)	169,249	(12%)	(1,957,563)	679,776	(35%)
Write-off	(370,847)	(635,427)	264,581	(42%)	(718,732)	347,885	(48%)	(741,694)	(1,205,663)	463,969	(38%)	(1,049,547)	307,853	(29%)
CENSUS														
Patient Days	244				174	70	40%	476				346	130	37%
Adjusted ADC	51				33	18	55%	46				34	12	36%
Adjusted Days	1,362				945	417	44%	2,490				1,895	596	31%
Employed FTE	366.24				357.51	8.73	2%	357.12				361.38	(4)	(1%)
Contract Labor FTE	32.19	N/A	N/A		21.30	10.88	51%	31.73	N/A	N/A	N/A	26.26	5	21%
Total Paid FTE	398.43				378.81	19.61	5%	388.86				387.64	1	0%
EPOB (Employee per Occupied Bed)	1.64				2.18	(0.54)	(25%)	1.63				2.24	(1)	(27%)
EPOC (Employee per Occupied Case)	0.25				0.37	(0.12)	(32%)	0.14				0.18	(0)	(26%)
Adjusted EPOB	9.15				11.83	(2.68)	(23%)	8.56				12.27	(4)	(30%)
Adjusted EPOC	1.40				2.00	(0.60)	(30%)	0.71				1.00	(0)	(29%)
SALARIES														
Per Adjust Bed Day	2,380				3,175	(795)	(25%)	2,650				3,108	(458)	(15%)
Total Salaries	3,241,107	3,541,667	(300,560)	(8%)	3,000,700	240,406	8%	6,600,182	7,080,688	(480,506)	(7%)	5,888,979	711,203	12%
Average Hourly Rate	$49.96				$47.38	$2.58	5%	$52.17				$46.00	$6.17	13%
Employed Paid FTEs	366.24				357.51	8.73	2%	357.12				361.38	(4.26)	(1%)
BENEFITS														
Per Adjust Bed Day	1,086				1,506	(420)	(28%)	1,200				1,858	(658)	(35%)
Total Benefits	1,478,605	2,075,152	(596,547)	(29%)	1,422,949	55,657	4%	2,987,652	4,146,252	(1,158,600)	(28%)	3,520,000	(532,349)	(15%)
Benefits % of Wages	46%	59%			47%	(2%)	(4%)	45%	59%			60%	(15%)	(24%)
Pension Expense	470,395	498,151	(27,756)	(6%)	392,449	77,946	20%	917,341	996,301	(78,961)	(8%)	1,003,727	(86,386)	(9%)
MDV Expense	518,757	748,612	(229,855)	(31%)	534,329	(15,572)	(3%)	1,223,434	1,497,224	(273,790)	(18%)	1,082,903	140,531	13%
Taxes, PTO accrued, Other	489,454	828,389	(338,936)	(41%)	496,171	(6,718)	(1%)	846,877	1,652,726	(805,849)	(49%)	1,433,371	(586,494)	(41%)
Salaries, Wages & Benefits	4,719,712	5,616,819	(897,107)	(16%)	4,423,649	296,063	7%	9,587,834	11,226,940	(1,639,106)	(15%)	9,408,980	178,854	2%
SWB/APD	3,466				4,681	(1,215)	(26%)	3,850				4,966	-1,116	(22%)
SWB % of Total Expenses	48%	55%	(7%)		45%	3%		51%	55%	(5%)		49%	2%	3%
PROFESSIONAL FEES														
Per Adjust Bed Day	1,979	2,362	(383)	(16%)	2,945	(966)	(33%)	2,034				2,679	(645)	(24%)
Total Physician Fee	1,399,376	1,463,822	(64,446)	(4%)	1,536,032	(136,656)	(9%)	2,952,381	2,926,045	26,336	1%	2,905,854	46,527	2%
Total Contract Labor	829,876	349,333	480,543	138%	629,779	200,097	32%	1,337,262	698,666	638,596	91%	928,160	409,102	44%
Total Other Pro-Fees	465,748	418,705	47,043	11%	617,513	(151,765)	(25%)	774,865	824,683	(49,818)	(6%)	1,242,459	(467,593)	(38%)
Total Professional Fees	**2,695,000**	**2,231,860**	**463,139**	**21%**	**2,783,323**	**(88,324)**	**(3%)**	**5,064,508**	**4,449,394**	**615,114**	**14%**	**5,076,473**	**(11,965)**	**(0%)**
Contract Paid FTEs	32				21.30	10.88	51%	31.73				26.26	5.48	21%
Contract AHR	146				167	(21)	(13%)	119				100	19	19%
Physician Fee per Adjust Bed Day	1,028				1,625	(598)	(37%)	1,186				1,534	(348)	(23%)
PHARMACY														
Per Adjust Bed Day	128				694	(566)	(82%)	98				553	(455)	(82%)
Total Rx Expense	174,072	461,460	(287,388)	(62%)	655,955	(481,883)	(73%)	243,997	922,919	(678,923)	(74%)	1,048,639	(804,643)	(77%)
MEDICAL SUPPLIES														
Per Adjust Bed Day	664				644	20	3%	491				529	(38)	(7%)
Total Medical Supplies	904,005	431,663	472,342	109%	608,302	295,703	49%	1,221,690	859,231	362,459	42%	1,001,617	220,073	22%
EHR SYSTEM														
Per Adjust Bed Day	(50)				137	(187)	(136%)	35				140	(105)	(75%)
Total EHR Expense	(68,269)	135,000	(203,269)	(151%)	129,805	(198,074)	(153%)	88,389	270,000	(181,611)	(67%)	266,197	(177,807)	(67%)
OTHER EXPENSE														
Per Adjust Bed Day	730				906	(176)	(19%)	717				872	(155)	(18%)
Total Other	994,682	943,346	51,336	5%	856,283	138,400	16%	1,785,668	1,802,130	(16,462)	(1%)	1,651,941	133,727	8%
DEPRECIATION AND AMORTIZATION														
Per Adjust Bed Day	324				343	(20)	(6%)	354				343	12	3%
Total Depreciation and Amortization	441,108	363,578	77,530	21%	324,565	116,543	36%	882,441	727,156	155,285	21%	649,130	233,312	36%
TOTAL EXPENSES	9,860,310	10,183,725	(323,415)	(3%)	9,781,881	78,428	1%	18,874,527	20,257,770	(1,383,243)	(7%)	19,102,976	(228,449)	(1%)

Northern Inyo Healthcare District

August 2024 – Financial Summary

** Variances are B / (W)	Current Month				Prior MTD			Year to Date				Prior YTD		
	Actual	Budget	Variance	Variance %	Actual	Change	Change %	Actual	Budget	Variance	Variance %	Actual	Change	Change %
Per Adjust Bed Day	7,240				10,350	(3,110)	(30%)	7,579				10,082	(2,503)	(25%)
Per Calendar Day	318,075	328,507	(10,433)	(3%)	315,545	2,530	1%	304,428	326,738	(22,310)	(7%)	308,113	(3,685)	(1%)

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2025

	8/31/2024	Aug Budget	8/31/2023	2025 YTD	2024 YTD	Budget Variance	PYM Change	PYTD Change
Gross Patient Service Revenue								
Inpatient Patient Revenue	3,787,918	3,664,038	3,728,137	7,702,860	7,034,841	123,880	59,781	668,020
Outpatient Revenue	15,612,963	15,010,563	14,800,302	29,257,518	28,493,566	602,400	812,661	763,952
Clinic Revenue	1,782,904	1,804,337	1,721,328	3,361,701	2,995,669	(21,433)	61,576	366,032
Gross Patient Service Revenue	21,183,785	20,478,938	20,249,767	40,322,080	38,524,076	704,847	934,018	1,798,004
Deductions from Revenue								-
Contractual Adjustments	(9,097,698)	(10,300,782)	(9,375,676)	(17,896,494)	(17,550,014)	1,203,084	277,978	(346,480)
Bad Debt	(1,932,456)	(714,992)	(917,527)	(1,277,787)	(1,957,563)	(1,217,464)	(1,014,929)	679,776
A/R Writeoffs	(370,847)	(635,427)	(718,732)	(741,694)	(1,049,547)	264,581	347,885	307,853
Other Deductions from Revenue	-	-	-	(152,618)	-	-	-	(152,618)
Deductions from Revenue	(11,401,001)	(11,651,201)	(11,011,935)	(20,068,592)	(20,557,123)	250,201	(389,066)	488,531
Other Patient Revenue								-
Incentive Income	-	-	-	-	-	-	-	-
Other Oper Rev - Rehab Thera Serv	-	-	-	2,435	1,387	-	-	1,048
Medical Office Net Revenue	-	-	-	-	-	-	-	-
Other Patient Revenue	-	-	-	2,435	1,387	-	-	1,048
Net Patient Service Revenue	**9,782,784**	**8,827,737**	**9,237,833**	**20,255,922**	**17,968,339**	**955,047**	**544,952**	**2,287,583**
CNR%	**46%**	**43%**	**46%**	**50%**	**47%**	**3%**	**1%**	**4%**
Cost of Services - Direct								-
Salaries and Wages	2,709,593	2,960,863.39	2,580,857	5,553,428	5,027,483	(251,271)	128,736	525,945
Benefits	1,302,187	1,827,557.27	1,244,252	2,578,549	3,020,889	(525,370)	57,935	(442,340)
Professional Fees	1,655,382	1,670,828	1,919,787	3,369,975	3,670,959	(15,446)	(264,405)	(300,984)
Contract Labor	791,983	333,382	572,961	1,241,806	798,425	458,600	219,022	443,381
Pharmacy	174,072	461,460	655,955	243,997	1,048,639	(287,388)	(481,883)	(804,643)
Medical Supplies	904,005	431,663	608,302	1,221,690	1,001,617	472,342	295,703	220,073
Hospice Operations	-	-	-	-	-	-	-	-
EHR System Expense	(68,269)	135,000	129,805	88,389	266,197	(203,269)	(198,074)	(177,807)
Other Direct Expenses	779,184	738,969.15	659,948	1,423,567	1,280,445	40,214	119,235	143,122
Total Cost of Services - Direct	8,248,136	8,559,723	8,371,866	15,721,401	16,114,654	(311,587)	(123,731)	(393,253)
								-
General and Administrative Overhead								-
Salaries and Wages	531,514	580,803	419,843	1,046,754	861,496	(49,289)	111,671	185,258
Benefits	176,418	247,595	178,697	409,103	499,112	(71,176)	(2,278)	(90,009)
Professional Fees	209,742	211,699	233,758	357,271	477,354	(1,957)	(24,016)	(120,083)
Contract Labor	37,893	15,951	56,818	95,456	129,736	21,942	(18,925)	(34,279)
Depreciation and Amortization	441,108	363,578	324,565	882,441	649,130	77,530	116,543	233,312
Other Administative Expenses	215,499	204,377	196,334	362,101	371,496	11,122	19,164	(9,395)
Total General and Administrative Overhead	1,612,174	1,624,003	1,410,015	3,153,126	2,988,323	(11,828)	202,159	164,804
Total Expenses	**9,860,310**	**10,183,725**	**9,781,881**	**18,874,527**	**19,102,976**	**(323,415)**	**78,428**	**(228,449)**
						-	-	-
Financing Expense	192,528	185,154	178,594	387,135	358,964	7,374	13,934	28,171
Financing Income	286,867	238,960	228,125	573,733	456,249	47,906	58,742	117,484
Investment Income	51,951	46,181	52,333	91,727	113,258	5,770	(382)	(21,531)
Miscellaneous Income	179,300	185,589	292,643	629,005	433,048	(6,289)	(113,343)	195,956
Net Income (Change in Financial Position)	**248,064**	**(1,070,412)**	**(149,542)**	**2,288,726**	**(491,045)**	**1,318,476**	**397,606**	**2,779,771**
Operating Income	(77,526)	(1,355,988)	(544,049)	1,381,396	(1,134,637)	1,278,463	466,523	2,516,032

EBIDA	689,172	(706,834)	175,023	3,171,167	158,085	1,396,006	514,149	3,013,082
Net Profit Margin	2.5%	-8.0%	-1.6%	11.3%	-2.7%	10.5%	4.2%	14.0%
Operating Margin	-0.8%	-15.4%	-5.9%	6.8%	-6.3%	14.6%	5.1%	13.1%
EBIDA Margin	7.0%	-8.0%	1.9%	15.7%	0.9%	15.1%	5.2%	14.8%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2025

	PY Balances	7/31/2024	7/31/2023	8/31/2024	8/31/2023	PM Change	PY Year
Assets							
Current Assets							
Cash and Liquid Capital	18,718,424	20,537,240	15,220,072	17,874,647	18,008,863	(2,662,593)	(134,216)
Short Term Investments	6,418,451	7,565,620	10,513,789	7,570,368	10,555,533	4,748	(2,985,165)
PMA Partnership	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	17,964,704	18,260,024	16,283,014	20,317,403	13,668,526	2,057,379	6,648,877
Other Receivables	4,753,311	4,292,445	3,071,746	4,360,263	321,629	67,818	4,038,635
Inventory	5,193,281	5,176,986	5,120,179	5,173,320	5,099,597	(3,666)	73,723
Prepaid Expenses	1,119,559	1,463,004	2,154,415	1,782,536	2,821,462	319,532	(1,038,927)
Total Current Assets	**54,167,729**	**57,295,319**	**52,363,215**	**57,078,537**	**50,475,610**	**(216,782)**	**6,602,927**
Assets Limited as to Use							
Internally Designated for Capital Acquisitions	-	-	-	-	-		
Short Term - Restricted	1,467,786	1,467,914	1,466,418	1,468,042	1,466,541	128	1,500
Limited Use Assets						-	-
LAIF - DC Pension Board Restricted	-	-	870,163	-	828,419	-	(828,419)
LAIF - DB Pension Board Restricted	15,684,846	15,684,846	15,684,846	15,684,846	13,076,830	-	2,608,016
PEPRA - Deferred Outflows	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-
Deferred Outflow - Excess Acquisition	573,097	573,097	573,097	573,097	-	-	573,097
Total Limited Use Assets	16,257,943	16,257,943	17,128,106	16,257,943	13,905,249	-	2,352,694
Revenue Bonds Held by a Trustee	376,411	370,707	1,072,480	365,005	912,490	(5,702)	(547,485)
Total Assets Limited as to Use	**18,102,140**	**18,096,564**	**19,667,005**	**18,090,990**	**16,284,281**	**(5,574)**	**1,806,709**
Long Term Assets							
Long Term Investment	1,846,138	751,539	2,776,508	754,812	2,783,284	3,273	(2,028,473)
Fixed Assets, Net of Depreciation	84,207,594	83,924,484	84,781,121	83,665,700	77,751,338	(258,784)	5,914,362
Total Long Term Assets	**86,053,732**	**84,676,023**	**87,557,629**	**84,420,512**	**80,534,623**	**(255,511)**	**3,885,889**
Total Assets	**158,323,601**	**160,067,906**	**159,587,849**	**159,590,039**	**147,294,513**	**(477,868)**	**12,295,525**
Liabilities							
Current Liabilities							
Current Maturities of Long-Term Debt	4,146,183	4,217,792	4,936,019	4,204,640	798,370	(13,152)	3,406,270
Accounts Payable	5,010,089	4,451,768	4,929,766	5,232,265	6,750,705	780,497	(1,518,441)
Accrued Payroll and Related	6,224,657	6,279,496	7,600,696	4,607,440	11,656,151	(1,672,056)	(7,048,711)
Accrued Interest and Sales Tax	109,159	192,510	169,971	261,700	244,123	69,189	17,576
Notes Payable	446,860	446,860	1,532,689	446,860	1,633,708	-	(1,186,847)
Unearned Revenue	(4,542)	(4,542)	(4,542)	(3,242)	(4,542)	1,300	1,300
Due to 3rd Party Payors	693,247	693,247	693,247	693,247	693,247	-	-
Due to Specific Purpose Funds	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	1,917,457	1,915,387	1,942,292	1,913,318	1,873,995	(2,070)	39,323
Total Current Liabilities	**18,543,109**	**18,192,519**	**21,800,138**	**17,356,227**	**23,645,757**	**(836,292)**	**(6,289,530)**
Long Term Liabilities							
Long Term Debt	36,301,355	36,202,581	37,511,965	36,103,552	33,455,530	(99,028)	2,648,022
Bond Premium	165,618	162,481	200,126	159,344	196,989	(3,137)	(37,645)
Accreted Interest	16,991,065	17,084,422	16,635,302	17,177,780	17,314,009	93,358	(136,229)
Other Non-Current Liability - Pension	47,257,663	47,257,663	47,257,663	47,257,663	47,257,663	-	-
Total Long Term Liabilities	**100,715,702**	**100,707,147**	**101,605,056**	**100,698,339**	**98,224,191**	**(8,808)**	**2,474,148**
Suspense Liabilities	-	-	-	-			
Uncategorized Liabilities (grants)	31,506	94,166	44,693	147,821	36,944	53,655	110,877
Total Liabilities	**119,290,317**	**118,993,832**	**123,449,887**	**118,202,387**	**121,906,892**	**(791,445)**	**(3,704,505)**
Fund Balance							
Fund Balance	31,992,030	37,565,498.41	31,992,032	37,630,883	23,268,194	65,385	14,362,690
Temporarily Restricted	1,467,786	1,467,914	1,466,417	1,468,042	2,610,472	128	(1,142,431)
Net Income	5,573,468	2,040,662	2,679,513	2,288,726	(491,045)	248,064	2,779,771
Total Fund Balance	**39,033,285**	**41,074,074**	**36,137,962**	**41,387,651**	**25,387,621**	**313,577**	**16,000,030**
Liabilities + Fund Balance	**158,323,601**	**160,067,906**	**159,587,849**	**159,590,039**	**147,294,513**	**(477,868)**	**12,295,525**
(Decline)/Gain		1,744,305	(1,044,798)	(477,868)	(415,868)	(2,222,173)	(62,000)

Key Financial Performance Indicators	FYE 2023 Average	Jul-24	Aug-24	Variance to Prior Month	Variance to FYE 2023 Average	Variance to Prior Year Month
Volume						
Admits	68	75	75	-	7	18
Deliveries	17	18	19	1	2	9
Adjusted Patient Days	977	1,164	1,362	198	385	219
Total Surgeries	120	177	177	-	57	29
ER Visits	810	888	905	17	95	55
RHC and Clinic Visits	4,353	4,252	3,127	(1,125)	(1,226)	(847)
Diagnostic Imaging Services	2,020	2,274	2,221	(53)	201	100
Rehab Services	762	733	835	102	73	71
AR & Income						
Gross AR (Cerner only)	$ 53,638,580	$ 56,859,164	$ 57,648,281	$ 789,118	$ 4,009,701	$ 6,245,436
AR > 90 Days	$ 23,440,542	$ 24,988,857	$ 32,958,845	$ 7,969,988	$ 9,518,303	$ 1,204,820
AR % > 90 Days	45.3%	44.5%	57.2%	12.6%	11.9%	-2.1%
AR Days	91.35	89.02	92.17	3.15	0.82	3.09
Net AR	$ 17,800,084	$ 18,260,024	$ 21,183,785	$ 2,923,761	$ 3,383,701	$ 4,591,499
Net AR % of Gross	33.1%	32.1%	36.7%	4.6%	3.7%	5.1%
Gross Patient Revenue/Calendar Day	$ 546,652	$ 617,364	$ 683,348	$ 65,984	$ 136,696	$ (35,854)
Net Patient Revenue/Calendar Day	$ 243,317	$ 337,843	$ 315,574	$ (22,269)	$ 72,257	$ 39,849
Net Patient Revenue/APD	$ 7,622	$ 8,998	$ 7,183	$ (1,814)	$ (439)	$ (778)
Wages						
Wages	$ 3,281,173	$ 3,359,076	3,241,107	$ (117,969)	$ (40,066)	$ (34,047)
Employed paid FTEs	384.63	366.38	366.24	(0.14)	(18.39)	8.87
Employed Average Hourly Rate	$ 48.51	$ 51.76	$ 49.96	$ (1.80)	$ 1.45	$ (1.82)
Benefits	$ 1,907,194	$ 1,509,407	$ 1,478,605	$ (30,802)	$ (428,589)	$ 478,881
Benefits % of Wages	58.7%	44.9%	45.6%	0.7%	-13.1%	14.6%
Contract Labor	$ 808,284	$ 507,387	$ 829,876	$ 322,489	$ 21,591	$ (122,392)
Contract Labor Paid FTEs	40.27	29.45	32.19	2.74	(8.09)	8.35
Total Paid FTEs	424.90	395.83	398.43	2.60	(26.47)	17.22
Contract Labor Average Hourly Rate	$ 112.84	$ 97.26	$ 145.55	$ 48.29	$ 32.71	$ (71.23)
Total Salaries, Wages, & Benefits	$ 5,996,651	$ 5,375,870	$ 5,549,587	$ 173,717	$ (447,064)	$ 322,442
SWB% of NR	79.8%	51.3%	56.7%	5.4%	-23.0%	-3.4%
SWB/APD	$ 5,912	$ 4,618	$ 4,075	$ (543)	$ (1,837)	$ (729)
SWB % of total expenses	66.0%	59.6%	56.3%	-3.4%	-9.8%	8.0%
Physician Spend						
Physician Expenses	$ 1,400,634	$ 1,553,004	1,399,376	$ (153,628)	$ (1,258)	$ 16,972
Physician expenses/APD	$ 1,451	$ 1,334	$ 1,028	$ (307)	$ (424)	$ (291)
				$ -	$ -	$ -
Supplies						

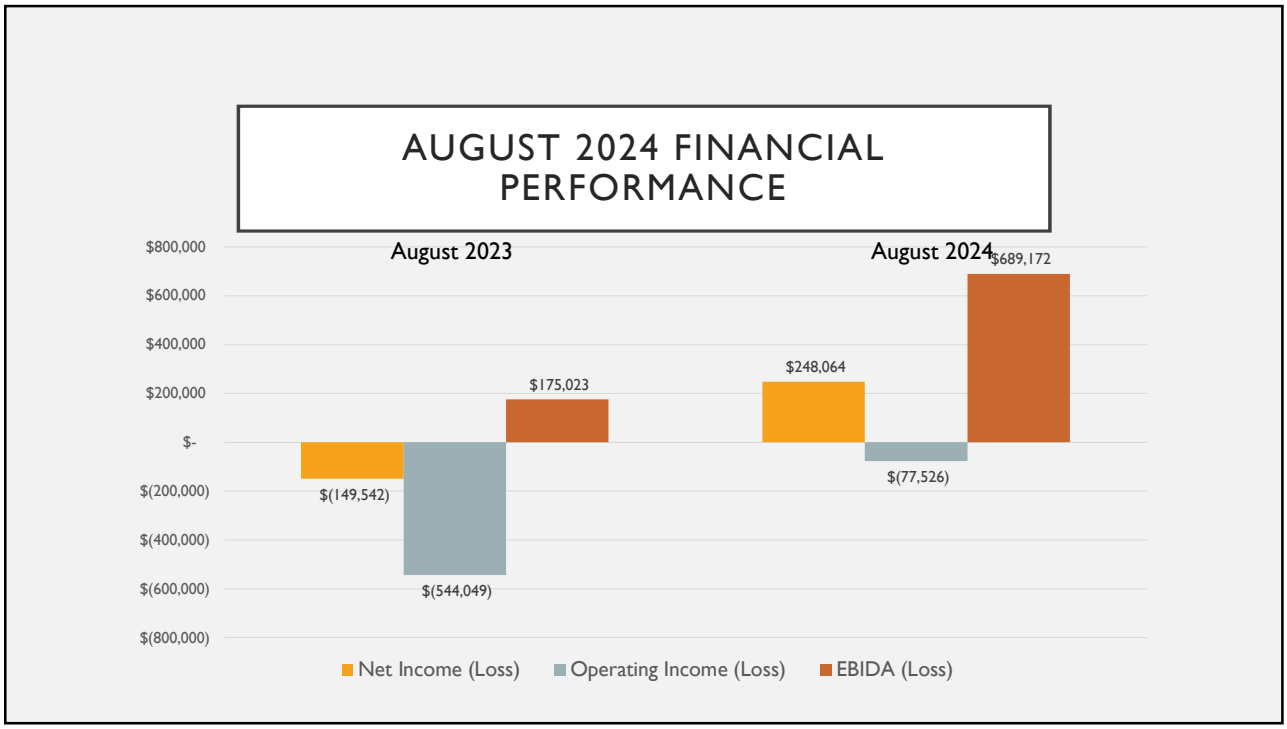
Supply Expenses	$ 544,557	$ 387,610	$ 904,005	$ 516,395	$ 359,448	$ (876,647)	
Supply expenses/APD	$ 579	$ 333	$ 664	$ 331	$ 85	$ (1,005)	
Other Expenses							
Other Expenses	$ 1,138,604	$ 1,696,938	$ 2,007,341	$ 310,403	$ 868,737	$ (231,226)	
Other Expenses/APD	$ 1,178	$ 1,458	$ 1,474	$ 16	$ 296	$ (583)	
Margin							
Net Income	$ (1,448,727)	$ 2,041,456	$ 248,064	$ (1,793,392)	$ 1,696,791	$ 2,190,998	
Net Profit Margin	-20.8%	19.5%	2.5%	-17.0%	23.3%	21.1%	
Operating Income	$ (2,495,327)	$ 1,459,716	$ (77,526)	$ (1,537,242)	$ 2,417,801	$ 2,003,765	
Operating Margin	-33.0%	13.9%	-0.8%	-14.7%	32.2%	19.8%	
EBITDA	$ (1,789,289)	$ 2,482,790	$ 689,172	$ (1,793,618)	$ 2,478,461	$ 2,307,767	
EBITDA Margin	-22.6%	23.7%	7.0%	-16.7%	29.6%	21.8%	
Debt Service Coverage Ratio	(5.8)	10.8	13.7	2.87	19.47	9.49	
Cash							
Avg Daily Disbursements (excl. IGT)	$ 363,636	$ 367,107	$ 407,122	$ 40,015	$ 43,486	$ (59,243)	
Average Daily Cash Collections (excl. IGT)	$ 340,919	$ 349,783	$ 262,199	$ (87,584)	$ (78,720)	$ 43,646	
Average Daily Net Cash	$ (22,716)	$ (17,324)	$ (144,923)	$ (127,599)	$ (122,207)	$ 102,889	
Unrestricted Funds	$ 25,185,410	$ 27,015,779	$ 24,366,780	$ (2,648,999)	$ (818,629)	$ (4,247,831)	
Change of cash per balance sheet	$ 204,360	$ 1,876,964	$ (2,648,999)	$ (4,525,962)	$ (2,853,359)	$ 768,883	
Days Cash on Hand (assume no more cash is collected)	83	98	84	(14)	1	25	
Estimated Days Until Depleted	1,109	508	408	(100)	(701)	122	
Years Until Cash Depletion	3.04	1.39	1.12	(0.27)	(1.92)	0.34	

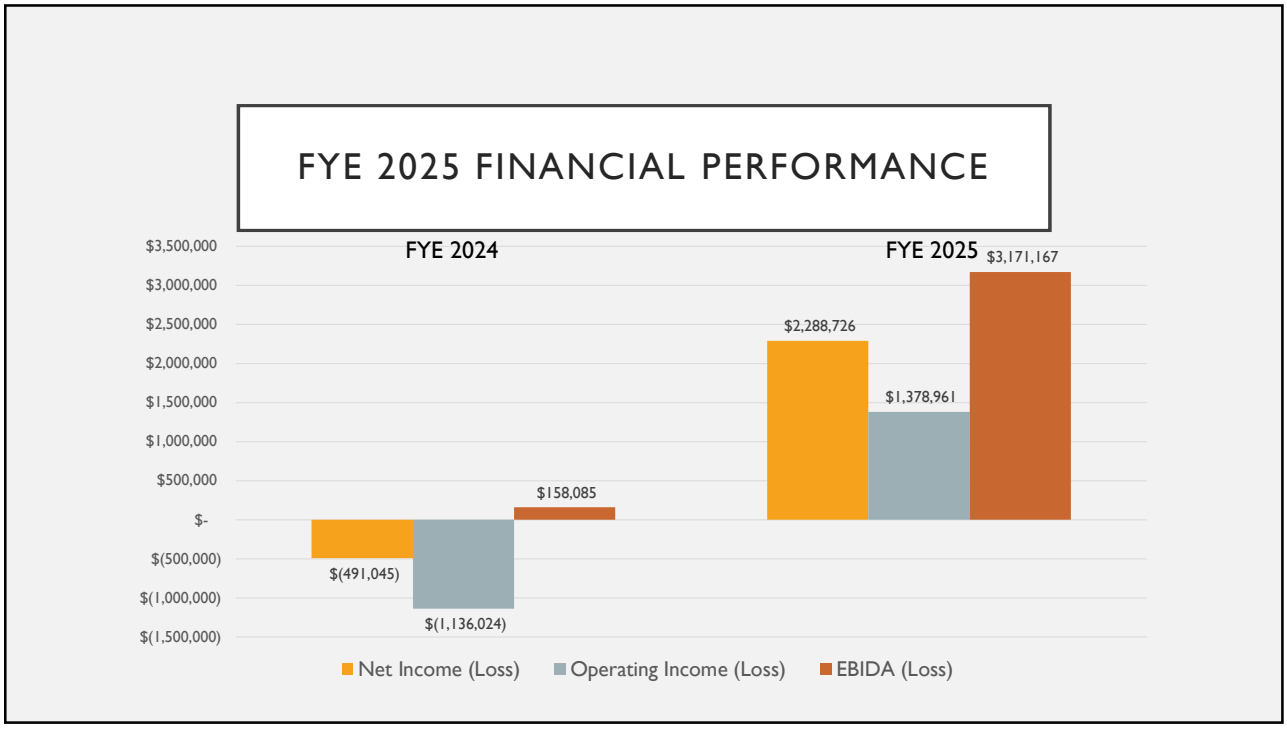
NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

NIHD FINANCIAL UPDATE

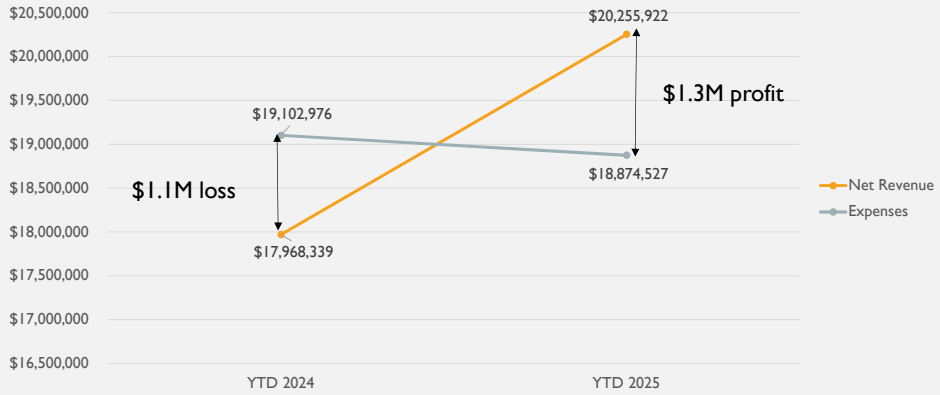
August 2024

INCOME

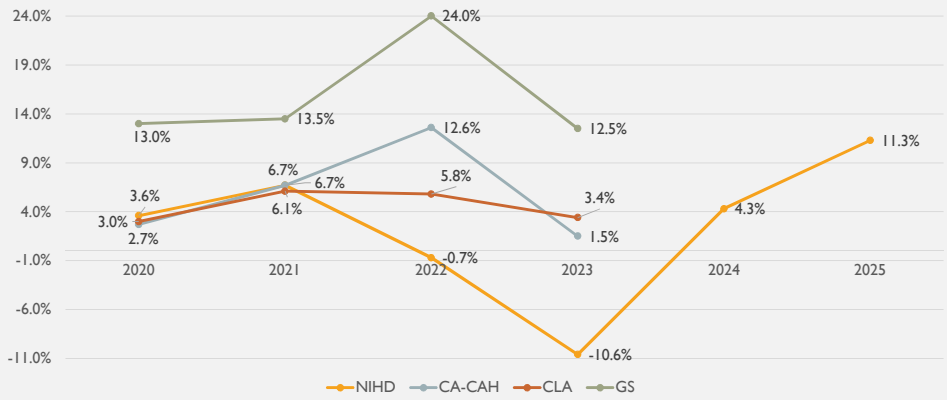

AUGUST 2024 FINANCIAL PERFORMANCE
August 2023
August 2024
$800,000
$600,000
$400,000
$200,000
$-
$(200,000)
$(400,000)
$(600,000)
$(800,000)
$(149,542)
$(544,049)
$175,023
$248,064
$(77,526)
$689,172
Net Income (Loss)
Operating Income (Loss)
EBIDA (Loss)


FYE 2025 FINANCIAL PERFORMANCE
FYE 2024
FYE 2025
$3,500,000
$3,000,000
$2,500,000
$2,000,000
$1,500,000
$1,000,000
$500,000
$-
$(500,000)
$(1,000,000)
$(1,500,000)
$(491,045)
$(1,136,024)
$158,085
$2,288,726
$1,378,961
$3,171,167
Net Income (Loss)
Operating Income (Loss)
EBIDA (Loss)

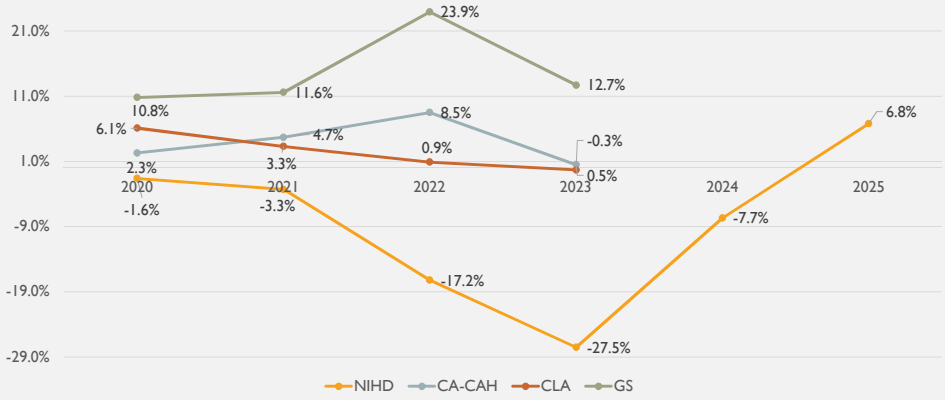
YTD OPERATING INCOME (LOSS) PERFORMANCE



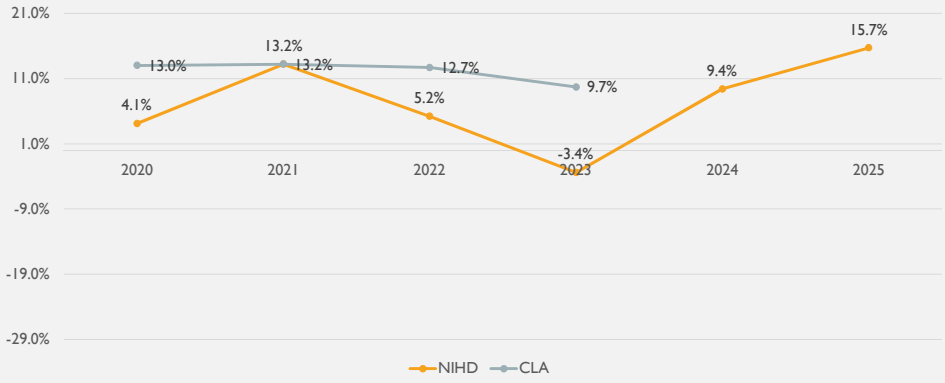
NET PROFIT MARGIN



OPERATING MARGIN

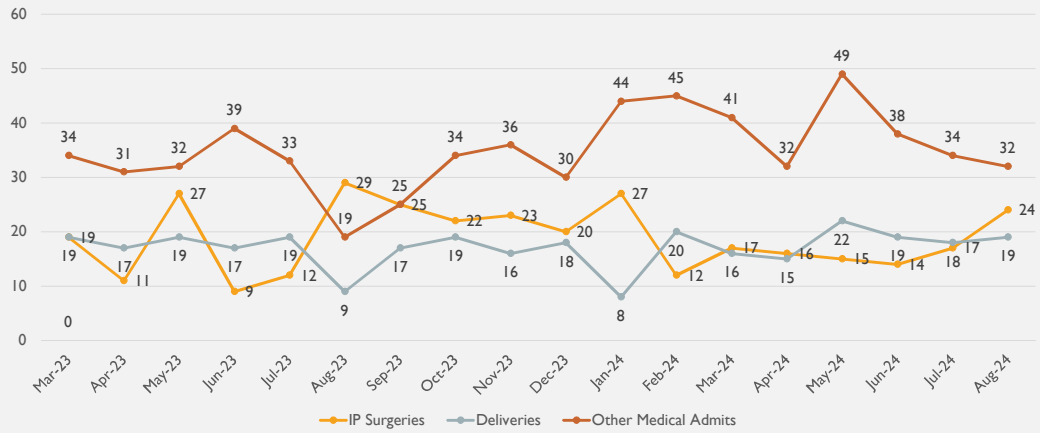


EBIDA MARGIN

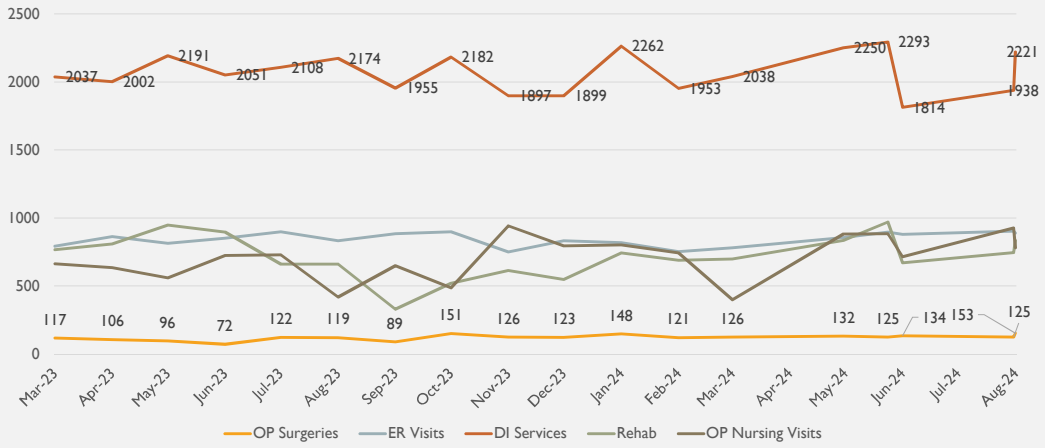


VOLUMES

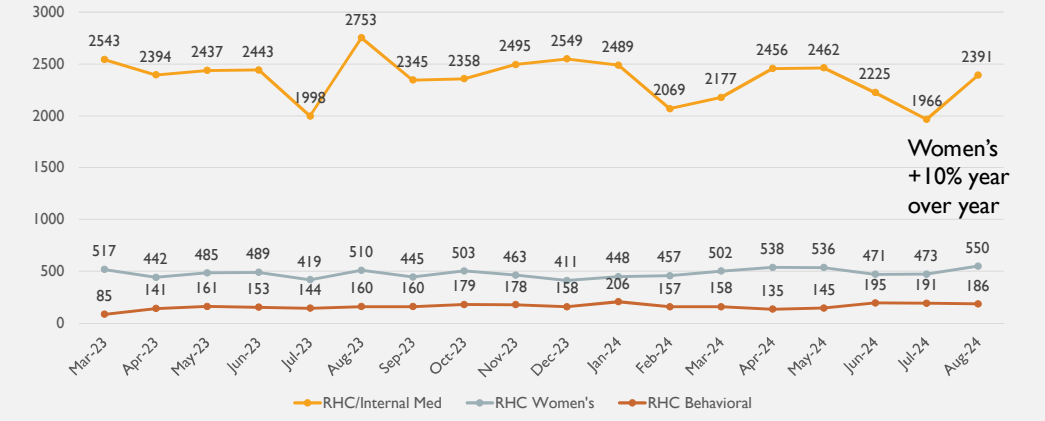
INPATIENT VOLUME PERFORMANCE



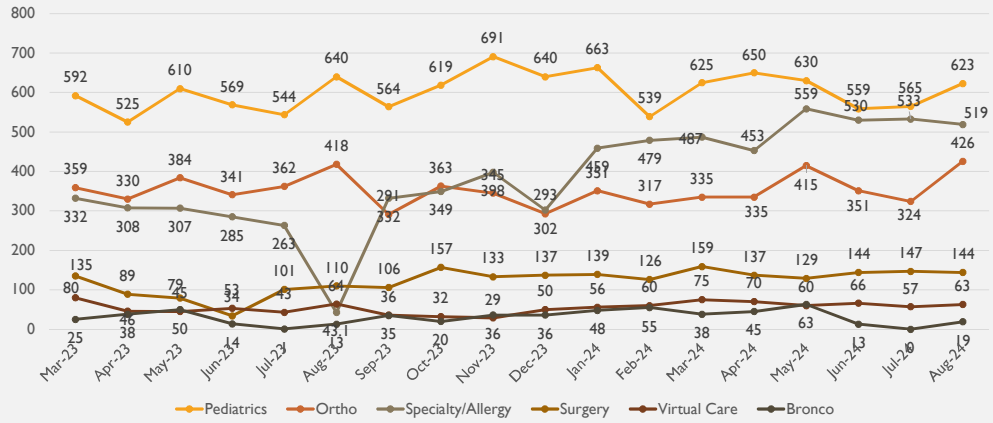
OUTPATIENT VOLUME PERFORMANCE



RHC VOLUME PERFORMANCE

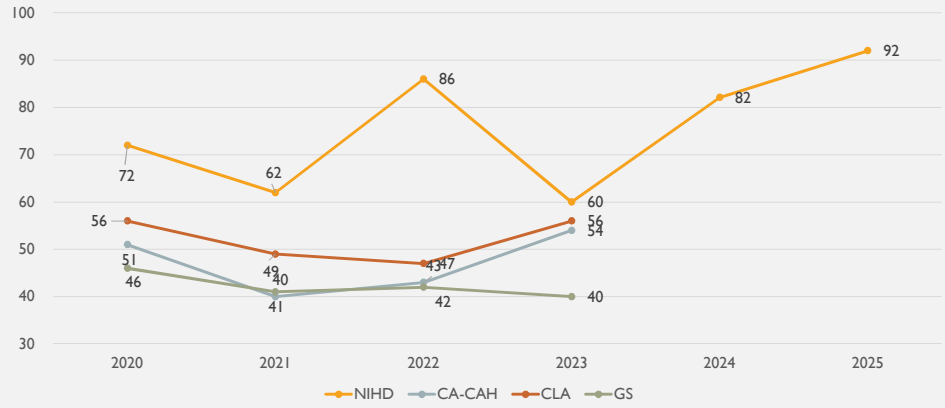


CLINIC VOLUME PERFORMANCE

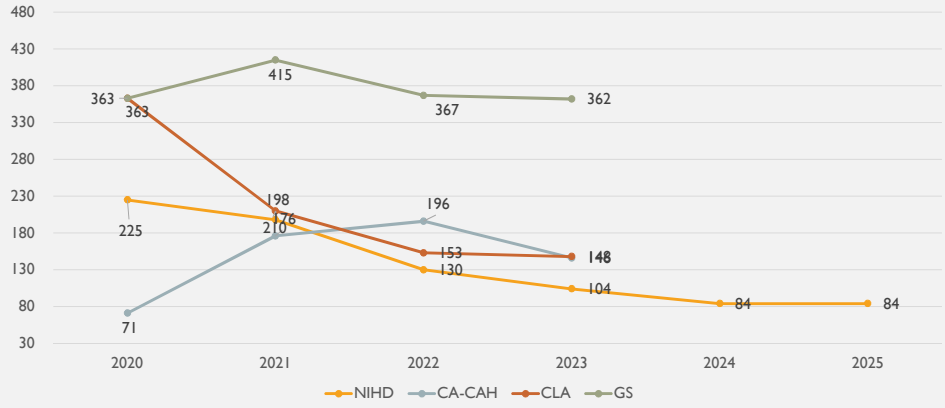


KEY PERFORMANCE INDICATORS

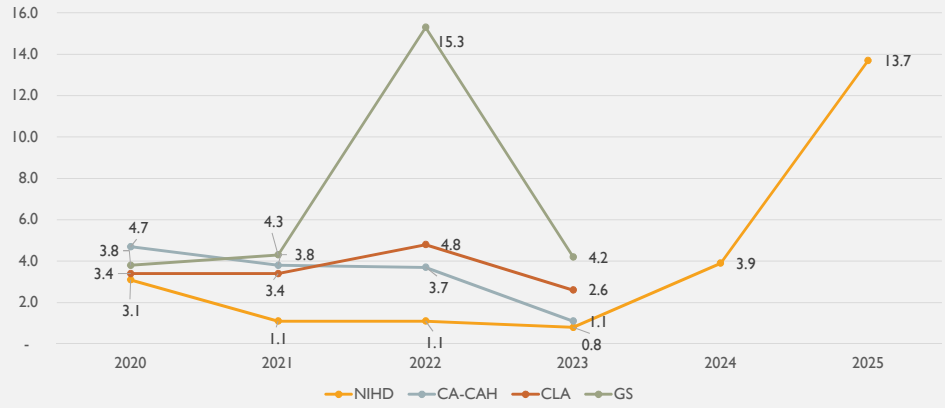
AR DAYS



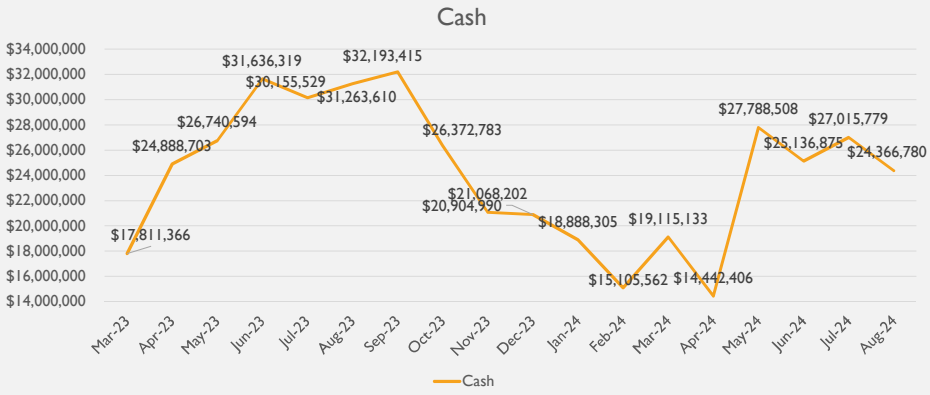
DAYS CASH ON HAND



DEBT SERVICE COVERAGE RATIO



UNRESTRICTED FUNDS



WAGE COSTS

	Aug 2022	Aug 2023	Aug 2024
Total Paid FTEs	459	379	398
Salaries, Wages, Benefits (SWB) Expense (incl. contract labor)	$5,381,190	$5,053,428	$5,549,587
SWB % of total expenses (including contract labor)	59%	55%	57%
Employed Average Hourly Rate	$42.07	$53.58	$49.96
Benefits % of Wages	55.7%	30.4%	46.6%

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Melissa Best-Baker called the meeting to order at 5:30 pm.
PRESENT	Melissa Best-Baker, Chair Jean Turner, Vice Chair Ted Gardner, Secretary David McCoy Barrett, Treasurer via zoom Mary Mae Kilpatrick, Member at Large Stephen DelRossi, Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Adam Hawkins, DO, Chief Medical Officer Alison Murray, Chief Human Resources Officer Sierra Bourne, MD, Chief of Staff
ABSENT	Andrea Mossman, Interim Associate Financial Officer
PUBLIC COMMENT	Chair Best-Baker reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board. There were no comments from the public.
NEW BUSINESS	Chair Best-Baker called attention to new business.
DR. JEPPSEN, EMERGENCY DEPARTMENT CHAIR	Dr. Jeppsen presented an update on the emergency department. Jeppsen expressed that things are going well. A doctor from UC Davis recently started, and NIHD has been hosting residents, and medical students from Arizona and New Mexico. The hope is to give residents and medical students experience working in a critical care access hospital with the potential of working at NIHD in the future. Treatment of stroke patients is going well. Scott Kobner has been doing educational presentations and the emergency department works to provide continuing education for the doctors.
COMPLIANCE OFFICER REPORT	Chair Best-Baker called attention to the compliance officer report. 1. Chair Best-Baker requested additional information about Language Line and CyraCom interpretative services. 2. Compliance Officer Dickson summarized the two different interpretative services. 3. Chair Best-Baker called attention to the workplace violence data. Compliance Officer Dickson explained the challenges and the need to keep patients and staff safe.
RESOLUTIONS	Chair Best-Baker called attention to the resolutions. 1. Resolution: 24-04 Appropriations a. CEO DelRossi summarized the resolution.

Motion: Jean Turner
Seconded: Ted Gardner
Roll call vote
Turner: Aye
Gardner: Aye
Kilpatrick: Aye
Barrett: Aye
Best-Baker: Aye
Passed: 5-0

2. Resolution: 24-05 Authorization of Operations Accounts
    a. CEO DelRossi summarized the resolution.

Motion: David Barrett
Seconded: Mary Mae Kilpatrick
Roll call vote
Turner: Aye
Gardner: Aye
Barrett: Aye
Kilpatrick: Aye
Best-Baker: Aye
Passed: 5-0

3. Resolution: 24-06 Resolution Approving Certain Deposits and Investments
    a. CEO DelRossi summarized the resolution.

Motion: Mary Mae Kilpatrick
Seconded: Ted Gardner
Roll call vote
Turner: Aye
Gardner: Aye
Barrett: Aye
Kilpatrick: Aye
Best-Baker: Aye
Passed: 5-0

4. Resolution: 24-07 New Named Fiduciaries for the NICLHD Plans
    a. CEO DelRossi summarized the resolution.

Motion: Mary Mae Kilpatrick
Seconded: Jean Turner
Roll call vote
Turner: Aye
Gardner: Aye
Barrett: Aye
Kilpatrick: Aye
Best-Baker: Aye
Passed: 5-0

CHIEF EXECUTIVE

Chair Best-Baker called attention to the CEO Report.

OFFICER REPORT

1. Position Recruitment: the goal is to continue to grow departments within the hospital.
2. Strategic Plan: Using key performance indicators we plan to quantify quarterly how we are meeting our strategic plan goals starting in 2025.

INTERIM ASSOCIATE FINANCIAL OFFICER REPORT

Chair Best-Baker called attention to the Financial and Statistical Reports.

1. Financial and Statistical Reports
    a. CEO DelRossi summarized the financial and statistical reports, highlighting specific growth or change.

Motion: Ted Gardner
Seconded: David Barrett
Roll call vote
Turner: Aye
Gardner: Aye
Barrett: Aye
Kilpatrick: Aye
Best-Baker: Aye
Passed: 5-0

2. Recruitment for Revenue Cycle Director – CEO DelRossi expressed our current consultant is moving out of the hospital industry and we are actively recruiting and interviewing to fill this position.
3. Preparations for Audit and Cost Report – CEO DelRossi expressed that we are preparing and on track for the December audit.

Public comment via Zoom chat regarding the CEO's salary. Discussion ensued and included an expression from Vice Chair Turner that NIHD offers fair market-value salaries to its employees.

CHIEF MEDICAL OFFICER REPORT

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

1. Chair Best-Baker and CMO Hawkins drew attention to the Quality department's diligence in meeting all 12 QIP measures, including the challenges of meeting them for 2024.
2. Vice Chair Turner and CMO Hawkins expressed appreciation for NIHD’s women's health services and appreciation for the Labor and Delivery department.
3. Drs. Kristin and Rich Meredick are leaving and there is active recruitment for those positions.
4. Dr. Wiles has finished his first year with us and has added service lines allowing patients to stay in town rather than seek services out of town.
5. Chair Best-Baker commented on fistulas and CMO Hawkins elaborated.

Public comment via Zoom: ‘No anesthesiologist is listed on our web page.’ CEO DelRossi explained that NIHD is in the process of updating the website. NIHD contracts with Anesthesiologists Dr. Theodore Rasoumoff and Dr. Paul Kim.

CHIEF OF STAFF REPORT

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

1. Dr. Sierra Bourne expressed that emergency department visits are up 400 visits from last year. A 'Years of Celebration' was held at Cardinal Village. She along with other medical staff collect coding resources and real-time feedback.

Public Comment: 'Is dialysis still being done at Toiyabe?' Dr. Hawkins expressed NIHD does not offer dialysis services but he believes that Toiyabe is offering dialysis services.

CONSENT AGENDA

Chair Best-Baker called attention to the consent agenda.

1. Removed three items from the consent agenda:
   a. September Department Leader Updates
   b. Department leader updates, Learning Internships, Clinical or Academic Rotations, and Career Shadowing, Opportunities
   c. Temporary Telecommuting Assignment Policy

Motion: Ted Gardner
Seconded: Jean Turner
Roll call vote
Turner: Aye
Gardner: Aye
Barrett: Aye
Kilpatrick: Abstain
Best-Baker: Aye
Passed: 4-0, 1 Abstention

2. Chair Best-Baker requested more information about 'Moonlight Mammogram nights.' Manager of Marketing Barbara Laughon expressed we extended hours on Wednesdays from 4:00-8:00 pm for breast cancer screening. There are three special days NIHD works with Southern Inyo Hospital, Toiyabe, and NIHD employees to offer mammogram days.
3. Chair Best-Baker requested more information about the Oncology Navigator. COO/CNO Murray explained that their role is to coordinate care with outside providers, assure follow-up, get information for our providers at NIHD, and coordinate the care specifically for oncology patients.
4. Chair Best-Baker drew attention to Learning Internships, Clinical or Academic Rotations, and Career Shadowing Opportunities Policy. She asked if ENTs qualify for a learning internship. COO/CNO Murray expressed that ENTs can join our program and that they need to go through the student onboarding process. COO/CNO Murray distinguished between clinical students working with patients and learning internships that do not. This policy includes both student and learning internships.

Public Comment: 'NIH may want to consider a physician rural hospital fellowship position.' CMO Hawkins expressed that NIHD has explored this possibility and wants to ensure the trainee has the volume and support they need to make it worthwhile.

5. Chair Best-Baker drew attention to the 'Temporary Telecommuting

Assignment Policy,' questioning whether employees in training can telecommute or work from home. CHRO Murray explained that most exempt employees can and are teleworking, this policy addresses non-exempt employees.

6. Vote to accept:
   a. September Department Leader Updates
   b. Department leader updates, Learning Internships, Clinical or Academic Rotations, and Career Shadowing, Opportunities
   c. Temporary Telecommuting Assignment Policy

Motion: Jean Turner
Seconded: Ted Gardner
Roll call vote
Turner: Aye
Gardner: Aye
Barrett: Aye
Kilpatrick: Aye
Best-Baker: Aye
Passed: 5-0

GENERAL INFORMATION FROM BOARD MEMBERS

Chair Best-Baker drew attention to general information from board members.

1. Chair Best-Baker is attending the ACHD annual meeting in Sacramento at the end of September.
2. Member at large Kilpatrick stated the NIH foundation is raffling a painting to raise funds for an AED machine needed for the third NIHD shuttle van.
3. Member at large Kilpatrick expressed appreciation regarding the ceremony honoring Halfen and Ungersma.
4. Vice Chair Turner is attending an ACHD board meeting and the ACHD annual meeting in Sacramento at the end of September.

Public Comment: 'Barb did a wonderful job on everything.'

PUBLIC COMMENT ON CLOSED SESSION ITEMS

There were no comments from the public.

ADJOURNMENT TO CLOSED SESSION

Adjournment to closed session at 6:33 pm.

RETURN TO OPEN SESSION

Called back to order at 7:49 pm.

Chair Best-Baker stated there were no reportable actions from the closed session.

ADJOURNMENT

Adjournment at 7:49 pm.

_____
Melissa Best-Baker
Northern Inyo Healthcare District
Chair

Attest: _____
Ted Gardner
Northern Inyo Healthcare District Chair
Secretary

October 2024 Statement

Open Date: 09/06/2024 Closing Date: 10/04/2024

[redacted]

[redacted]

NORTHERN INYO HOSPITA

STEPHEN DELROSSI [redacted]

New Balance	**$6,436.88**
Minimum Payment Due	**$65.00**
Payment Due Date	**11/01/2024**

[redacted]

[redacted]

Activity Summary

Previous Balance	+	$295.55
Payments	-	$295.55
Other Credits		$0.00
Purchases	+	$6,436.88
Balance Transfers		$0.00
Advances		$0.00
Other Debits		$0.00
Fees Charged		$0.00
Interest Charged		$0.00
[redacted]		[redacted]
Credit Line		$37,500.00
Available Credit		$31,063.12
Days in Billing Period		29

Payment Options: [redacted]

[redacted]

Account Number	[redacted]
Payment Due Date	11/01/2024
New Balance	$6,436.88
Minimum Payment Due	$65.00

24-Hour Cardmember Service: [redacted]

. to pay by phone

. to change your address

Amount Enclosed $_____

[redacted]

[redacted]

What To Do If You Think You Find A Mistake On Your Statement
If you think there is an error on your statement, please call us at the telephone number on the front of this statement, or write to us at: [redacted]
In your letter or call, give us the following information:
▶ *Account information:* Your name and account number.
▶ *Dollar amount:* The dollar amount of the suspected error.
▶ *Description of Problem:* If you think there is an error on your bill, describe what you believe is wrong and why you believe it is a mistake.
You must contact us within 60 days after the error appeared on your statement. While we investigate whether or not there has been an error, the following are true:
▶ We cannot try to collect the amount in question, or report you as delinquent on that amount.
▶ The charge in question may remain on your statement, and we may continue to charge you interest on that amount. But, if we determine that we made a mistake, you will not have to pay the amount in question or any interest or other fees related to that amount.
▶ While you do not have to pay the amount in question, you are responsible for the remainder of your balance.
▶ We can apply any unpaid amount against your credit limit.
Your Rights If You Are Dissatisfied With Your Credit Card Purchases
If you are dissatisfied with the goods or services that you have purchased with your credit card, and you have tried in good faith to correct the problem with the merchant, you may have the right not to pay the remaining amount due on the purchase.
To use this right, all of the following must be true:
1. The purchase must have been made in your home state or within 100 miles of your current mailing address, and the purchase price must have been more than $50. (Note: Neither of these are necessary if your purchase was based on an advertisement we mailed to you, or if we own the company that sold you the goods or services.)
2. You must have used your credit card for the purchase. Purchases made with cash advances from an ATM or with a check that accesses your credit card account do not qualify.
3. You must not yet have fully paid for the purchase.
If all of the criteria above are met and you are still dissatisfied with the purchase, contact us in writing at: Cardmember Service, [redacted]
While we investigate, the same rules apply to the disputed amount as discussed above. After we finish our investigation, we will tell you our decision. At that point, if we think you owe an amount and you do not pay we may report you as delinquent.
Important Information Regarding Your Account
1. **INTEREST CHARGE:** Method of Computing Balance Subject to Interest Rate: We calculate the periodic rate or interest portion of the **INTEREST CHARGE** by multiplying the applicable Daily Periodic Rate (**"DPR"**) by the Average Daily Balance (**"ADB"**) (including new transactions) of the Purchase, Advance and Balance Transfer categories subject to interest, and then adding together the resulting interest from each category. We determine the **ADB** separately for the Purchases, Advances and Balance Transfer categories. To get the **ADB** in each category, we add together the daily balances in those categories for the billing cycle and divide the result by the number of days in the billing cycle. We determine the daily balances each day by taking the beginning balance of those Account categories (including any billed but unpaid interest, fees, credit insurance and other charges), adding any new interest, fees, and charges, and subtracting any payments or credits applied against your Account balances that day. We add a Purchase, Advance or Balance Transfer to the appropriate balances for those categories on the later of the transaction date or the first day of the statement period. Billed but unpaid interest on Purchases, Advances and Balance Transfers is added to the appropriate balances for those categories each month on the statement date. Billed but unpaid Advance Transaction Fees are added to the Advance balance of your Account on the date they are charged to your Account. Any billed but unpaid fees on Purchases, credit insurance charges, and other charges are added to the Purchase balance of the Account on the date they are charged to the Account. Billed but unpaid fees on Balance Transfers are added to the Balance Transfer balance of the Account on the date they are charged to the Account. In other words, billed and unpaid interest, fees, and charges will be included in the **ADB** of your Account that accrues interest and will reduce the amount of credit available to you.To the extent credit insurance charges, overlimit fees, Annual Fees, and/or Travel Membership Fees may be applied to your Account, such charges and/or fees are not included in the ADB calculation for Purchases until the first day of the billing cycle following the date the credit insurance charges, overlimit fees, Annual Fees and/or Travel Membership Fees (as applicable) are charged to the Account. Prior statement balances subject to an interest-free period that have been paid on or before the payment due date in the current billing cycle are not included in the **ADB** calculation.
2. **Payment Information:** We will accept payment via check, money order, the internet (including mobile and online) or phone or previously established automatic payment transaction. You must pay us in U.S. Dollars. If you make a payment from a foreign financial institution, you will be charged and agree to pay any collection fees added in connection with that transaction. The date you mail a payment is different than the date we receive the payment. The payment date is the day we receive your check or money order at U.S. Bank National Association, [redacted] or the day we receive your internet or phone payment. All payments by check or money order accompanied by a payment coupon and received at this payment address will be credited to your Account on the day of receipt if received by 5:00 p.m. CT on any banking day. Payments sent without the payment coupon or to an incorrect address will be processed and credited to your Account within 5 banking days of receipt. Payments sent without a payment coupon or to an incorrect address may result in a delayed credit to your Account, additional interest charges, fees, and/or Account suspension. The deadline for on-time internet and phone payments varies, but generally must be made before 5:00 p.m. CT to 8 p.m. CT depending on what day and how the payment is made. Please contact Cardmember Service for internet, phone, and mobile crediting times specific to your Account and your payment option. Banking days are all calendar days except Saturday, Sunday and federal holidays. Payments due on a Saturday, Sunday or federal holiday and received on those days will be credited on the day of receipt. There is no prepayment penalty if you pay your balance at any time prior to your payment due date.
3. **Credit Reporting:** We may report information on your Account to Credit Bureaus. Late payments, missed payments or other defaults on your Account may be reflected in your credit report.

NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

Cardmember Service [redacted]

Important Messages

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

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

Skip the mailbox. Switch to e-statements and securely access your statements online. Get started at usbank.com/login.

Transactions

Payments and Other Credits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
09/25	09/25	0000	INTERNET PAYMENT THANK YOU	$295.55CR	
			TOTAL THIS PERIOD	**$295.55CR**	

Purchases and Other Debits

Post Date	Trans Date	Ref #	Transaction Description	Amount	Notation
09/06	09/03	[redacted]	TOTALLY CHO [redacted]	$2,079.41	Christmas Gift
09/09	09/07	[redacted]	MARRIOTT MISSION VALLE SAN DIEGO CA FOR 04 NIGHTS [redacted]	$197.23	Board Clerk Conference
09/10	09/09	[redacted]	CURTIN CONVENTION & EX [redacted]	$1,142.40	PT Convention
09/10	09/09	[redacted]	American Hospital I As [redacted]	$78.00	Education
09/23	09/22	[redacted]	HYATT REGENCY SAN FRAN [redacted] FOR 02 NIGHTS [redacted]	$452.52	PT Convention
09/23	09/22	[redacted]	HYATT REGENCY SAN FRAN [redacted] CA FOR 02 NIGHTS [redacted]	$452.52	PT Convention
09/30	09/28	[redacted]	OPTIMUM 7715 [redacted]	$192.31	Rental Property
09/30	09/29	[redacted]	FACEBK [redacted]	$400.00	Marketing
10/01	09/30	[redacted]	FACEBK [redacted]	$18.62	Marketing
10/04	10/03	[redacted]	USPS PO [redacted] BISHOP CA	$657.00	Mail
10/04	10/02	[redacted]	UNITED [redacted] TX [redacted] LAS VEGAS TO OHARE OHARE TO LA GUARDIA LA GUARDIA TO DULLES DULLES TO LAS VEGAS	$502.90	Beckers
10/04	10/02	[redacted]	UNITED [redacted] TX	$66.99	Beckers
10/04	10/02	[redacted]	UNITED [redacted] TX	$36.99	Beckers
10/04	10/02	[redacted]	UNITED [redacted] TX	$159.99	Beckers
			TOTAL THIS PERIOD	**$6,436.88**	

Continued on Next Page

NORTHERN INYO HOSPITA
STEPHEN DELROSSI [redacted]

Cardmember Service [redacted]

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	23.74%	
**PURCHASES	$6,436.88	$0.00	YES	$0.00	23.74%	
**ADVANCES	$0.00	$0.00	YES	$0.00	29.99%	

Contact Us

Phone	Questions	Mail payment coupon with a check	Online
[redacted]	[redacted]	[redacted]	[redacted]

End of Statement

USI CONSULTING GROUP

GASB 67 AND 68 DISCLOSURE

REPORTING AS OF JUNE 30, 2024

NORTHERN INYO COUNTY LOCAL HOSPITAL DISTRICT RETIREMENT PLAN

Table of Contents

All the items listed below are required by GASB 67 and GASB 68 but are not included in this report:

Statement of Changes in Fiduciary Net Position

Statement of Fiduciary Net Position

Investments That Represent 5% or More of the Plan's Fiduciary Net Position

Investment Policy

Pension Board Composition

Authority to Amend Plan

Report Prepared By:

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Certification

This report presents the results of the June 30, 2024 GASB 67 and GASB 68 Disclosure for the Northern Inyo County Local Hospital District Retirement Plan (the Plan). The report is intended to satisfy the requirements of both GASB 67 and GASB 68. This report may not be appropriate for any other purpose.

The report has been performed in accordance with generally accepted actuarial principles and practices. It is intended to comply with the Actuarial Standards Board Standards of Practice.

I certify that the actuarial assumptions and methods that were selected by me and represent my best estimate of anticipated actuarial experience under the Plan.

In preparing this disclosure report, I have relied on employee data provided by the Plan Sponsor, and on asset and contribution information provided by the Plan Sponsor or Trustee. I have audited neither the employee data nor the financial information, although I have reviewed them for reasonableness.

The results in this disclosure report are based on the Plan as summarized in the Summary of Plan Provisions section of this report and the actuarial methods and assumptions detailed in the Description of Actuarial Methods and Procedures and Description of Actuarial Assumptions sections of this report.

Future actuarial measurements may differ significantly from the current measurements presented in this report due to factors such as, but not limited to, the following: plan experience differing from that anticipated by the economic or demographic assumptions; changes in economic or demographic assumptions; increases or decreases expected as part of the natural operation of the methodology used for these measurements (such as the end of an amortization period or additional cost or contribution requirements based on the plan's funded status); and changes in plan provisions or applicable law. Due to the limited scope of this report, an analysis of the potential range of such future measurements has not been performed.

I have no relationship with the employer or the Plan that would impair, or appear to impair, my objectivity in performing the work presented in this report. I am a member of the American Academy of Actuaries and meet its Qualification Standards to render the actuarial opinion contained herein.

Ellen A. Kucenski, FSA, FCA, MAAA
Enrolled Actuary 23-07674

September 19, 2024

Money-Weighted Rate of Return
December 31, 2023

Beg. Value 12,097,336 **Ending Value** 12,152,002

	Date	Employer Contributions	Employee Contributions	Benefit Payments	Admin. Expenses	Period Invested	Period Weight	Net External Cash Flows w/ Interest
Beg. of Yr.	7/1/2023					12	1.000	10,833,094
July	7/31/2023	537,000	-	(537,716)	-	11	0.917	(647)
August	8/31/2023	537,000	-	(34,650)	(699)	10	0.833	457,566
September	9/30/2023	386,000	-	(833,737)	-	9	0.750	(412,164)
October	10/31/2023	413,000	-	(35,444)	(858)	8	0.667	349,974
November	11/30/2023	827,707	-	(334,324)	-	7	0.583	462,616
December	12/31/2023	1,121,016	-	(610,376)	-	6	0.500	483,221
January	1/31/2024	37,665	-	(35,444)	-	5	0.417	2,121
February	2/29/2024	72,428	-	(827,471)	(1,019)	4	0.333	(728,750)
March	3/31/2024	350,000	-	(553,195)	-	3	0.250	(197,665)
April	4/30/2024	350,000	-	(35,444)	-	2	0.167	308,822
May	5/31/2024	700,000	-	(35,886)	(1,017)	1	0.083	657,026
June	6/30/2024	-	-	(50,453)	(12,759)	0	0.000	(63,212)
End of Yr.	6/30/2024	5,331,816	-	(3,924,140)	(16,352)			12,152,002

Money-Weighted Rate of Return **-10.45%**

Schedule of Investment Returns
Last 10 Fiscal Years

Year Ended June 30:	Annual Money-Weighted Rate of Return, Net of Investment Expense
2015	3.86%
2016	3.11%
2017	-0.48%
2018	-1.16%
2019	-0.47%
2020	8.74%
2021	-4.36%
2022	36.17%
2023	9.33%
2024	-10.45%

Contributions Compared to ADEC and Payroll
Schedule of Contributions Last 10 Fiscal Years

	2024	2023	2022	2021	2020
Actuarially determined employer contribution (ADEC)	$ 4,730,922	$ 4,960,082	$ 9,056,000	$ 7,752,000	$ 6,072,000
Contributions in relation to the ADEC	4,743,446	5,973,722	5,599,234	-	5,500,000
Contribution deficiency (excess)	$ (12,524)	$ (1,013,640)	$ 3,456,766	$ 7,752,000	$ 572,000
Covered payroll	$ 8,563,359	$ 8,609,073	$ 9,243,630	$ 9,302,388	$ 10,780,522
Contributions as a % of covered payroll	55.39%	69.39%	60.57%	0.00%	51.02%

	2019	2018	2017	2016	2015
Actuarially determined employer contribution (ADEC)	$ 5,484,000	$ 4,716,000	$ 5,340,000	$ 3,900,000	$ 4,320,000
Contributions in relation to the ADEC	6,060,000	5,340,000	5,340,000	3,900,000	4,320,000
Contribution deficiency (excess)	$ (576,000)	$ (624,000)	$ -	$ -	$ -
Covered payroll	$ 11,537,345	$ 12,968,106	$ 13,529,712	$ 15,892,425	$ 17,664,833
Contributions as a % of covered payroll	52.53%	41.18%	39.47%	24.54%	24.46%

Discount Rate Calculation

The long-term expected rate of return on investments may be used to discount liabilities to the extent that the plan's fiduciary net position and future contributions are projected to be sufficient to cover expected benefit payments and administrative expenses for current plan members. Projections of the plan's fiduciary net position incorporate all cash flows for contributions from the employer and employee and administrative expenses. Professional judgment should be applied to the projections of contributions in circumstances where (a) contribution amounts are established by statute or contract or (b) a formal written policy exists. Consideration should also be given to the most recent five-year contribution history as key indicators of future contributions. It should not include cash flows for future plan members.

If the amount of the plan's fiduciary net position is projected to be greater than or equal to the benefit payments and administrative expenses made in that period, the actuarial present value of payments should be discounted using the long-term expected rate of return on those investments. A 20-year, high quality (AA/Aa or higher), tax-exempt municipal bond yield or index rate must be used to discount benefit payments for periods where the fiduciary net position is not projected to cover expected benefit payments and administrative expenses.

Plans that are projected to have sufficient fiduciary net position indefinitely will use the long-term expected return on investments to determine liabilities but will have to substantiate their projected solvency. GASB permits alternative methods to evaluate the sufficiency of the plan's net fiduciary position. Based on the plan's current net pension liability and current contribution policy, the plan's projected fiduciary net position will be sufficient to cover projected benefit payments and administrative expenses indefinitely. Therefore, since the fund is not projected to run out of money, we have used the 6.25% interest rate assumption to discount plan liabilities.

Target Allocation and Expected Rate of Return

Actuarial Valuation as of July 1, 2024

Asset Class	Target Allocation	Long-Term Expected Real Rate of Return*	Weighting
US Equity - Large Cap	41.00%	5.10%	2.09%
Non-US Equity - Developed	16.50%	5.32%	0.88%
Non-US Equity - Emerging	5.50%	6.13%	0.34%
Commodities	2.00%	2.44%	0.05%
Real Estate	5.00%	3.79%	0.19%
US Corporate Bonds - Core	9.50%	2.85%	0.27%
US Corporate Bonds-Long Duration	8.25%	2.54%	0.21%
US Corporate Bonds-Diversified Income	5.25%	2.85%	0.15%
US Treasuries (Cash Equivalents)	7.00%	0.00%	0.00%
	100.00%		4.18%
Long-Term Inflation Expectation			2.40%
Long-Term Expected Nominal Return			6.58%

**Long-Term Real Returns are provided by USI Advisors, Inc. The returns are geometric means.*

The long-term expected rate of return on pension plan investments was determined using a building block method in which best-estimate ranges of expected future real rates of return are developed. Best estimates of the real rates of return for each major asset class are included in the pension plan's target asset allocation.

The information above is based on geometric means and does not reflect additional returns through investment selection, asset allocation and rebalancing. An expected rate of return of 6.25% was used.

Schedule of Changes in Net Pension Liability and Related Ratios
Last 10 Fiscal Years

	2024	2023	2022	2021	2020
Total pension liability					
Service cost	$ 1,240,702	$ 1,376,714	$ 1,706,921	$ 1,951,401	$ 1,781,772
Interest	2,346,115	2,183,032	2,179,367	2,298,637	2,694,973
Changes of benefit terms	-	-	-	-	-
Differences between expected and actual experience	1,766,631	3,910,725	769,805	880,397	2,640,361
Changes of assumptions	(15,685,950)	-	96,057	1,737,567	6,850,017
Benefit payments, including refunds of member contributions	(3,924,140)	(2,603,583)	(6,023,511)	(13,117,516)	(8,053,422)
Net change in total pension liability	(14,256,642)	4,866,888	(1,271,361)	(6,249,514)	5,913,701
Total pension liability - beginning	59,354,999	54,488,111	55,759,472	62,008,986	56,095,285
Total pension liability - ending: (a)	$ 45,098,357	$ 59,354,999	$ 54,488,111	$ 55,759,472	$ 62,008,986
Plan fiduciary net position					
Contributions - employer	$ 5,331,816	$ 7,403,934	$ 347,300	$ 3,000,000	$ 5,242,000
Contributions - member	-	-	-	-	-
Net investment income (loss)	(1,336,658)	817,781	2,082,706	(746,702)	1,893,587
Benefit payments, including refunds of member contributions	(3,924,140)	(2,603,583)	(6,023,511)	(13,117,516)	(8,053,422)
Administrative expenses	(16,352)	(58,167)	(57,983)	(54,472)	(58,625)
Other	-	-	-	-	-
Net change in plan fiduciary net position	54,666	5,559,965	(3,651,488)	(10,918,690)	(976,460)
Plan fiduciary net position - beginning	12,097,336	6,537,371	10,188,859	21,107,549	22,084,009
Plan fiduciary net position - ending: (b)	12,152,002	12,097,336	6,537,371	10,188,859	21,107,549
Net pension liability - ending: (a) - (b)	$ 32,946,355	$ 47,257,663	$ 47,950,740	$ 45,570,613	$ 40,901,437
Plan fiduciary net position as a % of total pension liability	26.95%	20.38%	12.00%	18.27%	34.04%
Covered payroll	$ 8,563,359	$ 8,609,073	$ 9,243,630	$ 9,302,388	$ 10,780,522
Net pension liability as a % of covered payroll	384.74%	548.93%	518.74%	489.88%	379.40%

	2019	2018	2017	2016	2015
Total pension liability					
Service cost	$ 2,121,997	$ 2,281,116	$ 2,812,178	$ 2,219,985	$ 2,683,298
Interest	2,726,359	2,805,649	3,053,437	3,047,939	3,356,235
Changes of benefit terms	-	-	-	-	-
Differences between expected and actual experience	3,016,650	1,343,607	(3,295,677)	1,385,608	108,261
Changes of assumptions	(84,200)	(185,137)	(417,283)	12,966,856	(1,841,294)
Benefit payments, including refunds of member contributions	(8,082,821)	(5,554,354)	(7,575,753)	(8,213,871)	(9,321,220)
Net change in total pension liability	(302,015)	690,881	(5,423,098)	11,406,517	(5,014,720)
Total pension liability - beginning	56,397,300	56,575,151	61,998,249	50,591,732	55,606,452
Total pension liability - ending: (a)	$ 56,095,285	$ 57,266,032	$ 56,575,151	$ 61,998,249	$ 50,591,732
Plan fiduciary net position					
Contributions - employer	$ 6,300,000	$ 5,340,000	$ 5,340,000	$ 3,900,000	$ 4,320,000
Contributions - member	-	-	-	-	-
Net investment income (loss)	(116,063)	(292,381)	(126,769)	880,376	1,223,136
Benefit payments, including refunds of member contributions	(8,082,821)	(5,554,354)	(7,575,753)	(8,213,871)	(9,321,220)
Administrative expenses	(64,562)	(88,502)	(55,640)	(51,336)	-
Other	-	-	-	-	-
Net change in plan fiduciary net position	(1,963,446)	(595,237)	(2,418,162)	(3,484,831)	(3,778,084)
Plan fiduciary net position - beginning	24,047,455	26,087,619	28,505,781	31,990,612	35,768,696
Plan fiduciary net position - ending: (b)	22,084,009	25,492,382	26,087,619	28,505,781	31,990,612
Net pension liability - ending: (a) - (b)	$ 34,011,276	$ 31,773,650	$ 30,487,532	$ 33,492,468	$ 18,601,120
Plan fiduciary net position as a % of total pension liability	39.37%	44.52%	46.11%	45.98%	63.23%
Covered payroll	$ 11,537,345	$ 12,968,106	$ 13,529,712	$ 15,892,425	$ 17,664,833
Net pension liability as a % of covered payroll	294.79%	245.01%	225.34%	210.74%	105.30%

Schedule of Net Pension Liability
Last 10 Fiscal Years

	2024	2023	2022	2021	2020
Total pension liability	$ 45,098,357	$ 59,354,999	$ 54,488,111	$ 55,759,472	$ 62,008,986
Plan fiduciary net position	12,152,002	12,097,336	6,537,371	10,188,859	21,107,549
Net pension liability (asset)	$ 32,946,355	$ 47,257,663	$ 47,950,740	$ 45,570,613	$ 40,901,437
Plan fiduciary net position as a % of total pension liability	26.95%	20.38%	12.00%	18.27%	34.04%
Covered payroll	$ 8,563,359	$ 8,609,073	$ 9,243,630	$ 9,302,388	$ 10,780,522
Net pension liability as a % of covered payroll	384.74%	548.93%	518.74%	489.88%	379.40%

	2019	2018	2017	2016	2015
Total pension liability	$ 56,095,285	$ 56,397,300	$ 56,575,151	$ 61,998,249	$ 50,591,732
Plan fiduciary net position	22,084,009	24,047,455	26,087,619	28,505,781	31,990,612
Net pension liability (asset)	$ 34,011,276	$ 32,349,845	$ 30,487,532	$ 33,492,468	$ 18,601,120
Plan fiduciary net position as a % of total pension liability	39.37%	42.64%	46.11%	45.98%	63.23%
Covered payroll	$ 11,537,345	$ 12,968,106	$ 13,529,712	$ 15,892,425	$ 17,664,833
Net pension liability as a % of covered payroll	294.79%	249.46%	225.34%	210.74%	105.30%

Disclosure Overview as of December 31, 2023

	Plan's Funded Status			Deferred Outflows/(Inflows) of Resources				
	Total Pension Liability	Plan Fiduciary Net Position	Net Pension Liability	Experience (Gains)/ Losses	Assumption Changes	Investment (Gains)/ Losses	Recognized in Net Pension Liability	Recognized in Total Pension Expense
Balances -- prior year disclosure	(59,354,999)	12,097,336	(47,257,663)	6,292,207	5,969,981	(1,059,353)	(47,257,663)	
Changes in net pension liability:								
Service cost	(1,240,702)		(1,240,702)					1,240,702
Interest	(2,346,115)		(2,346,115)					2,346,115
Net investment income (loss)		(1,336,658)	(1,336,658)					1,336,658
Contributions - employer		5,331,816	5,331,816				5,331,816	
Contributions - member		-	-					-
Changes of benefit terms	-		-					-
Benefit payments, including refunds of member contributions	3,924,140	(3,924,140)	-					
Administrative expense		(16,352)	(16,352)					16,352
Other		-	-					-
Recognized in total pension expense								
Differences between expected and actual experience				(2,380,254)			2,380,254	2,380,254
Changes of assumptions					1,064,028		(1,064,028)	(1,064,028)
Differences between projected and actual earnings on pension plan investments						(25,266)	25,266	25,266
Deferred outflows/inflows of resources								
Differences between expected and actual experience	(1,766,631)		(1,766,631)	1,766,631			(1,766,631)	
Changes of assumptions	15,685,950		15,685,950		(15,685,950)		15,685,950	
Differences between projected and actual earnings on pension plan investments						1,848,105	(1,848,105)	(1,848,105)
Total pension expense							(4,433,214)	4,433,214
Balances -- end of year	(45,098,357)	12,152,002	(32,946,355)	5,678,584	(8,651,941)	763,486	(32,946,355)	

Changes in the Net Pension Liability

	Increase (Decrease)		
	Total Pension Liability (a)	Plan Fiduciary Net Position (b)	Net Pension Liability (a) - (b)
Balances as of June 30, 2023	$ 59,354,999	$ 12,097,336	$ 47,257,663
Changes for the year:			
Service cost	1,240,702		1,240,702
Interest	2,346,115		2,346,115
Differences between expected and actual experience	1,766,631		1,766,631
Changes of benefit terms	-		-
Changes of assumptions	(15,685,950)		(15,685,950)
Contributions - employer		5,331,816	(5,331,816)
Contributions - member		-	-
Net investment income (loss)		(1,336,658)	1,336,658
Benefit payments, including refunds of member contributions	(3,924,140)	(3,924,140)	-
Administrative expense		(16,352)	16,352
Other		-	-
Net changes	(14,256,642)	54,666	(14,311,308)
Balances at June 30, 2024	$ 45,098,357	$ 12,152,002	$ 32,946,355

Components of the Pension Expense for the Fiscal Year Ended June 30, 2024

Description		Amount
Service cost	$	1,240,702
Interest on the total pension liability		2,346,115
Differences between expected and actual experience		2,380,254
Changes of assumptions		(1,064,028)
Changes of benefit terms		-
Member contributions		-
Projected earnings on pension plan investments		(511,447)
Differences between projected and actual earnings on plan investments		25,266
Pension plan administrative expense		16,352
Other changes in fiduciary net position		-
Total pension expense	$	4,433,214

Increase (Decrease) in Pension Expense from the Recognition of the Effects of Differences Between Expected and Actual Experience

Year	Differences between Expected and Actual Experience	Recognition Period (Years)	2024	2025	2026	2027	2028	2029
2016	$ 1,385,608	9.0	$ 153,960					
2017	(3,295,677)	8.7	(378,813)	$ (265,173)				
2018	1,343,607	8.5	158,071	158,071	$ 79,039			
2019	3,016,650	8.5	354,900	354,900	354,900	$ 177,450		
2020	2,640,361	8.3	318,116	318,116	318,116	318,116	$ 95,433	
2021	880,397	8.2	107,365	107,365	107,365	107,365	107,365	$ 21,477
2022	769,805	4.1	187,757	187,757	18,777			
2023	3,910,725	3.6	1,086,313	1,086,313	651,786			
2024	1,766,631	4.5	392,585	392,585	392,585	392,585	196,291	
Net increase (decrease) in pension expense			$ 2,380,254	$ 2,339,934	$ 1,922,568	$ 995,516	$ 399,089	$ 21,477

Increase (Decrease) in Pension Expense from the Recognition of the Effects of Changes of Assumptions

Year	Changes of Assumptions	Recognition Period (Years)	2024	2025	2026	2027	2028	2029
2016	$ 12,966,856	9.0	$ 1,440,760					
2017	(417,283)	8.7	(47,964)	$ (33,571)				
2018	(185,137)	8.5	(21,781)	(21,781)	$ (10,889)			
2019	(84,200)	8.5	(9,906)	(9,906)	(9,906)	$ (4,952)		
2020	6,850,017	8.3	825,303	825,303	825,303	825,303	$ 247,593	
2021	1,737,567	8.2	211,898	211,898	211,898	211,898	211,898	$ 42,383
2022	96,057	4.1	23,429	23,429	2,341			
2023	-	3.6	-	-	-			
2024	(15,685,950)	4.5	(3,485,767)	(3,485,767)	(3,485,767)	(3,485,767)	(1,742,882)	
Net increase (decrease) in pension expense			$ (1,064,028)	$ (2,490,395)	$ (2,467,020)	$ (2,453,518)	$ (1,283,391)	$ 42,383

Increase (Decrease) in Pension Expense from the Recognition of Differences Between Projected and Actual Earnings on Pension Plan Investments

Year	Differences between Projected and Actual Earnings on Pension Plan Investments	Recognition Period (Years)	2024	2025	2026	2027	2028
2020	$ (860,263)	5	$ (172,051)				
2021	1,389,559	5	277,912	$ 277,911			
2022	(1,788,711)	5	(357,742)	(357,742)	$ (357,743)		
2023	(462,372)	5	(92,474)	(92,474)	(92,474)	$ (92,476)	
2024	1,848,105	5	369,621	369,621	369,621	369,621	$ 369,621
Net increase (decrease) in pension expense			$ 25,266	$ 197,316	$ (80,596)	$ 277,145	$ 369,621

Interest on the Total Pension Liability Recognized in Expense

	Amount for Period	Portion of Period	Interest Rate	Interest on the Total Pension Liability
Beginning total pension liability	$ 59,354,999	100%	4.00%	$ 2,374,200
Service cost	1,240,702	100	4.00	49,628
Benefit payments, including refunds of member contributions	(3,924,140)	50	4.00	(77,713)
Total interest on the pension liability				$ 2,346,115

Projected Earnings on Pension Plan Investments Recognized in Expense

	Amount for Period	Portion of Period	Projected Rate of Return	Projected Earnings
Beginning plan fiduciary net position	$ 12,097,336	100%	4.00%	$ 483,893
Contributions - employer	5,331,816	50	4.00	105,591
Contributions - member	-	50	4.00	-
Benefit payments, including refunds of member contributions	(3,924,140)	50	4.00	(77,713)
Administrative expense and other	(16,352)	50	4.00	(324)
Total projected earnings				$ 511,447

Pension Expense and Deferred Outflows and Inflows of Resources Related to Pensions

For the fiscal year ended June 30, 2024, the recognized pension expense is $4,433,214. As of June 30, 2024, deferred outflows and inflows of resources related to pensions are reported as follows:

	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ 5,943,757	$ (265,173)
Changes of assumptions	3,639,247	(12,291,188)
Net difference between projected and actual earnings on pension plan investments	763,486	
Total	$ 10,346,490	$ (12,556,361)

Amounts reported as deferred outflows and inflows of resources related to pensions will be recognized in the pension expense as follows:

Year Ended June 30:	
2025	$ 46,855
2026	(625,048)
2027	(1,180,857)
2028	(514,681)
2029	63,860
Thereafter	-

Deferred Outflows and Inflows of Resources from Differences Between Expected and Actual Experience

Year	Experience Losses (a)	Experience Gains (b)	Amounts Recognized in Pension Expense through June 30, 2024 (c)	Balances at June 30, 2024	
				Deferred Outflows of Resources (a) - (c)	Deferred Inflows of Resources (b) - (c)
2017		$ (3,295,677)	$ (3,030,504)		$ (265,173)
2018	$ 1,343,607		1,106,497	$ 237,110	
2019	3,016,650		2,129,400	887,250	
2020	2,640,361		1,590,580	1,049,781	
2021	880,397		429,460	450,937	
2022	769,805		563,271	206,534	
2023	3,910,725		2,172,626	1,738,099	
2024	1,766,631		392,585	1,374,046	
				$ 5,943,757	$ (265,173)

Deferred Outflows and Inflows of Resources from Changes of Assumptions

Year	Increases in the Total Pension Liability (a)	Decreases in the Total Pension Liability (b)	Amounts Recognized in Pension Expense through June 30, 2024 (c)	Balances at June 30, 2024	
				Deferred Outflows of Resources (a) - (c)	Deferred Inflows of Resources (b) - (c)
2017		$ (417,283)	$ (383,712)		$ (33,571)
2018		(185,137)	(152,467)		(32,670)
2019		(84,200)	(59,436)		(24,764)
2020	$ 6,850,017		4,126,515	$ 2,723,502	
2021	1,737,567		847,592	889,975	
2022	96,057		70,287	25,770	
2024		(15,685,950)	(3,485,767)		(12,200,183)
				$ 3,639,247	$ (12,291,188)

Deferred Outflows and Inflows of Resources from Differences Between Projected and Actual Earnings on Pension Plan Investments

Year	Investment Earnings Less Than Projected (a)	Investment Earnings Greater Than Projected (b)	Amounts Recognized in Pension Expense through June 30, 2024 (c)	Balances at June 30, 2024	
				Deferred Outflows of Resources (a) - (c)	Deferred Inflows of Resources (b) - (c)
2021	$ 1,389,559		$ 1,111,648	$ 277,911	
2022		$ (1,788,711)	(1,073,226)		$ (715,485)
2023		(462,372)	(184,948)		(277,424)
2024	1,848,105		369,621	1,478,484	
				$ 1,756,395	$ (992,909)

Sensitivity of the Net Pension Liability to Changes in the Discount Rate

	Current Discount Rate (6.25%)	1% Decrease (5.25%)	1% Increase (7.25%)
Net pension liability as of June 30, 2024	$ 32,946,355	$ 39,085,344	$ 27,853,740

Participant Breakdown as of June 30, 2024

	Participant Count
Inactive plan members or beneficiaries currently receiving benefits	15
Inactive plan members entitled to but not yet receiving benefits	68
Active plan members	81
Total members	164

Description of Significant Changes Prior to Year End

There were no significant plan changes since the last published valuation.

DROP Balances

Currently, there is no Deferred Retirement Option Plan (DROP). Therefore, the DROP balances are $0.

Valuation Date and Roll Forward Process

The Plan Sponsor uses the January 1, 2023 Actuarial Valuation to calculate the ADEC for the fiscal year ending 2024.

The January 1, 2024 Actuarial Valuation directly calculated the June 30, 2024 Total Pension Liability (TPL).

A measurement date of December 31st is used for GASB 67/68 calculations.

Funding Policy

The Plan Sponsor's Funding Policy is to contribute the ADEC plus additional amounts from time to time.

Assumption Selection

The selections of all assumptions used in determining the total pension liability were made in conformity with Actuarial Standards of Practice issued by the Actuarial Standards Board.

The actuarial assumptions used in the valuation were based on standard tables modified for certain plan features such as eligibility for full and early retirement where applicable and input from the plan sponsor. A full actuarial experience study has not been completed.

Description of Actuarial Methods

Asset Valuation Method

The plan uses the Market Value of Assets.

Measurement Date

The plan uses a Measurement Date of December 31 coincident with the plan year, and a reporting Date of June 30th coincident with the Fiscal year.

Actuarial Cost Method

Cost method for determining the GASB liability: Entry Age Normal Actuarial Cost Method (level percentage of salary).

Entry Age Normal Actuarial Cost Method (level percentage of salary).

Normal Cost: Under this method, the total normal cost is the sum of amounts necessary to fund each active member's normal retirement benefit if paid annually from entry age to assumed retirement age. Entry age is the age at which the employee would have been first eligible for the plan, if it had always been in effect. The normal cost for each participant is expected to remain a level percentage of the employee's salary. The normal cost for the plan is the difference between the total normal cost for the year and the anticipated member contributions for that year.

Past Service Liability: The present value of future benefits that relates to service before the valuation date is the total past service liability. The unfunded past service liability is the difference between the total past service liability and any assets (including accumulated member contributions).

Experience Gains and Losses: All experience gains and losses (the financial effect of the difference between the actual experience during the prior period and the result expected by the actuarial assumptions for that prior period) appear directly in the past service liability and are amortized at the same rate the plan is amortizing the remaining unfunded past service liability.

Description of Actuarial Assumptions

Changes in Actuarial Assumptions

The valuation reflects changes in the actuarial assumptions listed below. (The assumptions used before and after these changes are more fully described in the next section.)

- Investment rate of return

The assumptions indicated were changed to represent the Enrolled Actuary's current best estimate of anticipated experience of the plan.

Investment rate of return (net of investment-related and administrative expenses)

6.25%. (Prior: 4.00%)

The assumption was changed to better reflect future expected experience. The change in assumption decreased liabilities by about 26%.

Rate of compensation increase (including inflation)

3.00%.

The plan does not have statistically credible data on which to form a rate of compensation increase assumption. The assumption is based on input from the plan sponsor and expectations of future inflation.

Inflation

2.40%.

This is consistent with the Social Security Administration's current best estimate of the ultimate long-term (75-year horizon) annual percentage increase in CPI, as published in the 2024 OASDI Trustees Report.

Mortality

RP-2014 Adjusted to 2006 Total Dataset Mortality Table projected to valuation date with Scale MP-2021.

Mortality Improvement

Projected to date of decrement using Scale MP-2021 (generational).

Retirement age

The later of age 65 or the 5th anniversary of participation, or age 70, if earlier.

Termination prior to retirement

Table T-8, The Actuary's Pension Handbook, Crocker-Sarason-Straight

Sample Rates	
Age	**Rate**
20	11.94%
25	11.62
30	11.21
35	10.55
40	9.40
45	7.54
50	4.83

Disability

None.

Administrative expenses

The estimate is based on actual expenses paid from the trust in the prior year.

Cost of living increases

N/A.

Payroll growth

3.00% per year.

Percent of active employees married

100%.

Spouse's age

Husbands are assumed to be 0 years older than wives.

Lump sum election percentage

50% of retiring participants are assumed to elect a lump sum and 50% are assumed to elect an annuity.

Lump Sum interest rates:

DOP before 7/1/2009: 8.0%

DOP after 7/1/2009: 6.50%

Lump Sum mortality:

DOP before 7/1/2009: 1984 UP Mortality Table set back 4 years.

DOP after 7/1/2009: RP-2000 Male Table set back 4 years.

Summary of Plan Provisions

This exhibit summarizes the major provisions of the Plan. It is not intended to be, nor should it be interpreted as a complete statement of all plan provisions. To the extent that this summary does not accurately reflect the plan provisions, then the results of this disclosure may not be accurate.

Effective Date

Original - March 1, 1975. Latest restatement adopted January 1, 2009.

Latest Amendment – Amendment No. 6, adopted May 17, 2023.

Plan Year

The calendar year.

Participation

An employee becomes a participant of the plan on the earliest January 1 or July 1 following the later of attainment of age 21 and completion of 1 year of service. The Plan was closed to new entrants effective January 1, 2013.

Employee Contributions

Effective July 1, 2023, employees are required to contribute to 3.5% of compensation.

Credited Service

A calendar year in which an employee works at least 1,000 Hours of Service.

Average Annual Compensation

Average of annual compensation for the highest consecutive 36-month period preceding the determination date. Compensation includes wages, shift differential, standby pay, and 50% of the value of any unused and unpaid sick leave existing at the time of termination of employment, and accrued after April 26, 1997.

Accrued Benefit

2.50% of Average Annual Compensation multiplied by years of Credited Service, but not less than $600.

Normal Retirement Benefit

Eligibility – The first day of the month coinciding with or following the later of Participant's attainment of age 65 or completion of 5 years of plan participation. However, the Normal Retirement Date shall not be later than age 70.

Benefit – Accrued benefit as of normal retirement date.

Early Retirement

Eligibility - The first day of the month following the later of age 55 and 5 years of Credited Service.

Benefit - Accrued benefit as of early retirement date.

Reduction Factors – 5/9% for each of the first 60 months, and 5/18% for each of the next 60 months, by which benefit commencement precedes normal retirement.

Late Retirement

Accrued benefit as of late retirement date.

Termination prior to retirement

Vesting - 50% vesting after 5 years of Credited Service increasing 10% per year until 100% vested after 10 years of Credited Service. Active participants automatically become 100% vested upon attainment of normal retirement age or if they become totally and permanently disabled.

Benefit - Accrued benefit as of date of termination, first payable upon normal retirement eligibility. Earlier benefit commencement may be elected, subject to early retirement eligibility and reduction factors.

Death prior to retirement

Vesting - Completion of 5 years of Credited Service

Benefit - Designated beneficiary will be entitled to receive a survivor benefit equal to the Actuarial Equivalent of your vested Accrued Benefit in the Plan.

Form of benefit

Normal form - Life Annuity. For married participants payable as an actuarially equivalent 100% Joint and Survivor Annuity.

Optional forms - Life Annuity, 10-Year Certain and Life Annuity, 50% Joint and Survivor Annuity, 100% Joint and Survivor Annuity or a Lump Sum.

Actuarial equivalence optional forms of annuities and lump sums prior to July 1, 2009

Interest - 8% per year.

Mortality - UP-1984 Mortality, setback 4 years for a Participant and plus 1 year for a joint annuitant

Actuarial equivalence optional forms of annuities and lump sums on or after July 1, 2009

Interest - 6.5% per year.

Mortality - RP 2000 Mortality Table for Males, set back 4 years for a Participant and set back 2 years for a joint annuitant

Cost-of-living increases

None.

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Aveed™ (testosterone undecanoate) Risk Evaluations and Mitigation Strategies (REMS) program		
Owner: PHARMACY DIRECTOR	Department: Pharmacy	
Scope: District Wide		
Date Last Modified: 09/12/2024	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

Purpose:
This policy serves to establish guidelines for the safe and compliant administration of Aveed (testosterone undecanoate) within our hospital, ensuring adherence to the Risk Evaluation and Mitigation Strategy (REMS) program. The purpose is to promote patient safety, minimize adverse events, and uphold REMS requirements.

Policy:
Our hospital is dedicated to the safe and responsible administration of Aveed in alignment with REMS guidelines. This policy outlines procedures for prescribing, storing, handling, administering, monitoring patients, documenting, and reporting Aveed administration within our facility.

Procedure:

1. **Prescription and Patient Eligibility:**
   a. Prescribing Aveed is limited to patients diagnosed with hypogonadism meeting REMS eligibility criteria.
   b. Prescribers must complete REMS certification and adhere to REMS requirements.
2. **Storage and Handling:**
   a. Aveed must be securely stored in a locked cabinet or designated area.
   b. Storage temperature should meet manufacturer recommendations.
   c. Access to Aveed should be restricted to authorized personnel.
3. **Administration:**
   a. Only REMS-certified healthcare providers are authorized to administer Aveed.
   b. Prior to administration, verify patient identification and dose appropriateness.
   c. Administer Aveed via intramuscular injection into the gluteal muscle using aseptic technique.
   d. Dispose of needles properly post-administration.
4. **Patient Monitoring:**
   a. Monitor patients for at least 30 minutes post injection for testosterone overdose, allergic reactions, and injection site reactions, specifically pulmonary oil microembolism (POME), and anaphylaxis.
   b. Educate patients on Aveed's risks, benefits, and follow-up care. In accordance with the REMS program requirements, all healthcare providers administering AVEED treatment must adhere to the guidelines outlined in the "What You Need to Know About AVEED Treatment: A Patient Guide." This comprehensive guide serves as an essential resource to ensure safe and informed administration of AVEED, covering crucial information on indications, dosing, administration procedures, potential risks, and monitoring protocols. Healthcare providers are required to familiarize themselves with the contents of this guide and ensure that patients receive appropriate education and counseling prior to initiating

AVEED therapy. Compliance with these guidelines is essential to mitigate potential risks associated with AVEED treatment and promote patient safety within our healthcare facility.

c. Schedule regular follow-up appointments to assess treatment progress.

5. **Documentation and Reporting:**

a. Document all Aveed administrations and patient information accurately in medical records.

b. Report adverse events, medication errors, and safety concerns as per hospital protocols.

References:

1. REMS Program for Aveed. https://aveedrems.com/
2. Aveed Prescribing Information. https://www.aveedusa.com/hcp/

RECORD RETENTION AND DESTRUCTION:

Will be maintained within the patient's medical record

CROSS REFERENCE POLICIES AND PROCEDURES:

1) Administration of Drugs and Biologicals

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: Bloodborne Pathogen Exposure Control Plan		
Owner: Manager Employee Health & Infection Control	Department: Infection Prevention	
Scope: District Wide		
Date Last Modified: 09/24/2024	Last Review Date: No Review Date 05/19/2023	Version: 9
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/01/2010	

PURPOSE:

The goal is of this plan is to minimize or eliminate health care worker exposure to bloodborne pathogens. This plan focuses on safer work practices, personal protective equipment, and engineering and administrative controls. Adhering to this plan ensures compliance with all applicable laws and regulations relating to bloodborne pathogens exposure, and is in accordance with The Division of Occupational Safety and Health (DOSH), better known as Cal/OSHA Bloodborne Pathogens Standard (Title 8, California Code of Regulations, and Section 5193). This plan continues our commitment to providing a safe and healthy environment in which to deliver patient care.

POLICY

Northern Inyo Healthcare District is committed to providing a safe and healthy environment for its entire staff. All employees and physicians working within this facility who may be potentially exposed will follow this policy and procedure to bloodborne pathogens. Failure to follow this policy and procedure may result in disciplinary actions. Bloodborne Pathogen exposure/injuries will be reviewed at Safety Committee, Infection Prevention, and Sharps Committee for any percutaneous injuries.

DEFINITIONS

Bloodborne pathogens – Pathogenic microorganisms that may be present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV).

Contaminated – The presence or the reasonably anticipated presence of blood or other potentially infectious materials on a surface or in or on an item.

Decontamination – The use of physical or chemical means to remove, inactivate or destroy bloodborne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use or disposal.

Engineering controls – Controls such as sharps disposal containers, needleless systems and sharps with engineered sharps injury protection that isolate or remove the bloodborne pathogens hazard from the workplace.

Engineered sharps injury protection – A physical attribute built into a needle device used for withdrawing other potentially infectious materials accessing a vein or artery, or administering medications or other fluids, which effectively reduces the risk of an exposure incident by a mechanism such as barrier creation, blunting,

encapsulation, withdrawal or other effective mechanisms; or a physical attribute built into any other type of needle device, or into a non-needle sharp, which effectively reduces the risk of an exposure incident.

Exposure incident – A specific eye, mouth, or other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that results from the performance of an employee's duties.

Healthcare Worker (HCW) - Refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.

Needleless system: A device that does not use a needle and is used to withdraw body fluids after initial venous or arterial access is established; to administer medication or fluids; or for any other procedure involving the potential for an exposure incident

Occupational exposure – A job category where skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials could be reasonably anticipated.

Other potentially infectious materials (OPIM) –

- Human body fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any other body fluid that is visibly contaminated with blood such as saliva or vomitus, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids such as in an emergency response
- Any unfixed tissue or organ (other than intact skin) from a human (living or dead)
- Any of the following, if known or reasonably likely to contain or be infected with HIV, HBV or HCV:
  - –Cell, tissue, or organ cultures from humans or experimental animals
  - –Blood, organs or other tissues from experimental animals
  - –Culture medium or other solutions

Passive safety: A feature that requires no action by the user.

Personal Protective Equipment (PPE): PPE is specialized clothing or equipment worn by an employee to minimize exposure to a variety of hazards.

Safety Engineered Devices: A device that has a built in sharps injury protection mechanism such as an attached sheath covering the needle or scalpel after use or needles that retract.

Sharps: Devices or objects capable of cutting or piercing. Examples include scalpels, razor blades, broken glass, microscope slides, and needles.

Sharps container: Rigid puncture resistant container with a secure lid that can safely store sharps waste.

Source individual – Any individual, living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include, but are not limited to, hospital and clinic patients, clients in institutions for the developmentally disabled, trauma victims, clients of drug and alcohol treatment facilities, residents of hospices and nursing homes, human remains, and individuals who donate or sell blood or blood components.

Standard precautions – An approach to infection control. Standard precautions expand the universal precautions concept *(see below)* to include all other potentially infectious materials with the intent of protecting

employees from any disease process that can be spread by contact with a moist body substance. This isolation technique includes substances such as feces, urine, saliva and sputum that were not included in Standard universal precautions unless they contained visible blood.

Universal precautions – Is an approach to infection control to treat all human blood and certain human body fluids as if they were known to be infectious for HIV, HBV and other bloodborne pathogens. Universal Precautions emphasizes the use of Personal Protective Equipment (PPE) barrier to prevent contact with blood and other potentially infectious materials Precautions apply to blood, semen, and vaginal secretions; amniotic, cerebrospinal, pericardial, peritoneal, pleural, and synovial fluids; and any other body fluid visibly contaminated with blood.

Work Practice Controls: Are controls that reduce the likelihood of exposure be altering the in manner in which a task is performed.

EXPOSURE DETERMINATION

The exposure determination looks at all job classifications to determine the potential for occupational exposure to blood or other potentially infectious materials. Health care worker (HCW) job classifications listed below have been determined to be at risk for occupational exposure. This list includes those job classifications in which only some employees have occupational exposure. All elements of this exposure control plan apply to all employees in these jobs.

- Activities Director
- Biomedical engineers
- Central Sterile Processing
- Diagnostic Imaging Technologists
- EKG technicians
- Environmental Services
- Laboratory employees
- Language Services
- Laundry
- Maintenance/Plant Operations
- Nursing- All
- Patient Access
- Pharmacy
- Physicians
- Rehab Department
- Cardiopulmonary Department
- Security
- Social Services
- Surgical Technicians
- Dietary
- Medical Records
- Any additional roles that require a worker to enter patient rooms

METHODS OF COMPLIANCE

This section reviews the numerous work practices and procedures necessary to minimize or eliminate un-protected exposure to bloodborne pathogens. Compliance with these practices and procedures is MANDATORY and is a condition of employment.

Standard Precautions

Refer to Lippincott Procedures Standard Precautions.

Use standard precautions in all patient care to prevent contact with blood and OPIM. Always treat the following body fluids as if infectious for HBV, HCV or HIV:

- * Human blood, blood components and products made from human blood
- * **Other potentially infectious materials (OPIM)**
  - –semen
  - –vaginal secretions
  - –cerebrospinal fluid
  - –synovial fluid
  - –pleural fluid
  - –pericardial fluid
  - –peritoneal fluid
  - –amniotic fluid
  - –any other body fluid contaminated with blood such as saliva or vomitus
  - –any unfixed tissue or organ from a human

In circumstances where it is difficult or impossible to differentiate between body fluid types, those fluids are assumed to be potentially infectious.

The Infection Preventionist of Northern Inyo Healthcare District (NIHD) and leadership is responsible for overseeing the use of standard precautions by all NIHD workforce members.

Engineering Controls:

Engineering controls are used to minimize or eliminate HCW occupational exposures to bloodborne pathogens. These controls include, but are not limited to:

- Devices with engineered sharps injury protection
- Needleless systems
- Safety design devices
- Hand washing facilities
- Sharps containers
- Laboratory safety hoods where appropriate
- Pneumatic Tube Safety
- Specimen containers
- Protective shields

Use of Needleless Systems, Needle Devices, Non-needle Sharps

When feasible, needless system(s) will be used for:

- Withdrawing OPIM after initial venous or arterial access is established.
- Administering medications or fluids
- Any other procedure involving the potential exposure incident for which a needle device with engineered sharps injury protection is available

When feasible, devices with engineered sharp injury protection will be used for:

- Withdrawing OPIM
- Accessing a vein or artery
- Administering medication or fluid
- Any other procedure involving the potential for an exposure incident for which a needle device with engineered sharps injury protection is available.

Non-needle sharps (e.g., scalpels, lancets) shall have engineered sharps injury protection mechanisms

Employees with potential occupational exposure to blood and OPIM will be trained in the use of engineering controls provided for their use. Additional training will be provided as necessary when new engineering controls are adopted.

NIHD Sharps Protection Injury Committee evaluates engineering control on an as needed basis and determines which ones provide the best protection without compromising patient care.

Engineered sharps injury protection devices are not required in the following situations only:

- An engineering control is not available in the marketplace during a pandemic or during a national shortage.
- A licensed health care professional, directly involved in a patient's care, determines in the reasonable exercise of clinical judgment, that the use of the engineering control will jeopardize the patient's safety or the success of a medical or nursing procedure involving the patient. In such cases, the use of this exception shall be investigated and documented by the Infection Preventionist or designee, and must be approved by the NIHD Infection Committee.
- The employer can demonstrate by means of objective product evaluation criteria that the engineering control is not more effective in preventing incidents than the alternative used by the employer.
- There is no reliable or specific safety performance information available on the safety performance of the safety control for this facility's procedures. NIHD actively determines whether the use of engineering controls lacking reliable or specific safety performance information will reduce the risk of exposure incidents occurring in this facility.
- The use of engineering controls will be re-evaluated annually during the yearly review of this exposure control plan. Additions or deletions will be made at that time or as indicated by ongoing monitoring activities.

Work Practice Controls:

The use of standard precautions is an integral part of this exposure control plan and of NIHD infection prevention program. Standard precautions will be practiced whenever exposure to blood or OPIM is anticipated. When differentiation between body fluid types is difficult or impossible, all other potentially infectious materials will be considered potentially infectious materials.

Work practice controls/procedures have been implemented to minimize exposure to bloodborne pathogens. Each department manager/supervisor is responsible for implementing, evaluating and monitoring compliance with these work practices. Infection Preventionist, department designee, and Department Safety Officers will monitor work practices as part of routine rounds through each area.

Specific infection control policies and procedures are in place to address work practices and procedures centered on the concept of standard precautions. The minimization and elimination of exposure to blood and OPIM is the primary goal.

The following is a summary of work practice controls:

- Hands will be washed with soap and water or alcohol based hand rub (ABHR) before patient contact, after the removal of gloves or other personal protective equipment and immediately following contact or exposure to blood or Other potentially infectious materials before clean/aseptic procedure, and after touching patient surroundings. *Wash hands with soap and water if there is any visible contamination with blood or other fluids.*
- Mucous membranes and eyes will be immediately flushed with water following exposure to blood or other potentially infectious materials.
- Eating, drinking, smoking, applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is reasonable likelihood of occupational exposure (e.g., nurses' station).
- Food, drink and oral medications will not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where blood or other potentially infectious materials may be present.
- All procedures involving blood or other potentially infectious materials will be performed in such a manner as to minimize splashing, spraying, spattering and generation of droplets.
- Specimens of blood or other potentially infectious materials will be placed in containers that prevent leakage during collection, handling, processing, storage, transportation or shipping. Syringes containing blood or other potentially infectious materials will not be transported with needles attached unless an engineered safety device is in place permanently shielding the needle.
- The container for storage, transport or shipping to outside of the facility will be labeled or color-coded with the legend "biohazard." These labels shall be fluorescent orange or orange-red, with lettering and symbols in a contrasting color. The surgery department labels are blue for specimens.
- If outside contamination of the primary container occurs, the primary container will be placed within a second container that prevents leakage during handling, processing, storage, transport or shipping and is properly labeled. If specimen could puncture the primary container, the primary container will be placed within the secondary container that is also puncture-resistant.
- Equipment that may be contaminated with blood or other potentially infectious materials will be decontaminated prior to servicing or shipping. If decontamination is not feasible, a biohazard-warning label (that meets the Cal/OSHA requirements) will be attached to the equipment identifying the contaminated portions. Information will be conveyed to all affected employees, servicing people and/or the manufacturer prior to handling to ensure that appropriate precautions are taken.
- Pneumatic Tube System: In case of a biohazard spill in the system:

- On control panel of the pneumatic tube system, the employee should immediately push“911 and hit the “Special Function” key. This disables the system and prevents other tubes from becoming contaminated.
- During the day notify maintenance and during off hours notify the Nursing Supervisor.
- To prevent this problem, all employees who may place either blood or urine in the tube, need to remember how important it is to carefully seal every biohazard bag.
- To prevent possible hand contamination, open all tubes slowly and carefully.

Pneumatic Tube educational video available on NIHD Intranet\\root.nih.org\home\Public\Video\EQUIPMENT-VIDEOS\PneumaticTube.wmv

Managing Blood/OPIM Spills.

- Basic principles
    - Standard precautions apply, including use off PPE as applicable
    - Spills should be cleaned before the area is cleaned (adding liquid to spills increase the size of the spill and should be avoided)
- Management small spill < 10cm
    - Secure the spill area notify appropriate personnel
    - Wipe the area immediately with paper toweling
    - Clean with approved hospital disinfectant
    - Management of large spill > 10cm
    - Secure the spill area and notify appropriate personnel
    - Contain the spill using spill kit
    - Remove absorbed material with a scraper and pan and place in a biohazard bag
- Clean with approved hospital disinfectant

Handling Contaminated Sharps

All procedures involving the use of sharps in connection with patient care will be performed using the following effective patient-handling techniques and other methods designed to minimize risk of a sharps injury:

- Contaminated needles and syringes, and other sharps will not be bent, broken, recapped or otherwise manipulated and will be disposed of in rigid-walled disposable sharps containers. ***Exception***: Syringes that contain radioactive pharmaceuticals that must be returned to the pharmaceutical company for disposal may be recapped using a safety device designed for this purpose or by the “one-handed” method.
- Reusable sharps will be placed in labeled, puncture resistant, leak-proof containers for appropriate cleaning and sterilization. Cleaning of such sharps will not require employees to reach their hands into sharps containers.
- Do not reuse disposable sharps under any circumstances.

- Contaminated sharps will be immediately, or as soon as possible after use, disposed of in rigid, puncture-resistant, leak proof containers that are labeled "Sharps Waste" or with the international biohazard symbol and the word "Biohazard."
- Sharps container seals must be leak resistant and difficult to reopen.
- Sharps containers will be readily available and easily accessible for all situations in which sharps are used or can be anticipated to be found, including dietary trays and laundry, if applicable.
- Sharps containers will be maintained in the upright position and will be replaced when reaches the fill line (2/3 full) to avoid overfilling.
- Broken glassware or sharps located on floor or other item that may be contaminated staff will not pick up by hand, but by mechanical means such as a brush and dustpan, tongs or forceps.
- No items shall be placed on top of the sharps container (e.g. germicidal wipes, Kleenex boxes
- Staff must ensure that no items are sticking out and/or stuck in the opening of sharps containers
- A safety device will be used (ex-point lock) if there is no engineered safety device.
- The employee or physician performing the procedure **SHOULD** dispose of his/her own sharps except in the Operating room.
- Always dispose of needles into sharps box with one-handed technique; do not open lid with second hand.

Personal Protective Equipment:

Personal protective equipment is an essential component of a plan to reduce or eliminate exposure to bloodborne pathogens. The following policies and procedures will be adhered to:

- Personal protective equipment will be used in conjunction with engineered controls and work practice controls.
- Where the potential for occupational exposure exists, staff will be provided, at no cost to the employee, appropriate personal protective equipment such as gloves, gowns, aprons, laboratory coats, splash goggles, glasses, face shields, masks, mouthpieces, resuscitation bags, pocket masks, hoods, shoe covers, etc.
- Appropriate personal protective equipment will not permit blood or other potentially infectious materials to pass through (e.g., impervious gowns) or to reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth or other mucus membranes under normal conditions of use.
- Hypoallergenic gloves, glove liners, powderless gloves, and other similar alternatives will be readily available to those employees who experience allergenic problems with the standard gloves.
- Department managers will insure that personal protective equipment in the appropriate size is readily available and utilized when necessary to provide the needed level of protection from anticipated exposure.
- The Infection Preventionist will monitor compliance by checking use of personal protective equipment as part of the environmental rounds, and department managers will monitor compliance on a day-to-day basis.

- Employees will be provided training on the appropriate use of personal protective equipment. Training will be completed at the time of initial assignment to a job classification or task/procedure that presents the potential for blood, body fluid or other potentially infectious material exposure.
- A staff member may temporarily and briefly decline to use personal protective equipment only under rare and extraordinary circumstances. If he/she believes, based on their own professional judgment, that its use would prevent the delivery of health care or public safety services or would pose an increased hazard to worker safety, then they may decline to use the personal protective equipment. If this occurs, the Infection Preventionist will investigate and document the circumstances to determine whether changes should be implemented to prevent a similar occurrence in the future. NIHD encourages employees to report all such instances.
- NIHD will be responsible for the cleaning, laundering, repairing, replacing and disposing of personal protective equipment as needed to maintain effectiveness at no cost to the employee.
- Any garment(s) penetrated by blood or other potentially infectious materials will be removed immediately or as soon as feasible, and placed in the designated area or container for storage until washed or disposed of by the facility.
- All personal protective equipment will be removed prior to leaving the work area and patients room
- Employees are responsible for placing their personal protective equipment, after removal, in a designated area or container for storage, washing, decontamination or disposal.
- Employees will wear gloves when it is reasonably anticipated that they will have hand contact with blood or other potentially infectious materials, mucous membranes and non-intact skin when performing vascular access procedures, and when handling or coming into contact with contaminated items or surfaces.
- Disposable gloves will be replaced, as soon as practical when contaminated, torn or punctured or when their ability to function as a barrier has been compromised.
- Disposable gloves will not be washed or decontaminated for reuse.
- Heavy duty, utility gloves may be decontaminated for reuse; however, they must be discarded if cracked, peeling, torn or exhibit any signs of deterioration that would compromise their barrier protection.
- Employees will wear masks in combination with eye protective devices such as glasses with solid sidepieces, goggles or face shields whenever splashes, spray, spatter or droplets of blood or other potentially infectious materials may be generated and eye, nose or mouth contamination can be reasonably anticipated.
- Gowns, aprons, lab coats or similar outer garments will be worn whenever the potential for exposure to blood or other potentially infectious materials is likely.
- Surgical caps or hoods, and impermeable shoe covers or boots will be worn in instances where “gross contamination” is anticipated (e.g., autopsies, orthopedic surgery, labor and delivery).

Cleaning and Decontaminating the Work Site:

Listed below are cleaning and decontaminating policies and procedures that must be followed:

- Environmental Services is responsible for maintaining the facility in a clean and sanitary manner. Policies and procedures have been developed and implemented to ensure that cleaning is scheduled appropriately and proper methods for cleaning and decontaminating are followed. A written schedule

for cleaning and decontaminating the worksite has been developed and is posted in Environmental Services work stations and in the Environmental Services manual

- All dirty linen is handled in compliance with standard precautions. All appropriate steps are taken to minimize or eliminate potential exposures. If the soiled linen is wet and presents the likelihood of causing exposure, a plastic bag will be used to prevent leakage or exposure.
- Linen will be bagged or containerized at the point of use and will not be sorted or rinsed in this location.
- The Infection Control Committee is responsible for reviewing and approving policies and procedures that address proper cleaning, disinfection, and/or sterilization of equipment or environmental surfaces that become contaminated.

A summary of cleaning requirements follows:

- All equipment and environmental and work surfaces will be cleaned and decontaminated as soon as possible after contact with blood or other potentially infectious materials.
- Contaminated work surfaces, or surfaces that come into contact with the hands, will be cleaned and decontaminated immediately or as soon as feasible in the event they become overtly contaminated, when blood or other potentially infectious materials fluid spills occur, or when procedures are completed, using a disinfectant with a hepatitis B or tuberculocidal claim.
- All bins, pails, cans and similar receptacles that become contaminated with blood or other potentially infectious materials will be cleaned and decontaminated immediately or as soon as feasible, no later than at the end of the work shift.
- Protective coverings such as plastic wrap, aluminum foil, or imperviously backed absorbent paper used to cover equipment or environmental surfaces will be removed, replaced and appropriately disposed of at the end of each work shift. If such covering becomes overtly contaminated, it will be removed and disposed of immediately or as soon as feasible.

Waste Disposal:

The California Medical Waste Management Act, in conjunction with this plan, will provide direction on the proper disposal of biohazardous waste to include sharps waste and wastes contaminated with blood or OPIM. The following will be placed in red plastic bags marked with the word and symbol for “biohazard” and disposed of using the biohazard waste pathway:

- Liquid or semi-liquid blood or other potentially infectious materials
- Contaminated items that contain liquid or semi-liquid blood or are caked with dried blood and are capable of releasing these materials when handled or compressed
- Contaminated sharps
- Pathological and microbiological wastes containing blood or other potentially infectious materials

Accepting Community Needles:

- NIHD will accept contaminated needles from the community for disposal
- Refer questions from persons with needles to infection control or maintenance.
- A sharps disposal unit is at the front of the hospital and all community sharps may be placed in this unit.
- Sharps containers may not be sold or given to patients or other individuals for home use.
- Sharps disposal located at NIHD front entrance (large **red** receptacle with the wording “sharps”)

- Must be in a rigid hard plastic bottle or container with screw lids.
- Sharp boxes designed for sharps. Will not be accepted otherwise.

- Any ambulance service may dispose of their needles/infectious waste at NIHD, at any time, but must dispose of it themselves in appropriate infectious waste containers.

Hepatitis B Vaccination Program:

In an effort to provide maximum protection from hepatitis B infection, NIHD offers a vaccination program, at no employee cost, to all staff that has potential occupational exposure to bloodborne pathogens. Components of the program are outlined below:

- The vaccination program will be discussed with applicable staff following the training outlined in this plan and within 10 days of initial assignment and annually during the bloodborne pathogens training program. The safety of the vaccine and the advantages of receiving the vaccine will be reviewed with all applicable staff. Details for receiving the vaccine also will be included.
- Vaccine will be provided when indicated by Employee Health as part of the initial employment physical for all new employees with potential exposure to blood or other potentially infectious materials. Employee Health follows up with each employee until the vaccination series is complete.
- Current employees also will be offered the HBV vaccine free of charge from Employee Health. The vaccine is offered to physicians and non-licensed contracted employees with potential exposure to blood free of charge.
- All employees have the right to decline immunization and are required to complete and sign the declination statement. If the employee subsequently changes his/her mind and requests the vaccine, it will be provided at no cost to the employee.

Post-Exposure Evaluation and Follow-Up: Follow P&P Exposure Evaluation-Blood Borne Pathogen

NOTE: Refer to - Initial Evaluation of NIHD HCW

A bloodborne pathogen exposure prophylaxis protocol has been implemented to provide an immediate, confidential medical evaluation and follow-up of employees exposed to blood or other potentially infectious materials. This protocol is in accordance with the most recent recommendations of the U.S. Public Health Service.

Note: *The Standard requires providers to follow procedures as recommended by the U.S. Public Health Service. The Centers for Disease Control and Prevention periodically issue new recommendations. Providers, and in particular, medical professionals who conduct post-exposure evaluations, need to keep updated on the CDC's recommendations.* Current recommendations and checklists are incorporated into packets and outlined below to ensure comprehensive and appropriate treatment.

- The protocol and information packets are available from the Employee Health policies and procedures manual. Detailed instructions and all necessary forms are included in the packet for the employee, supervisor and physician, to ensure the evaluation is comprehensive and thorough.
- The Emergency Department Physician conducts initial Medical Evaluation of the exposed healthcare worker. The initial workflow is conducted by Nursing Supervisor, Emergency Department Nurses, Infection Prevention Nurse, or Employee Health Nurse Specialist. Follow up labs are conducted by

Employee Health Nurse Specialist or Infection Prevention Nurse. A primary care physician conducts follow up medical care.

- If the healthcare worker refuses post-exposure medical evaluation and laboratory testing, "refusal of care document" will be signed, and healthcare worker is encouraged to follow up with their primary care as soon as possible.
- Medical evaluation and laboratory tests will be provided at no cost to the employee.
- All medical records will be maintained in the patient's confidential employee health file.

Reporting and Documenting Sharps Injuries:

All sharps related injuries will be reported as an occupational injury following the facility's Occupational Injury and Illness Reporting procedure. All sharps devices used within the facility will be available and displayed to assist the employee in identifying the device that caused the injury. A report denoting the frequency of use of the types and brands of sharps involved in exposure incidents will be generated and reported to the Safety and Infection Control Committees annually. Frequency of use will be approximated by product ordering trends. All sharps devices used within the facility will be available and displayed to assist the employee in identifying the device that caused the injury.

In addition, all sharps injuries will be recorded on the sharps injury log within 14 working days of the date the incident was reported. The log will be maintained for a minimum of five years by Employee Health.

The log will include the following information

- Job classification of the exposed employee.
- Date and time of the exposure incident.
- Type and brand of the sharp involved, if known.
- A description of the exposure incident which must include:
  - Job classification of the exposed employee.
  - Department or work area where the exposure incident occurred.
  - The procedure the exposed employee was performing at the time of the incident.
  - How the incident occurred.
  - The body part involved in the exposure incident.
  - If the sharp had engineered sharps injury protection, whether the protective mechanism was activated, and whether the injury occurred before the protective mechanism was activated, during activation, or after activation.
  - If the sharp had no engineered sharps injury protection, the injured employee's opinion as to whether and how such a mechanism could have prevented the injury.
  - The employee's opinion about whether any other engineering, administrative or work practice control could have prevented the injury.

Communicating Hazards to Employees:

In addition to the provisions of standard precautions, the following hazard communication provisions are implemented as part of the exposure control plan:

- Biohazardous waste will be collected in red bags pre-printed with both the word **BIOHAZARD** and the biohazard symbol.
- Warning labels with the legend **BIOHAZARD** will be affixed to refrigerators and freezers containing blood or other potentially infectious materials-and all other containers used to store, transport or ship blood or other potentially infectious materials.
- Biohazardous wastes will be labeled with the legend **BIOHAZARDOUS WASTE** or **SHARPS WASTE** as appropriate. Labels shall be fluorescent orange or orange-red, with lettering and symbols in a contrasting color.

The following items *do not* require hazard labels/signs:

- Containers of blood or blood products already labeled as to their contents and released for transfusion or other clinical use.
- Individual containers, tubes and specimen cups of blood or other potentially infectious materials placed in biohazard labeled bags or containers for storage, transport, shipment or disposal.
- Primary specimen containers, as all staff are trained to use standard precautions when handling patient specimens.
- Laundry bags and containers, as both staff and laundry workers are trained in standard precautions.
- Biohazardous (regulated) waste which has been decontaminated (e.g., processed in a sterilizer) prior to disposal.

Note: *The California Medical Waste Management Act also requires hazard-warning signs/labels of biohazardous waste. The requirements of this exposure plan are not intended to supersede these requirements but augment them.*

Information and Training:

All employees and physicians covered by this plan will be provided training at the time of initial assignment to an at-risk job classification.

Training will be provided by the Infection Preventionist, or designee, or assigned training. Training will be provided in the language and vocabulary appropriate to the employee's education, literacy and language background.

Training will occur:

- At the time of initial assignment to an at-risk job classification.
- Annually, within 12 months of the previous training.
- When changes affect the employee's occupational exposure, such as new engineering, administrative or work practice controls, modifications of tasks/procedures or institution of new tasks/procedures. This training may be limited to these changes.

The training program will contain, at a minimum, the following elements:

- Copy and explanation of the Standard – A copy of Cal/OSHA's Bloodborne Pathogens Standard is available for review in the Infection Prevention department and this plan.
- Epidemiology and symptoms – A general explanation of the epidemiology and symptoms of bloodborne pathogens.

- Modes of transmission – A general explanation of the modes of transmission of bloodborne pathogens.
- Employer's exposure control plan – An explanation of the plan and how an employee can obtain a copy.
- Risk identification – An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials.
- Methods of compliance – An explanation of the use and limitations of methods to prevent or reduce exposure, including appropriate engineering controls, administrative or work practice controls, and personal protective equipment.
- Personal protective equipment – Information on the types, proper use, location, removal and an explanation of the basis for selecting personal protective equipment.
- Decontamination and disposal – Information on handling and the decontamination and disposal of personal protective equipment.
- Hepatitis B vaccination – Information on the hepatitis B vaccine, including its efficacy, safety, method of administration, the benefits of being vaccinated, and that it will be offered free of charge.
- Emergencies – Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials.
- Exposure incident – An explanation of the procedure to follow if an exposure incident occurs, including how the incident should be reported, the medical follow-up available and the procedure for recording the incident on the sharps injury log.
- Post-exposure evaluation and follow-up – Information on the post-exposure evaluation and follow-up that will be provided to the employee after an exposure incident.
- Signs and labels – An explanation of the signs, labels and/or color-coding used to identify hazards.
- Interactive questions and answers – An opportunity for interactive questions and answers with the trainer.

Recordkeeping:

Records covered in this section are available through Human Resources, Employee Health, and Infection Prevention. Records must be made available under these circumstances:

- All records (training records, medical records and sharps injury log) will be provided upon request to Cal/OSHA and NIOSH for examination and copying.
- Employee training records will be provided upon request to employees and employee representatives.
- Employee medical records will be provided to the subject employee upon request for examination and photocopying. Anyone with written consent from this employee may also request the employee health and medical records.
- The sharps injury log is available upon request to examine and photocopy, and will be made available to employees and to employee representatives upon request.

Medical Records

Employee Health will maintain a medical record for each employee who performs duties that may result in an exposure incident. These records will include the following information:

- The name and social security number of the affected employee.
- A copy of the employee's hepatitis B vaccination status including the dates of all hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination.
- A copy of all examination and medical testing results, and follow-up procedures.
- The employer's copy of the health care professional's written opinion.
- A copy of the information provided to the health care professional.
- These records will be kept confidential and will not be disclosed or reported without the employee's expressed written consent except as required by Title 8, California Code of Regulations, Section 3204, and other applicable laws. These records will be maintained within the above listed departments for at least the duration of employment plus 30 years.

Training Records

Full documentation of training must be completed for all employees trained. Documentation will be maintained by, and be the responsibility of, department managers, within Learning Management System, and the Infection Preventionist or Employee Health Nurse.

- Training records must include, at a minimum, the following:
- Date of training session
- Summary of content
- Names and job titles of attendees
- Names and qualifications of trainers

Annual Review:

A review of this plan is conducted each year. The Infection Preventionist and Sharps Injury Prevention Committee members, and Safety Committee will conduct this review. Frontline health care workers—those who have contact with patients and use sharps frequently—will be included in this review. As part of the review process, the committee will consider the effectiveness of the program in preventing "exposure incidents" and will include a review of current engineering controls and work practice. The Infection Preventionist Manager is responsible for reviewing and updating the Bloodborne Pathogen Exposure Control Plan annually or more frequently if necessary to reflect any new or modified tasks and procedures that affect occupational exposure. The annual review process will include soliciting input from frontline healthcare workers who have contact with patients and use sharps frequently.

CROSS-REFERENCE P&P:

1. Handling of Soiled Linen
2. Blood Borne Pathogen Exposure - Initial Evaluation of NIHD HCW
3. Infectious/Non-Infectious Waste Disposal Procedure
4. Injury and Illness Prevention Program
5. Lippincott Standard Precautions
6. Personal Protective Equipment (PPE's) Putting On

7. Personal Protective Equipment (PPE's) Removing with critical notes
8. Personal Protective Equipment (PPE's) and Supplies
9. Pneumatic Tube Use
10. Infection Prevention Plan (IPP)*
11. Employee Health Medical Management of Vaccine Reactions in Adult Health Care Workers (HCW)
12. MEDICAL WASTE MANAGEMENT PLAN
13. Sharps Committee Charter
14. Designated Areas for Food and Drink Near Patient Care Areas*
15. InQuiseek – Blood Borne Pathogens: Exposure Control
16. InQuiseek – Infection Control Policy

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RECORD RETENTION AND DESTRUCTION:

See medical records and training records section of this annual plan.

Sharps injury training records will be kept for at least six years.

Sharps Injury log will be kept for 10 years

Supersedes: v.8 Bloodborne Pathogen Exposure Control Plan, Sharps Injury Protection Plan

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Credentialing Healthcare Practitioners in the Event of a Disaster		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: District-Wide		
Date Last Modified: 09/24/2024	Last Review Date: 10/01/2024	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/15/2020	

PURPOSE:

The purpose of this policy is to outline the credentialing procedure by which a practitioner can be granted temporary privileges in a disaster at Northern Inyo Healthcare District (NIHD).

DEFINITIONS:

1. **Disaster** – an emergency that, due to its complexity, scope, or duration, threatens an organization's capabilities and requires additional and sometimes outside assistance to sustain patient care, safety, or security functions.
2. **Volunteer Healthcare Practitioner** – a licensed independent practitioner or other individual required by law and regulation to have a license, certification, or registration who is presenting to assist in patient care during a disaster. This individual may have existing privileges at NIHD or may be a volunteer not currently privileged at NIHD. Additionally, licensed locum tenens practitioners from a staffing agency, for the purpose of this policy, are also defined as volunteer healthcare practitioners regardless of whether the practitioner is being compensated for the work performed.

POLICY:

1. In the event of a disaster or emergency where the District's emergency management plan has been activated and the District is unable to handle the immediate patient care needs, the medical staff may grant disaster privileges to individuals seeking to volunteer or offer their services after the policy applicability has been met and the procedure outlined in this document has been followed.
2. The following medical staff members listed in order of highest to lowest rank are authorized to grant disaster privileges as further described in this document:
    a. Chief of Staff
    b. Physician member of the Medical Executive Committee
    c. Any department chief
    d. Any active medical staff member
    e. Designee of any of the above
3. In the event of similar ranking individuals being available, preference would be given to the medical staff member with the practice most appropriate to the background or training of the practitioner seeking disaster privileges.
4. Practitioners granted disaster privileges are expected, to the best of their abilities and under extenuating circumstances, to provide the standard of care commensurate with their designated clinical role under the supervision of a paired medical staff member or Advanced Practice Provider. This may include, but is not limited to clinical care, documentation, availability for call, procedures, and consultation with supervising providers when necessary.

5. This policy and procedure is applicable only when the following has occurred:
    a. NIHD declares a disaster and activates its emergency operations plan.
    b. The Medical Executive Committee (MEC) recognizes the disaster situation as one in which this policy applies. The MEC may choose to convene a special meeting for this purpose or conduct a vote through electronic means. If the nature of the disaster is such that any delay caused by first obtaining a vote of the MEC could reasonably cause patient harm, the highest ranking on-site medical staff member may recognize the disaster situation. That staff member may grant disaster privileges to volunteering practitioners as per the procedure detailed below. This decision must then be approved by the MEC within 24 hours.

PROCEDURE:

1. Recruitment of Volunteer Healthcare Practitioners
    a. If a Department Chief or on-site responsible physician (e.g., hospitalist or emergency medicine physician on-duty) determines that he/she is unable to cover care in his/her service during a disaster and needs additional immediate assistance, a medical staff member or appropriate District personnel (e.g., Incident Command member, House Supervisor, or medical staff office personnel) can begin contacting possible volunteer healthcare practitioners. Reasonable efforts should be made, under the circumstances, to first contact existing NIHD practitioners with appropriate privileges, followed by existing NIHD privileged practitioners who may qualify for disaster privileges or actively-practicing locum tenens practitioners of an appropriate specialty, prior to contacting or accepting other outside volunteer practitioners.
    b. Volunteer healthcare practitioners may also be proactively recruited in the course of disaster staffing preparations when the nature of the disaster allows it. In this case, the medical staff office, Chief Medical Officer, or appropriate medical staff member with responsibilities in determining staffing for the service may contact possible volunteer healthcare practitioners to determine availability.
    c. All District departments and supervisory personnel shall be instructed to direct all volunteering health care practitioners that present to the District to a member of the Incident Command Center, medical staff office personnel, or an on-site responsible medical staff member for possible disaster privileging.
2. Identification Documentation Required
    a. The volunteer healthcare practitioner shall be required to produce a valid government-issued photo identification with a signature (e.g., driver's license or passport).
    b. If the practitioner is not currently privileged at NIHD, he or she will also be required to produce at least one of the following in addition to a government-issued photo identification:
        i. a current license to practice medicine, or other certification or registration, issued by a state, federal, or regulatory agency; or
        ii. identification indicating that the individual is a member of a Disaster Medical Assistance Team, the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group; or
        iii. identification indicating that the individual has been granted authority, by a federal, state or municipal entity, to render patient care, treatment, or services in disaster circumstances; or

iv. a signed statement by a current District department leader or medical staff member with personal knowledge regarding the practitioner's identity and ability to act as a qualified practitioner during a disaster.

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

d. If such identification documents are not readily accessible, the medical staff member will be responsible for making the final decision whether to allow the volunteer practitioner to participate in disaster care.

e. The identification information on the Request for Disaster Privileges form shall be completed by the volunteering healthcare practitioner.

3. Verifications
   a. If the practitioner is currently privileged at NIHD, the medical staff office will confirm their credentials file is up to date and will perform primary source verification of licensure as soon as feasible, but no later than 72 hours after the time that the practitioner presents him/herself. No other primary source verification is necessary provided that the credentials file is up to date.
   b. Volunteering practitioners without current NIHD privileges shall be requested to indicate his/her malpractice carrier (if any) and the name of the hospital(s) where he/she currently holds privileges (if applicable). Primary source verification of licensure, certification or registration, insurance, and hospital affiliations shall be made as soon as the disaster is under control, or within 72 hours from the time the volunteer practitioner presents him- or herself to the hospital, whichever comes first. A query to the National Practitioner Data Bank (NPDB) and Office of Inspector General (OIG) shall also be submitted, unless technologically not possible. In the event this information cannot be verified, emergency approval of disaster privileges may still be granted pending verification.
   c. If primary source verification of licensure, certification or registration cannot be completed within 72 hours of the volunteer's arrival due to extraordinary circumstances, it is performed as soon as possible. The following must be documented:
      i. Reason(s) the verification could not be performed within the 72 hours.
      ii. Evidence of the volunteer practitioner's demonstrated ability to continue to provide adequate care, treatment, or services.
      iii. Evidence of the attempt to perform primary source verification as soon as possible.
4. Approval of Disaster Privileges
   a. The available information shall be reviewed by the highest ranking available individual(s) authorized to grant emergency approval of disaster privileges. The highest ranking available individual(s) shall interview the volunteer to determine the appropriate scope of assigned responsibilities, and make a recommendation based on the available information.
   b. If approved for disaster privileges, approval will be documented on the Request for Disaster Privileges form.
5. Supervision Required
   a. The volunteer practitioner shall be partnered with a member of the medical staff or Advanced Practice Provider (APP) staff. Whenever possible, the partner shall be of similar specialty.
   b. As appropriate and under the circumstances, the medical staff member or APP staff member will oversee the performance of the volunteer practitioner through direct observation, mentoring, or

medical record review. Partnering information shall be recorded with the other information regarding the volunteer practitioner. More than one practitioner may be partnered with a single medical staff member or APP.

c. The volunteer practitioner shall be issued a temporary identification badge (if available) indicating his/her name, status as an approved volunteer practitioner, notation of his/her partner, and when relevant, the specific area(s) of the District in which the practitioner shall be permitted to render care. Current NIHD practitioners may use his/her existing NIHD hospital identification badge in addition to a temporary badge (if available) which identifies he or she is approved for temporary disaster privileges in the specific patient care area.

6. Review and Termination of Privileges
    a. A decision whether to continue the volunteer practitioner's assigned disaster responsibilities is to be made within 72 hours of the practitioner's arrival.
    b. Any such disaster privileges may be terminated at any time, with or without cause or reason, and any such termination shall not give rise to any rights of review, hearing, appeal or other grievance mechanism. Disaster privileges shall be terminated immediately if any information is received that suggests the volunteer healthcare practitioner is not capable of rendering services as approved.
    c. Once the care of disaster victims can be adequately assumed by an appropriate member of the regular medical staff or APP staff with existing privileges for that service, then the volunteer practitioner's privileges will be terminated. An individual who has had privileges terminated pursuant to this section shall be eligible to have disaster privileges reinstated, should circumstances warrant.
    d. Disaster privileges may be terminated by the assigned partner or any of the grantors listed in this policy.
    e. The District will make every effort to recognize and thank the services provided by the volunteer healthcare practitioners once the disaster is over.

REFERENCES:

1. The Joint Commission (2024) EM 12.02.03
2. California Medicaid Services §485.623 Condition of Participation: Emergency Services
3. "Disaster Privileging." Northwell Health. Policy retrieved March 26, 2020. https://medicine.hofstra.edu/pdf/policy/disaster-privileging.pdf

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Request for Disaster Privileges form (attached)
2. InQuiseek – Severe Weather and External Disaster Policy
3. InQuiseek – Credentialing and Employment Policy

Supersedes: v.4 Credentialing Healthcare Practitioners in the Event of a Disaster

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Discharge Instructions Emergency Department		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: Emergency Department		
Date Last Modified: 08/13/2024	Last Review Date: 06/19/19	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 05/01/2018	

PURPOSE: To ensure patients leaving the Emergency Department (ED) receive comprehensive and clear instructions for continued care, promoting their safety and wellbeing post-discharge.

POLICY: Discharge instructions are mandatory for all patients discharged from the Emergency Department. These instructions will be in a typed written format utilizing the computerized discharge instruction software within the body of the electronic medical record (EMR). The generated discharge instructions will be verbally reviewed with the patient or responsible party. In addition, the patient or responsible party will sign a copy of the same instructions indicating that the nurse has reviewed the discharge document with them and that any questions have been answered. The patient will be referred to their own or other physician as appropriate for follow-up care, or may return to the Emergency Department if needed.

PROCEDURE:

1. The ED Physician will enter his/her discharge instructions in the EMR, or on the first page of the ED paper chart during downtime procedure.
2. Discharge instructions for each patient will be generated and printed from the EMR. In the event of downtime procedure, hard copies of discharge documents are located in the Discharge Downtime Binders. Binders are classified by adult and pediatric and are located within the Emergency Department.
3. Physician utilization of discharge topics include: illnesses, medications, follow-up, activity limitations, devices, equipment, treatment, dressings, wound care, diet, lifestyle, environment, procedures, tests, preparations and health/wellness promotions.
4. The instructions will be reviewed with the patient and/or responsible party by a Registered Nurse (RN). All questions will be addressed and a signature will be obtained indicating that all questions have been answered. The original discharge instructions will be given to the patient, family or responsible party. The copy will become part of the medical record after being signed and timed by the RN.
5. Any special instructions such as School or Work Releases will be created if needed and a copy of same will be retained in the medical record.
6. In addition to signing the discharge instructions provided to the patients, the RN will document in the Discharge Summary section found the in EMR. The RN will write a narrative note in the discharge section of the paper chart if discharge occurs during downtime procedure.
7. Discharge instructions can be printed in Spanish during the printing process.

REFERENCES:

1. Emergency Nurses Association. (2017). Safe Discharge From the Emergency Setting Position Statement. Retrieved from https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/safedischargefromed.pdf?sfvrsn=998ee45f_6

RECORD RETENTION AND DESTRUCTION: Medical records will be maintained by the medical records department at NIHD.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Standards of Care in the Emergency Department

Supersedes: v.2 Discharge Instructions Emergency Department

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL PROCEDURE

Title: Evaluation of Pregnant Patients in the Emergency Department		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: Emergency Department, Perinatal		
Date Last Modified: 04/24/2024	Last Review Date: 01/05/2022	Version: 4
Final Approval by: Medical Executive Committee	Original Approval Date: 01/09/2004	

PURPOSE:
To ensure quality care for pregnant patients presenting in the Emergency Department (ED) for evaluation and potential treatment. To delineate clear roles and responsibilities of the Emergency and Perinatal departments as it pertains to management of this group of patients.

PROCEDURE:

1. All pregnant patients presenting to the Emergency Department will initially be seen in accordance with ED medical screening policies and procedures.

2. Stable patients at 20 weeks or greater gestation will be sent to the Perinatal Department for evaluation. The on-call obstetric (OB) provider will be consulted by the Perinatal RNs, and will see the patient as necessary (in accordance with the Emergency Medical Treatment and Labor Act (EMTALA) and patient condition). If the patient is cleared (discharged) from the Perinatal Department by the OB provider and has non-OB complaints that were not addressed by the OB provider, the patient shall return to the ED to be evaluated by the ED physician. If it is determined by the OB provider (Physician) that the patient needs further evaluation in the ED then the OB physician will directly contact the on call Emergency Department physician before the patient is transferred back down to the ED. This determination should only be made by the physician and is not at the discretion of the Perinatal RN, Emergency RN, or RN House Supervisor.

3. Patients who are deemed clinically unstable will not be transferred to the Perinatal Department until stabilized. The Emergency Department physician is in charge of determining if the patient is stable for transfer to the Perinatal Department. If the patient becomes unstable while in the Perinatal unit before the on call OB physician arrives, the ED physician may be called to the Perinatal unit to assist in emergent stabilization of the patient.

4. Patients at less than 20 weeks gestation will be evaluated by the ED physician who will consult, as needed, with the OB physician on-call.

5. For patients at 20 weeks or greater gestation who are not immediately transferred to the Perinatal Department, the ED physician will consult with the on-call OB provider in a timely manner as dictated by the care required and at the discretion of the treating ED physician.

6. If patient appears to be in active labor or delivery appears imminent, notify Perinatal Department to prepare for the patient and accompany patient to Perinatal Department.

7. If delivery is in progress, patient will be cared for by the ED physician until the on-call OB provider arrives. Perinatal RNs may be requested to assist in the ED if available.

8. The decision to admit or discharge a patient at 20 weeks or greater gestation will be at the discretion of the OB provider evaluating the patient for pregnancy-related problems. If not pregnancy-related, then the ultimate disposition of the patient will be determined after a discussion between the on call OB provider and the ED physician has taken place.

9. For patients at 20 weeks or greater gestation who are not immediately transferred to the Perinatal Department, a Perinatal RN should evaluate the patient in the ED if staffing allows and both departments are agreeable. The Perinatal RN will coordinate their evaluation with the treating ED physician so as not to interfere with care being provided in the ED. If after initial evaluation in the Emergency Department, it is determined by the ED physician and the on call OB provider that the patient is to be transferred to the Perinatal unit then this evaluation will be performed in the Perinatal unit, not the Emergency Department (if it has not already taken place).

REFERENCES:

1. EMTALA; California Hospital EMTALA Manual; A guide to patient anti-dumping laws. Lipton, M.S. 2018.

RECORD RETENTION AND DESTRUCTION:

Documentation in medical record is maintained per the Health Information Management Service (HIMS) department at NIHD.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. EMTALA Policy
2. Medical Screening Exam of the Obstetrical Patient

Supersedes: v.3 Evaluation of Pregnant Patients in the Emergency Department

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: 08/14/2024	Last Review Date: No Review Date	Version: 2
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. 2.5% of interpretations will be randomly selected for peer review on an ongoing basis.
    b. All charts identified by critical indicators, concerns or complaints will be peer reviewed by the Chief of Radiology or designee. Critical indicators are reviewed by the Department of Radiology on an annual basis.
    c. The reviewing radiologist will document the level of agreement with the original interpretation in accordance with the following scale:
    (1) – Concur with interpretation
    (2a) – Discrepancy in interpretation (understandable miss) - unlikely to be significant
    (2b) – Discrepancy in interpretation (understandable miss) – likely to be significant
    (3a) – Discrepancy in interpretation/should be made most of the time – unlikely to be significant
    (3b) – Discrepancy in interpretation/should be made most of the time – likely to be significant
    d. Castes rated (3a) and (3b) will be considered significant discrepancies and should be referred for review to the Chief of Radiology or designee.
    e. Cases rated (2b) and higher will be referred for review to the Radiology Services committee.
    f. External peer review may be utilized if there are concerns about conflict of interests or the possession of the appropriate level of experience or skill by the internal reviewers.
    g. Peer review 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: v.1 Medical Staff Department Policy - Radiology

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Medical Staff Professional Conduct Policy		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Medical Staff and Advanced Practice Providers		
Date Last Modified: 10/01/2024	Last Review Date: 10/01/2024	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/19/2013	

PURPOSE: The purpose of this policy is to ensure safe patient care by promoting a cooperative and professional healthcare environment, and to create a fair process for communicating and addressing complaints regarding behavioral concerns of privileged practitioners at Northern Inyo Healthcare District (NIHD).

POLICY: All practitioners shall conduct themselves at all times while on District premises in a courteous, professional, respectful, collegial, and cooperative manner. This applies to interactions and communications with or relating to Medical Staff colleagues, Advanced Practice Providers (APPs), nursing and technical personnel, other caregivers, other District personnel, patients, patients' family members and friends, visitors, and others. Such conduct is necessary to promote high quality patient care and to maintain a safe work environment. Inappropriate, discriminatory, or harassing behavior, as defined below, is prohibited.

DEFINITIONS:

1. **"Discrimination"** is conduct directed against any individual (e.g., against another Medical Staff member, APP, District employee, or patient) that deprives the individual of full and equal accommodations, advantages, facilities, privileges, or services, based on the individual's race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender, or sexual orientation.
2. **"Sexual harassment"** is unwelcome verbal or physical conduct of a sexual nature, which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory or sexual-themed cartoons, drawings or posters) that is deemed severe or pervasive by the "reasonable person" standard (as per the U.S. Equal Employment Opportunity Commission). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct indicating that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.
3. **"Inappropriate Behavior"** is marked by disrespectful behavior manifested through personal interaction with practitioners, District personnel, patients, family members, or others, which:
    a. interferes, or tends to interfere with high quality patient care or the orderly administration of District operations or the Medical Staff; or

b. creates a hostile work environment; or
c. is directed at a specific person or persons, would reasonably be expected to cause substantial emotional distress, and serves no constructive purpose in advancing the goals of health care.

Examples of prohibited inappropriate conduct may include, but are not limited to, any of the conduct described below if it is found to interfere, or tends to interfere, with patient care or the orderly administration of the District or Medical Staff; or, if it creates a hostile work environment; or, if it is directed at a specific person or persons, causes substantial emotional distress, and has no legitimate purpose:

a. Any striking, pushing, or inappropriate touching of District staff or others;
b. Any conduct that would violate Medical Staff and/or District policies relating to discrimination and/or sexual harassment;
c. Forcefully throwing, hitting, pushing, or slamming objects in an expression of anger or frustration;
d. Yelling, screaming, or using an unduly loud voice directed at patients, District employees, other practitioners, or others;
e. Refusing to respond to a request by any caregiver for orders, instructions, or assistance with the care of a patient, including, but not limited to, repeated failure to respond to calls or pages;
f. Use of racial, ethnic, epithetic, or derogatory comments, or profanity, directed at District employees or others;
g. Criticism which is unreasonable and unprofessional of District or Medical Staff personnel (including other practitioners), policies or equipment, or other negative comments that undermine patient trust in the District or Medical Staff in the presence or hearing of patients, patients' family members, and/or visitors;
h. Use of medical record entries to criticize District or Medical Staff personnel, policies, or equipment, other practitioners, or others;
i. Unauthorized use and/or disclosure of confidential or personal information related to any employee, patient, practitioner, or other person;
j. Use of threatening or offensive gestures;
k. Intentional filing of false complaints or accusations;
l. Any form of retaliation against a person who has filed a complaint against a practitioner alleging violation of the above standard of conduct;
m. Use of physical or verbal threats to District employees, other practitioners, or others, including, without limitation, threats to get an employee fired or disciplined;
n. Persisting to criticize, or to discuss performance or quality concerns with particular District employees or others after being asked to direct such comments exclusively through other channels;
o. Persisting in contacting a District employee or other person to discuss personal or performance matters after that person or a supervisory person, the Chief Executive Officer, or designee, or Medical Staff leader, has requested that such contacts be discontinued [NOTE: Practitioners are encouraged to provide comments, suggestions and recommendations relating to District employees, services or facilities; where such information is provided through appropriate administrative or supervisory channels];

p. Obstructing the peer review process by intentionally refusing, without justification, to attend meetings or respond to questions about the practitioner's conduct or professional practice when the practitioner is the subject of a focused review or investigation.

PROCEDURE:

1. District Staff Response ("Walk Away Rule")
    a. Any District employee who believes that he or she is being subjected to inappropriate or discriminatory behavior or sexual harassment within the meaning of this Policy by a Medical Staff privileged practitioner is authorized and directed to take the following actions:
        i. Promptly contact his/her immediate supervisor or Human Resources to report the situation and to arrange for the transition of patient care as appropriate in order to permit the employee to avoid conversing or interacting with the practitioner;
        ii. Discontinue interaction with the practitioner except to the extent necessary to transition patient care responsibility safely and promptly from the employee to another qualified person as directed by the employee's supervisor;
        iii. Consult with supervisory personnel or with the Director of Human Resources about filing a written report of the alleged incident.
2. Handling of Complaints
    a. All complaints and related documentation in which the subject of the complaint is a privileged practitioner will be directed to the Medical Staff Office. The Medical Staff Office will review the complaint and forward it for review as follows:

        i. For complaints involving concerns about quality of care, the patient encounter and related information will be submitted for peer review through the relevant Department Chief(s)/Chair(s) or designee, following the normal peer review process. If determined to need additional review, the case may be referred to committee (standing or ad hoc), external peer review, recommendation for Focused Professional Practice Evaluation (FPPE) or other appropriate action. Any adverse privilege actions as a result of peer review will comply with the procedures detailed in the Medical Staff Bylaws.

        ii. For complaints involving behavioral concerns suspected to be related to impairment (physical, emotional, or psychiatric), the review will be delegated to the Physician Wellness Committee after consultation with the Chief of Staff.

        iii. For complaints involving behavioral concerns not suspected to be related to impairment, including reports of discriminatory behavior or sexual harassment, the report will be submitted to the Chief of Staff, Department Chief/Chair, or designee for review. The reviewer (or designated ad hoc committee) will make a reasonable effort, through personal interviews and/or other fact-finding activities, to determine whether the allegations are credible. If it is determined that a formal corrective action investigation may be needed, the case should be referred to the Chief of Staff and/or Medical Executive Committee for determination and proper notice procedures as per the Medical Staff Bylaws.

        iv. For any complaint involving any conduct such that failure to take immediate action may result in an imminent danger to the health of any individual, the Chief of Staff, Medical Executive Committee, or Chief or Chair of the Department may summarily restrict or

suspend the individual's clinical privileges under the procedures further outlined in the Medical Staff Bylaws. The Chief Medical Officer and/or Administrator On-Call shall be notified of such summary restriction or suspension.

b. Practitioners who are the subject of a complaint shall be provided a summary of the complaint, either verbally or in writing, in a timely fashion (in no case more than 30 days from receipt of the complaint by the Chief of Staff, Department Chief/Chair, or designee). The practitioner shall be offered an opportunity to provide a written response to the complaint and any such response will be kept along with the original complaint.

c. Practitioners will be notified that attempts to confront, intimidate, or otherwise retaliate against the complainant is a violation of Medical Staff Professional Conduct Policy and may result in corrective action against the practitioner as further detailed in the Medical Staff Bylaws.

d. If the practitioner signs an agreement to keep the complaint and related information in strict confidence and to use the information exclusively within the formal Medical Staff peer review process, he or she may review a copy of the complaint and any supporting documentation submitted with the complaint by the complainant, with names redacted, in the Medical Staff Office. The practitioner may not photograph or keep a copy of the complaint (see attached **Confidentiality Agreement**).

3. Progressive Discipline for Verified Inappropriate Behavior
   a. If this is the first incident of verified inappropriate behavior the Chief of Staff or designee shall discuss the matter with the subject of the complaint, emphasizing that the behavior must cease. The subject of the complaint may be asked to apologize to the complainant. The approach during this initial intervention should be collegial and helpful.

   b. Further isolated incidents that do not constitute persistent, repeated inappropriate behavior will be handled by providing the subject of the complaint with notification of each incident, and a reminder of the expectation he or she comply with Medical Staff Professional Conduct Policy.

   c. If it is determined that there is repeated inappropriate behavior, a letter of admonition will be sent to the practitioner, and, as appropriate, a rehabilitation action plan developed by the Chief of Staff or Department Chief/Chair, with the advice and counsel of the Medical Executive Committee as indicated.

   d. If in spite of admonition and intervention, inappropriate behavior recurs, the Chief of Staff or designee shall meet with and advise the practitioner such behavior must immediately cease or corrective action (as per the Medical Staff Bylaws) will be initiated. This "final warning" shall be sent to the practitioner in writing.

   e. If after the "final warning" the behavior recurs, corrective action shall be initiated pursuant to the Medical Staff Bylaws.

4. Documentation and Records
   a. It is the responsibility of the Medical Staff Office to track the progress of all complaints and keep accurate records of any resolutions in the practitioner's quality file. All complaints (excepting any complaints that were found to have no substance or validity during the review process) will

be reviewed at the time of re-credentialing and as part of the practitioner's periodic Ongoing Professional Practice Evaluation (OPPE).

b. Complaints and all related investigation documents and reports shall be identified and maintained as confidential peer review documents protected under Evidence Code 1157.

REFERENCES:

1. Stanford Healthcare (2019). Medical Staff Code of Professional Behavior. Stanford, CA. Director of Medical Staff Services.

RECORD RETENTION AND DESTRUCTION:

1. Documentation of complaints and related records are to be kept for the length of the practitioner's career, plus 6 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Northern Inyo Healthcare District Medical Staff Bylaws

Supersedes: v.2 Professional Conduct. Prohibition or Discriminatory Behavior; v.1 Practitioner Complaint Resolution Process

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Pediatric and Newborn Consultation Requirements		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Medical Staff and Advanced Practice Providers		
Date Last Modified: 07/07/2022	Last Review Date: 10/01/2024	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 11/14/2018	

PURPOSE:

The purpose of this policy is to outline the requirements for pediatric and newborn patient consultation to the pediatric service.

POLICY:

1. Consultation on pediatric patients is required in the following circumstances:
    a. Any critically ill infant or child.
    b. Prior to surgery in any child with potential for significant complications.
    c. Following surgery for unexpectedly prolonged inpatient stay or prolonged IV therapy or electrolyte imbalance.
    d. At any time a provider has concerns.
2. Consultation on newborns/nursery patients is required in the following circumstances:
    a. Any newborn admitted to Neonatal Pediatrics for any reason (IV therapy, oxygen therapy, etc.).
    b. Any infant requiring transfer to another facility.
    c. Infants requiring phototherapy.
    d. Infants requiring treatment for hypoglycemia.
    e. Infants with unstable vital signs or suspected sepsis.
    f. Infant with persistent vomiting or abdominal distension.
    g. Infants born before 35 weeks gestation.
    h. Infant of mother with signs/symptoms concerning for chorioamnionitis.
    i. At any time a provider has concerns.
3. The request for consultation should be directed to the physician listed as being on-call for the pediatric service and/or a pediatric or neonatal specialist if higher level of care is needed. Medical staff members on-call for the pediatric service may be a pediatrician or a family practice physician having qualified for and been granted the appropriate privileges to provide consultation.

REFERENCES:

1. 22 CCR §70537. Pediatric Service General Requirements.
2. American Academy of Pediatrics.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Pediatric Standards of Care and Routines

2. Admission Procedure of Pediatric Patient
3. Admission, Care, Discharge, and Transfer of the Newborn

Supersedes: v.1 Pediatric and Newborn Consultation Requirements

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Safely Surrendered Baby Policy and Procedure		
Owner: Manager of ED and Disaster Planning	Department: Emergency Department	
Scope: Emergency Department Perinatal		
Date Last Modified: 06/19/2024	Last Review Date: 12/20/2020	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/2001	

PURPOSE:
The intent of this policy is to meet the legal requirements of the Newborn Safe Surrender Law (Health and Safety Code 1255.7).

POLICY:

1. Northern Inyo Hospital District (NIHD) shall post a sign in the Emergency Department (ED) utilizing a statewide logo that has been adopted by the State Department of Social Services that notifies the public of the location where a minor child 72 hours old or younger may be safely surrendered.
2. Any personnel on-duty at NIHD is authorized to accept physical custody of a newborn who is 72 hours old or younger from a parent or individual who has lawful custody of the child and who voluntarily surrenders the child. When a newborn is received in an area other than the ED, the ED must be notified. If the child appears older than 72 hours, NIHD will still accept the newborn for surrender.
3. A member of the ED Staff shall do the following:

    a. Place a coded, confidential ankle bracelet on the infant. The bracelet is found in the safe surrender kit, which is found in the ED and Perinatal units.
    b. Provide, or make a good faith effort to provide, the parent or other individual surrendering the infant a copy of unique, coded, confidential ankle bracelet identification in order to facilitate reclaiming the child. However, possession of the ankle bracelet identification, in and of itself, does not establish parentage or a right to custody of the child.
    c. Provide, or make a good faith effort to provide, to the parent or other individual surrendering the child a medical information questionnaire, which may be declined, voluntarily filled out and returned at the time the child is surrendered, or later filled out and mailed in an envelope provided for this purpose. This medical information questionnaire shall not require any identifying information about the child or the parent or individual surrendering the child, other than the identification code provided in the ankle bracelet placed on the child. Every questionnaire provided pursuant to a safe surrender shall begin with the following notice in no less than 12-point type: *Notice: The baby you have brought in today may have serious medical needs in the future that we don't know about today. Some illnesses, including cancer, are best treated when we know about family medical histories. In addition, sometimes relatives are needed for lifesaving treatments. To make sure this baby will have a healthy future, your assistance in completing this questionnaire fully is essential. Thank You*
    d. Ensure that a medical screening examination and any necessary medical care is provided to the surrendered child as soon as possible without requiring consent of the parent or other relative to provide that care to the minor child pursuant to a safe surrender.

4. After the medical screening exam is complete and the child is determined to be stable, or is stabilized, the child will be placed in the Perinatal Department Nursery, for routine newborn care.
5. The Nursing Supervisor shall be notified as soon as possible.
6. The Nursing Supervisor shall notify Social Services.
7. Social Services or the Nursing Supervisor shall notify Child Protective Services (CPS) of the safe surrender as soon as possible, but no later than 48 hours after the physical custody of a child has been accepted.
8. Any medical information pertinent to the child's health, including, but not limited to, information obtained pursuant to the medical information questionnaire shall be provided to CPS without obtaining a HIPAA release. However, any personal identifying information that pertains to a parent or individual who surrenders a child shall be blacked out from any medical information provided to CPS or the county agency providing child welfare services.
9. Since child protective services will assume temporary custody of the child immediately on receipt of notice, NIHD employees will surrender physical custody of the child to the agency upon demand.
10. Should the person who surrendered the child request that the hospital return the child to him/her before CPS assumes custody of the child, then, NIHD personnel will either return the child to the parent or individual or contact CPS if NIHD personnel know or reasonably suspect that the child has been the victim of child abuse or neglect. The voluntary surrendering of a child is not in and of itself a sufficient basis for reporting child abuse or neglect. The child will not be returned to the requesting person if the hospital has been notified that a dependency petition has been filed in juvenile court.
11. The person requesting the return of the newborn must present positive identification or evidence that the requesting person is the person who surrendered the child.

PROCEDURE:

When a baby is surrendered anywhere on the NIHD campus other than the perinatal department, the infant will be taken to the ED for immediate evaluation and will follow the ED Safe Surrender pathway as outlined below.

If a mother presents to the Perinatal Department at NIHD and decides to safe surrender the newborn after the birth of the baby, follow the steps in the Perinatal Safe Surrender pathway as outlined below.

<u>Emergency Department Pathway</u>

1. At the time of the presentation, attempt to verify the age of the infant by physically examining the child, specifically looking for presence of umbilical cord.
2. When the infant is received in the Emergency Department, staff will immediately call the Perinatal Unit and the ED physician and notify them that they have a surrendered newborn and request their assistance.
3. The Perinatal nurse will bring either a radiant warmer if appropriate or a basinet to the Emergency Department.
4. The ED physician will perform a medical screening examination.
5. Notify the Supervisor and Social Service Worker of the surrendered newborn.
6. Place an identification bracelet on the infant’s wrist and ankle.
7. Make a duplicate bracelet with identical numbers to give to the person surrendering the baby in case the person wants to reclaim the child at a later date.
8. The identification band will contain the following information:
    A. The infant’s name or Baby Boy/Girl Doe
    B. Tag number
    C. Sex of infant

D. Date & time of birth, or admit date and time if birth data is unknown

9. Ask the person surrendering the newborn to complete a family medical history questionnaire.
10. Admit the newborn to the Perinatal Department Nursery.
11. Notify the on-call pediatrician of the admission.
12. The admitting nursery nurse will follow policy and procedure for admitting the newborn to the nursery.
13. Discharge planning per CPS plan.

PROCEDURE: Perinatal Department Pathway

1. The newborn birth occurs in the Perinatal Department at NIHD.
2. The newborn medical record of live birth remains connected to the mother's medical record at this time.
3. Decision to safe surrender by mother occurs.
4. Time and date of safe surrender is documented in the EHR. No further documentation in this medical record shall occur. Baby chart is to be made confidential and locked as soon as it is complete.
5. Create a Baby Boy/Girl Doe medical record for newborn.
    A. Do not put parent information/demographics into the chart. Use CPS as the guarantor.
    B. For new Baby Boy/Girl Doe record:
        I. Admit H&P to be completed. No live birth information or neonate H&P in the new chart.
        II. Admit assessment to be completed (as if new admission starting from this point forward)
        III. Pediatrician to enter all admission orders.
6. Print new identification band and place new infant security tag on newborn. Be sure to remove old ones concurrently.
7. Notification to CPS shall occur with no parent information given. Document the reporting call in the new Baby Boy/Girl Doe EHR.
8. Discontinue live baby chart.
9. Initiate safe surrender packet:
    A. Apply the band to the newborn from the safe surrender kit.
    B. Give the second band to the mother from the safe surrender kit.
    C. Offer medical history questionnaire, the birth parent may refuse to complete this.
    D. Follow all other documentation instructions from safe surrender kit.
10. Notify the HIMS Department of new born safe surrender. In order to maintain confidentiality of the surrendering individual, a VS 136 form titled "Certificate of Finding of Unknown Child or Safely Surrendered Baby" will be completed by HIMS staff. Once completed, the HIMS staff will have the Perinatal Manager sign the form. If a birth certificate has been issued in error, it must be sealed and a VS 136 form issued in its place.
11. Schedule newborn follow up in Baby Boy/Girl Doe chart.
12. Discharge planning per CPS plan.
13. If the surrendering mother request the return of the newborn within 14 days of the safe surrender and contacts NIHD hospital staff for direction, direct mother to reach out to CPS for next steps.

REFERENCES:

1. California Health and Safety Code, Division 2.Chapter 2, Article 1-1225.7. (2010) Retrieved from: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1255.7

2. California Health and Safety Code, An act to amend Section 1255.7 of the Health and Safety Code, (2013) relating to child protection. Retrieved from: http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1001-_1050/ab_1048_bill_20100930_chaptered.pdf

3. California Department of Social Services. (2024). *Safely Surrendered Baby Law*

   Retrieved from http://www.cdss.ca.gov/inforesources/Safely-Surrendered-Baby

CROSS REFERENCE POLICIES AND PROCEDURES:

Admission Care. Discharge, and Transfer of the Newborn

Evaluation and Medical Screening of Patients Presenting to the Emergency Department

Supersedes: v.4 Safely Surrendered Baby Policy and Procedure

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Sublocade™ (Buprenorphine): Risk Evaluation and Mitigation Strategies (REMS) Program		
Owner: PHARMACY DIRECTOR	Department: Pharmacy	
Scope: District Wide		
Date Last Modified: 09/12/2024	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:
This policy aims to establish guidelines for the secure, safe, and Risk Evaluation and Mitigation Strategies (REMS)-compliant administration of Sublocade within our hospital facility. Sublocade, an extended-release formulation of buprenorphine, is prescribed for individuals diagnosed with opioid use disorder (OUD). The policy intends to ensure patient safety, minimize misuse, abuse, and diversion risks, and uphold compliance with the REMS program.

POLICY:
Our hospital is committed to the safe and responsible administration of Sublocade in accordance with REMS requirements. This policy outlines procedures for prescription, storage, handling, administration, patient monitoring, documentation, and reporting of Sublocade within our facility.

PROCEDURE:

1. **Prescription and Patient Eligibility:**
   a. Prescribers must be REMS-certified and adhere to REMS requirements when prescribing Sublocade.
   b. Only patients diagnosed with opioid use disorder who meet REMS eligibility criteria will receive Sublocade prescriptions.
   c. Sublocade is dispensed only to a health care provider.
   d. Sublocade is never dispensed directly to a patient.
   e. The comments section in the EMR will include verbiage to notify healthcare providers to not dispense Sublocade directly to the patient.

2. **Storage and Handling:**
   a. Sublocade should be securely stored in a locked cabinet or designated medication storage area as per manufacturer guidelines.
   b. Storage temperature must be maintained as specified by the manufacturer to ensure medication integrity.

c. Access to Sublocade should be restricted to authorized personnel only.

3. **Administration:**
   a. Prior to administration, healthcare providers must verify patient identification and confirm the prescribed dose's appropriateness.
   b. Sublocade is administered via subcutaneous injection into the abdomen by trained healthcare professionals using aseptic technique.
   c. Proper needle disposal procedures must be followed post-administration.
4. **Patient Monitoring:**

a. Patients receiving Sublocade must be monitored for signs of opioid withdrawal, injection site reactions, and adverse effects.
b. Healthcare providers should educate patients on Sublocade's risks, benefits, and provide instructions for follow-up care.
c. Regular follow-up appointments should be scheduled to assess treatment progress and adjust therapy as necessary.

5. **Documentation and Reporting:**
a. All Sublocade administrations and related patient information must be accurately documented in the medical record.
b. Adverse events, medication errors, and safety concerns should be reported to regulatory agencies and documented as per hospital protocols.

REFERENCES:

1. REMS Program for Sublocade. https://www.sublocaderems.com/#Main
2. Sublocade Prescribing Information. https://www.sublocaderems.com/pdfs/PrescribingInformation

RECORD RETENTION AND DESTRUCTION:

Will be maintained in the patient's electronic health care record

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Administration of Drugs and Biologicals

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Utility Systems Electrical and Generator Failure		
Owner: Maintenance Manager	Department: Maintenance	
Scope: Northern Inyo Healthcare District (NIHD)		
Date Last Modified: 08/06/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

To ensure the safety and continued operation of Northern Inyo Healthcare District's (NIHD) critical systems in the event of electrical and generator failure, in compliance with the National Fire Protection Association (NFPA) and The Joint Commission (TJC) standards.

SCOPE:

This policy applies to all staff involved in the operation, maintenance, and oversight of the hospital's electrical systems and emergency power supply systems (EPSS).

DEFINITIONS:

EPSS (Emergency Power Supply System): This is the infrastructure that provides emergency power during a main electrical system failure.

NFPA 99: Standard for Health Care Facilities, which covers the performance criteria for electrical systems in healthcare settings.

NFPA 110: Standard for Emergency and Standby Power Systems, which defines the installation, maintenance, operation, and testing of EPSS.

TJC (The Joint Commission): An organization that accredits and certifies healthcare organizations and programs in the United States.

POLICY:

Northern Inyo Healthcare District (NIHD) will ensure the continuous and reliable operation of all critical utility systems, including electrical and generator systems, to maintain patient safety and operational continuity. All electrical and generator systems shall be maintained, tested, and operated according to NFPA standards and TJC requirements.

PROCEDURE:

1. Emergency Power Supply System (EPSS) Requirements

1.1 **Maintenance and Testing**

- **Monthly Testing:** The EPSS shall undergo a monthly test under load for a minimum of 40 minutes, as per NFPA 110.
- **Annual Testing:** Perform a 4-hour continuous run of the EPSS under load once a year, as per NFPA 110.
- **Annual load test (for situations not meeting monthly testing requirements) for diesel powered EPSS**
    - At least 50% of the nameplate rating for 30 minutes
    - At least 75% of the nameplate rating for 1 hour
    - Total test duration of not less than 1.5 continuous hours
- **Triennial or 36-month** generator test 30% of nameplate rating for 4 continuous hours for diesel powered EPSS.

When combining both tests for diesel powered EPSS, the first three hours of the test is required to be not less than 30% of the emergency generator nameplate kW rating or the minimum exhaust gas temperature. The last hour cannot be less than 75% of the emergency generator nameplate kW rating for a total of 4 continuous hours.

- **Fuel Testing:** Fuel for the generators shall be tested annually to ensure compliance with NFPA 110 and NFPA 99 requirements.

1.2 **Documentation**

- Maintain records of all testing, maintenance, and repairs of the EPSS for a minimum of three years or as required by TJC standards.

2. Electrical System Failure

2.1 **Immediate Response**

- Upon detection of an electrical system failure, the following actions shall be taken:
    - **Initiate EPSS:** The emergency generator shall automatically start within 10 seconds as per NFPA 110 standards.
    - **Notify the Engineering Department:** The Engineering Department must be notified immediately to assess and rectify the failure.
    - **Implement Emergency Procedures:** Clinical and non-clinical staff should implement their respective emergency procedures, ensuring patient safety.

2.2 **Patient Safety**

- Ensure all life-sustaining equipment is connected to emergency power outlets.
- Prioritize critical areas (e.g., operating rooms, intensive care units) for restoration of power.

3. Generator Failure

3.1 **Immediate Response**

- In the event of generator failure during an electrical outage:

- **Manual Start:** Attempt a manual start of the generator according to the manufacturer's guidelines.
- **Activate Backup Plan:** If the generator cannot be started manually, activate the backup power plan, including the use of portable generators if available.

3.2 **Notification and Escalation**

- **Notify Hospital Administration:** Immediate notification to the Hospital Administrator on Call (AOC) and the Engineering Department.
- **Contact External Support:** If the internal team cannot resolve the issue, contact external vendors for emergency repair services.

4. Post-Incident Review

4.1 **Incident Reporting**

- Complete an incident report detailing the failure, response actions, and resolution timeline.

4.2 **Root Cause Analysis**

- Conduct a root cause analysis (RCA) within 48 hours to identify the cause of the failure and prevent recurrence.

4.3 **Corrective Actions**

- Implement corrective actions based on the findings of the RCA and document all steps taken.

4.4 **Review and Improvement**

- The incident, response, and corrective actions shall be reviewed during the next scheduled Environment of Care (EC) committee meeting to assess performance and update procedures if necessary.

Responsibility

- **Maintenance Department:** Responsible for the maintenance, testing, and repair of the hospital's electrical systems and EPSS.
- **Clinical Staff:** Ensure patient safety and follow emergency procedures during power failures.
- **Hospital Administration:** Provide oversight and ensure compliance with NFPA and TJC standards.

Training

All relevant staff will be trained on this policy and procedure annually. Training records will be maintained in compliance with TJC standards.

Compliance

Failure to adhere to this policy may result in disciplinary action up to and including termination. This policy is subject to annual review and updates as necessary to comply with NFPA and TJC standards.

REFERENCES:

NFPA 99, 2018 Edition

NFPA 110, 2019 Edition

The Joint Commission (TJC) Environment of Care (EC) Standards

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: v.1 Utility Systems Electrical and Generator Failure

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Utility Systems Inventory		
Owner: Maintenance Manager	Department: Maintenance	
Scope:		
Date Last Modified: 08/19/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

The purpose of this policy is to ensure the accurate and up-to-date inventory of all utility systems within Northern Inyo Healthcare District (NIHD) to comply with California state regulations, The Joint Commission (TJC) standards, and other applicable federal guidelines. This policy aims to maintain safety, efficiency, and compliance in the operation and maintenance of hospital utility systems.

SCOPE:

This policy applies to all utility systems at Northern Inyo Healthcare District (NIHD), including but not limited to electrical, water, heating, ventilation, air conditioning (HVAC), medical gas, vacuum systems, and emergency power supply systems (EPSS). It applies to all personnel involved in operating, maintaining, and managing these systems.

DEFINITIONS:

- **Utility Systems:** The essential infrastructure that supports the hospital's operations, including but not limited to electrical, plumbing, HVAC, medical gas systems, and emergency power systems.
- **Inventory:** A detailed and updated record of all utility systems, including their components, locations, and operational status.

RESPONSIBILITIES:

- **Facilities Management:** Responsible for maintaining an accurate inventory of all utility systems, ensuring compliance with applicable regulations, and conducting regular audits.
- **Safety Officer:** Ensures the inventory complies with safety regulations and standards.
- **Maintenance Staff:** Responsible for updating the inventory following repairs, replacements, or upgrades to utility systems.
- **Compliance Officer:** Ensures that all regulatory requirements are met and that records are maintained in accordance with hospital policies and state and federal regulations.

POLICY:

1. **Inventory Maintenance:**

- The Facilities Management Department shall maintain an up-to-date inventory of all utility systems, including system descriptions, locations, manufacturer details, installation dates, and maintenance history.
- The inventory shall be reviewed and updated annually or whenever significant changes occur.

2. **Regulatory Compliance:**
   - The inventory process shall comply with California Code of Regulations (CCR) Title 22, Division 5, and TJC Environment of Care (EC) standards, particularly EC.02.05.01 and EC.02.05.05.
   - Compliance with the Centers for Medicare & Medicaid Services (CMS) requirements under the Conditions of Participation (CoPs) for hospitals shall also be ensured.
3. **Data Management:**
   - The inventory shall be maintained electronically, with backups stored in accordance with hospital data management policies.
   - The system shall allow for easy access, retrieval, and updating of records by authorized personnel.
4. **Training:**
   - All personnel involved in utility systems management and inventory maintenance shall receive training on the inventory system, regulatory requirements, and safety protocols.
   - Training records shall be maintained by the Human Resources Department.
5. **Audits and Reviews:**
   - The Facilities Management Department shall audit the inventory annually to ensure accuracy and compliance.
   - The audit results shall be reported to the hospital's Safety Committee, and any discrepancies shall be addressed promptly.

PROCEDURE:

1. **Inventory Creation and Updates:**
   - **Step 1:** Identify all utility systems and components, including those related to electricity, water, HVAC, medical gases, and EPSS.
   - **Step 2:** Record the necessary details for each system, including manufacturer information, installation date, and maintenance history.
   - **Step 3:** Update the inventory following any repairs, upgrades, or replacements of utility systems.
   - **Step 4:** Review and validate the inventory for accuracy at least annually or after any significant changes.
2. **Compliance Checks:**
   - **Step 1:** Ensure the inventory aligns with CCR Title 22, Division 5, TJC EC standards, and CMS CoPs.
   - **Step 2:** Document compliance in the inventory system and retain records for inspection.
3. **Audit Process:**
   - **Step 1:** Conduct an internal audit of the inventory annually.
   - **Step 2:** Report findings to the Safety Committee.
   - **Step 3:** Implement corrective actions for any identified discrepancies.

REFERENCES:

- California Code of Regulations (CCR), Title 22, Division 5.
- The Joint Commission (TJC) Environment of Care Standards (EC), particularly EC.02.05.01 and EC.02.05.05.

- Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs) for hospitals.
- National Fire Protection Association (NFPA) 99: Health Care Facilities Code.
- NFPA 110: Standard for Emergency and Standby Power Systems.

RECORD RETENTION AND DESTRUCTION:

- **7 years**

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: v.1 Utility Systems Inventory EC.02.05.01 EP 3-4

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Utility Systems Pneumatic Tube Failure		
Owner: Maintenance Manager	Department: Maintenance	
Scope: Northern Inyo Healthcare District (NIHD)		
Date Last Modified: 08/08/2024	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date:	

PURPOSE:

To establish a standardized procedure for the prompt and effective response to pneumatic tube system failures in the hospital to ensure minimal disruption to Northern Inyo Healthcare District (NIHD) operations and patient care, and to comply with all relevant regulations and codes.

SCOPE:

This policy applies to all Northern Inyo Healthcare District (NIHD) staff involved in operating, maintaining, and using the pneumatic tube system within the facility.

DEFINITIONS:

Pneumatic Tube System:

A network of tubes that use air pressure to transport items such as medications, lab specimens, and documents between different areas of the hospital.

Failure:

Any interruption in the normal operation of the pneumatic tube system that prevents it from functioning as intended.

RESPONSIBILITIES:

Maintenance Department:

Ensure that the pneumatic tube system is properly maintained and that staff are trained in the procedures for responding to failures.

Nursing and Clinical Staff:

Report any system failures immediately and follow alternate procedures outlined in this document.

POLICY:

In the event of a pneumatic tube system failure, hospital staff shall follow the procedures outlined below to ensure that critical items are transported without delay and that the system is repaired promptly.

PROCEDURE:

1. Reporting a System Failure

1.1**.** Immediate Notification:

- Any staff member who detects a failure in the pneumatic tube system must immediately notify the Maintenance Department via the designated communication method (e.g., phone, maintenance ticket via intranet).
- If the failure occurs after hours, contact the House Supervisor.

2. Initial Response

2.1. Maintenance Department:

- Assess the failure to determine its scope and impact on hospital operations.
- If the issue is minor, attempt a system reset using the control panel.
- If the issue is mechanical or technical, perform necessary repairs in accordance with manufacturer guidelines and NFPA 99 standards.
- If repairs cannot be completed within 30 minutes, proceed to **Section 3: Alternate Procedures**.

3. Alternate Procedures

3.1. Manual Transport:

- Implement manual transport of critical items (e.g., medications, lab specimens) using designated staff runners

3.2. Communication**:**

- Inform all relevant departments of the system failure and the expected duration of downtime.
- Provide regular updates on the status of repairs and alternate transport arrangements.

4. Patient Safety Considerations:

- Prioritize the manual transport of items critical to patient care.
- Ensure that all transported items are handled in accordance with hospital policies to maintain safety and integrity.

5. System Restoration

5.1. Verification:

- Once repairs are completed, Maintenance Department shall verify that the system is fully operational.

- Perform a test run to ensure proper functionality before resuming normal operations.

5.2. Notification:

- Notify all relevant departments that the pneumatic tube system is back online.
- Log the completion of the repair and any findings in the system log.

6. Post-Failure Review

6.1.Incident Review:

- Conduct a post-incident review to evaluate the response to the system failure.
- Document any lessons learned and update this policy as needed to prevent future occurrences.

6.2.Training:

- Provide additional training to staff if the review identifies areas for improvement in responding to pneumatic tube system failures.

Compliance

All hospital staff must comply with this policy. Non-compliance may result in disciplinary action in accordance with Northern Inyo Healthcare District (NIHD) policies.

Review and Revision

This policy shall be reviewed annually and revised as necessary to ensure continued compliance with applicable codes and standards.

REFERENCES:

California Code of Regulations (CCR), Title 22, Division 5: Licensing and Certification of Health Facilities.

California Health and Safety Code, Section 1275: Requirements for the maintenance and operation of health facilities.

Joint Commission Environment of Care (EC) Standards: EC.02.05.05 – Utility Systems.

National Fire Protection Association (NFPA) 99: Health Care Facilities Code.

Occupational Safety and Health Administration (OSHA) Standards: OSHA 29 CFR 1910.147 – The control of hazardous energy (lockout/tagout).

Hospital Policies and Procedures: Specific to the hospital's operational protocols.

RECORD RETENTION AND DESTRUCTION:

CROSS REFERENCE POLICIES AND PROCEDURES:

Supersedes: v.1 Utility Systems Pneumatic Tube Failure