Northern Inyo Healthcare District

Board Meeting

Board Meeting - August 20, 2025

Agenda

Consent Agenda

Chief of Staff Report

Chief Executive Officer Report

Finance Committee

Quality Committee

Chief Financial Officer Report

Mission

* Strong Stewardship * Ethical Oversight *
*Eternal Local Access *

Vision Statement

To be an energized, high performing advocate for the communities we serve, our patients and our staff. The board governs with an eye on the future of health care and its effects on the District and patient care. The Board is committed to continuous evaluation, dedication to our mission, and improvements as a board.

Values

* Integrity * Innovate Vision * Stewardship * Teamwork *

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
Board of Directors' Regular Meeting

August 20, 2025, 5:00 pm
Northern Inyo Healthcare District invites you to join this meeting

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.

TO CONNECT VIA ZOOM: (A link is also available on the NIHD Website)
https://us06web.zoom.us/j/3257893484?pwd=VrgnzdFhLFICk7h6MlbfqehXlilrqm.1#success
Meeting ID: 325 789 3484
Password: 623576

PHONE CONNECTION:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 325 789 3484

Board Member David McCoy Barrett will participate in the meeting via teleconference from the following location, in accordance with Government Code § 54953(b):
3400 Warner Blvd.
Burbank, CA 91505

Board Member Melissa Best-Baker will participate in the meeting via teleconference from the following location, in accordance with Government Code § 54953(b):
1389 Center Drive
Medford, OR 97501

This teleconference location will be accessible to the public, and the agenda will be posted at this location at least 72 hours in advance of the meeting. Members of the public may attend and participate from this location. All votes taken during the meeting will be conducted by roll call.

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1. Call to Order at 5:00 pm
2. Public Comment: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are

limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes for all public 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.

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3. 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 for July 16, 2025, Special Board Meeting
    b. Approval of minutes for July 16, 2025, Regular Board Meeting
    c. Approval of minutes for July 17, 2025, Special Board Meeting
    d. Approval of minutes for July 24, 2025, Special Board Meeting
    e. Approval of minutes for August 1, 2025, Special Board Meeting
    f. Approval of Policies and Procedures
        i. Appointment of Infection Preventionist
        ii. Evaluation of Pregnant Patients in the Emergency Department
        iii. Fall Prevention and Management
        iv. Medical Ethics Referrals and Consultations
        v. Medical Records Delinquency Policy
        vi. Medical Staff History and Physical (H&P) Policy
        vii. Medical Waste Management Plan
        viii. Receiving Process
        ix. Spurious Cell Counts and Sample Interferences Workflow
        x. Standardized Procedure - Furnishing Medications/Devices Policy for the NP or CNM
        xi. Standardized Procedure - Laboratory and Diagnostic Testing Policy for the NP or CNM
        xii. Standardized Procedure - Management of Acute Illness Policy for the NP or CNM

xiii. Standardized Procedure - Management of Chronic Illness Policy for the NP or CNM

xiv. Standardized Procedure - Management of Minor Trauma Policy for the NP or CNM

xv. Standardized Procedure – Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife

xvi. Utilization of Personnel from Outside Agencies

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4. New Business:
    a. Presentation on Medical Executive Committee Roles and Responsibilities, Shelley Carder Esq.– *Information Item*
    b. Chief of Staff Report, Samantha Jeppsen MD
        i. Medical Executive Meeting Report – *Information Item*
        ii. Medical Staff Initial Appointments 2025-2026 – *Action Item*
        iii. Medical Staff Initial Appointments 2025-2026 – Proxy Credentialing – *Action Item*
        iv. Medical Staff Reappointments 2025-2026 – *Action Item*
        v. Additional Privileges – *Action Item*
    c. Chief Executive Officer Report
        i. Chief Business Development Officer Follow-up – *Information Item*
        ii. Conflict of Interest – *Information Item*
    d. Finance Committee
        i. Purchasing threshold limits for leaders memo – Information *Item*
            1. Purchasing and Signature Authority – *Action Item*
        ii. Appropriations Resolution 25-03 – *Action Item*
        iii. NIHD Financial Investment Opportunity – *Action Item*
    e. Quality Committee
        i. MOU – NIHD and Inyo County Health and Human Services – *Action Item*
        ii. Board Resolution 25-02 MOU with Inyo County Health and Human Services for use of District meeting space – *Action Item*
        iii. Compliance Report – *Information Item*
    f. Appointment of Alternate Board Members – *Action Item*
    g. Chief Nursing Officer / Chief Operating Officer Report

i. Pharmacy Update – *Information Item*

h. Chief Financial Officer Report

i. Finance Department Update – *Information Item*

ii. Financial & Statistical Reports (*Board will consider the approval of these reports)*

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

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6. Public comments on closed session items
7. Adjournment to closed session to/for:
    a. Public Employee Appointment / Discussion
    Pursuant to Government Code § 54957(b)(1)
    Title: Chief Executive Officer Candidate
    b. Conference with Labor Negotiators
    Pursuant to Government Code § 54957.6
    Agency designated representative: Human Resources
    Unrepresented Employee: CEO
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.

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Turner called the meeting to order at 10:49 am.
PRESENT	Jean Turner, Chair Melissa Best-Baker, Vice Chair David Lent, Secretary David McCoy Barrett, Treasurer Laura Smith, Member at Large Christian Wallis, Interim Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer
ABSENT	Adam Hawkins, DO, Chief Medical Officer Alison Murray, Chief Human Resources Officer, Chief Business Development Officer Andrea Mossman, Chief Financial Officer
PUBLIC COMMENT	Chair Turner reported that at this time, audience members may speak on any items on the agenda that are within the jurisdiction of the Board. There were no comments from the public.

NEW BUSINESS

BOARD SELF-ASSESSMENT INTRODUCTION

Chair Turner called attention to the speaker Tom Scaglione

CEO Wallis introduced Tom Scaglione

Tom facilitated the opening of the Board's self-assessment session. He framed this as an opportunity to deepen shared understanding, enhance governance practices, and support alignment between the Board and executive leadership. Key points from his introduction included:

- **Purpose of the Assessment:** Tom encouraged the Board to reflect candidly on its own performance and dynamics using a six-question framework. He emphasized the importance of distinguishing governance from management and described how recurring misalignment in these roles often contributes to conflict or confusion.
- **Common Governance Challenges:** Drawing from his broader experience, Tom noted that many healthcare district boards struggle with:
    - Board members inadvertently stepping into operational roles
    - Uneven expectations for the CEO or staff
    - A lack of shared language or clarity around accountability
- **Goals of the Session:**
    - Identify common strengths and concerns among Board members
    - Explore areas where expectations between the Board and executive team diverge

    - Build a foundation for more structured CEO evaluations, including consideration of a 360-degree review process
- **Cultural Readiness:** Tom discussed the role of a "just culture" in board governance—promoting honest feedback without fear of retribution. He encouraged the Board to use the assessment not as a performance rating, but as a learning and growth tool.

Board Questions & Comments:
Board members responded positively to the session framing and engaged in discussion about the value of self-reflection and feedback loops.

BETA D&O LIABILITY EDUCATION

Chair Turner called attention to Beta D&O Liability Education.

Board Clerk Reed introduced the Jonathan Stewart from Beta Healthcare Group.

The Board received an overview of directors and officers (D&O) liability and employment risk from Beta Healthcare Group. Key points included:

- **Risk Overview:** Risk was defined as uncertainty to be managed. Risk treatment options include avoidance, acceptance, transfer (e.g., insurance), or mitigation.
- **Primary Board Exposure:** Among 250 recent claims, nearly all involved employment practices—harassment, discrimination, retaliation, or wage/hour issues.
- **Risk Mitigation Strategies:**
    - Maintain and fairly apply current HR policies
    - Promote a culture of respect and fairness from the top
    - Prioritize live training for high-risk topics
    - Address employee concerns early, even if legal counsel is needed
    - Ensure appropriate Employment Practices Liability (EPL) and Directors and Officers (D&O) coverage is in place
- **Governance Role:** Boards are responsible for ensuring risks are identified and managed—not for operational decisions. Red flags include recurring complaints, high turnover, or patterns of workplace conflict.
- **Just Culture:** Organizations should distinguish system issues from individual recklessness and intervene based on behavior, not outcomes.
- **Organizational Learning:** Encouraged learning from internal and external incidents to avoid repeated claims.

Board Questions & Comments:
The Board requested clarification on D&O coverage for executive staff; follow-up from underwriting was offered. Members also flagged patient litigation and provider contract disputes as additional high-risk areas. Beta offered to share materials on governance oversight of quality and safety.

RECESS FOR LUNCH

12:04 - 12:49 pm

BOARD SELF-ASSESSMENT

HIGHEST PRIORITY FOR THE BOARD IN THE NEXT YEAR

The Board identified the CEO hiring process as the top strategic priority for the coming year. Members emphasized the importance of selecting a candidate who demonstrates fiscal competence, strong communication skills, and a commitment to transparency and collaborative leadership. Desired qualities also included the ability to rebuild internal morale and public trust following a period of organizational strain.

Board members acknowledged that past leadership challenges were shaped not only by the individual in the CEO role but also by dynamics within the Board itself. There was consensus that the incoming CEO must be set up for success through clearly defined expectations, open and aligned Board communication, and consistent support. The group recognized the transition as a pivotal moment to reset tone, culture, and accountability.

Improving internal Board communication was also highlighted as a priority. Members shared reflections on how inconsistent messaging and interpersonal tensions had sometimes undermined cohesion. There was a shared desire to foster a more constructive and unified culture, both within the Board and in interactions with the Executive Team and hospital staff.

Board Questions & Comments

- Discussed the importance of aligning on shared expectations for the CEO before final selection and onboarding.
- Reflected on how Board behavior and tone set the stage for executive success or strain.
- Raised the need for respectful, clear communication—both internally and externally—as a standard moving forward.
- Highlighted the risk of reverting to past patterns and emphasized the importance of proactive, intentional governance.
- Expressed hope that the CEO search would be an inflection point for organizational culture and Board function.

BOARD SELF-ASSESSMENT

MOST SIGNIFICANT STRENGTHS

The Board reflected on the strengths each member brings to the organization, noting a wide range of professional backgrounds, community leadership experience, and unique perspectives that enrich governance. Members described the Board as composed of strong leaders with a shared commitment to ensuring continued access to high-quality healthcare for the local community.

Discussion emphasized the value of consensus-driven decision-making, especially under pressure. One member remarked that the Board is “better in

the storm than in the calm," noting how the group coalesces and operates effectively during moments of organizational crisis. The ability to engage in robust discussion while maintaining mutual respect was viewed as a defining strength. Members acknowledged that while perspectives differ, there is a collective desire to serve and a foundation of trust that enables progress when it matters most.

The conversation also surfaced an interest in building on these strengths by applying the same level of collaboration and unity to everyday decision-making. Members recognized that while the Board responds well during urgent moments, they want to improve consistency and communication during routine governance and relationship-building.

Members affirmed that the Board's diversity—of skillsets, backgrounds, and personal networks—is a strategic asset. Specific references were made to members with hospital experience, community history, tribal representation, and leadership roles in other sectors. The group discussed the opportunity to make more intentional use of these strengths in guiding strategic priorities.

Board Questions & Comments

- Highlighted the Board's resilience and unified decision-making under pressure.
- Emphasized the importance of leveraging individual skills and relationships beyond crisis moments.
- Acknowledged the Board's cultural and experiential diversity as a strength worth incorporating more formally into roles, onboarding, and strategy.
- Reflected on the desire to sustain trust and collaboration during standard operations, not only in emergencies.
- Noted that existing Board culture encourages respect, curiosity, and honest debate.

BOARD SELF-ASSESSMENT

MOST SIGNIFICANT WEAKNESSES

The Board discussed challenges impacting governance effectiveness and the hospital's overall performance. A key concern was the lack of assurance that information provided to the Board is adequately vetted through essential operational lenses, including legal, finance, compliance, clinical, and HR. Several Board members emphasized the importance of receiving well-rounded, multidisciplinary input to make informed decisions. One member noted that in past decisions, the Board had moved forward without clarity on whether internal stakeholders had reviewed or signed off on the materials presented.

Communication was identified as a significant weakness. Members acknowledged that communication both within the Board and between the Board and Executive Team had, at times, been inconsistent or unclear. There was discussion about the need for better systems to ensure information flows in

a timely, complete, and candid manner. One member expressed frustration with moments where the Board received incomplete or overly curated information and said this created obstacles to effective governance.

The relationship between the Board and the Executive Team was also cited as a concern. Members reflected on a perceived lack of trust or cohesion, noting moments of misalignment or defensiveness. It was observed that there have been times when Board members felt they had to press hard in public meetings to get answers or accountability, which may have contributed to tension or adversarial dynamics. There was acknowledgment that some of the Board's past behavior may have inadvertently reinforced this divide.

Concerns were raised about the Board's tendency to become too operational, focusing on day-to-day issues instead of strategic direction. This tendency was partially attributed to frustration with communication gaps and the lack of confidence that issues were being handled effectively at the management level. It was suggested that clearer role delineation and improved transparency from the Executive Team could help the Board stay more comfortably within its governance lane.

Lastly, there was reflection on messaging and tone. A member encouraged the Board to remain positive in its public communication and to consider how its actions and language affect employee morale. The Board's public posture, they suggested, should champion the hospital and its staff while continuing to fulfill oversight responsibilities.

Board Questions & Comments:
Comments emphasized the need for strategic thinking rather than daily operational distractions. One member noted that when "defensiveness" is present, it reflects a lack of trust, and highlighted the importance of receiving input from the appropriate departments before making decisions. Another pointed to the need for a cohesive internal tone and messaging, with the Board acting as positive representatives of the district.

BOARD SELF-ASSESSMENT

KEY ISSUES FOR THE BOARD TO FOCUS ON IN THE NEXT YEAR

The Board identified several areas for sustained focus over the next 12 months. Financial stability emerged as a critical concern, including support for the Executive Team's turnaround efforts, close oversight of the budget, and improvements in billing practices. There was a shared understanding that the Board must stay informed and engaged in financial matters without stepping into operational management.

The CEO search was again noted as a key priority, with comments highlighting the importance of selecting someone well-suited not only to the hospital's strategic needs but also to the cultural context of the region. The Board expressed interest in fostering a healthier relationship with the Executive Team,

recognizing that mutual trust and clear roles are essential to effective governance.

Operational areas mentioned for increased Board engagement included orthopedic service line rebuilding, IT infrastructure, and overall staff performance and morale. Members acknowledged a need to deepen their understanding of these areas and maintain consistent involvement moving forward.

Board Questions & Comments

- Expressed concern about the long-term financial health of the district and interest in supporting sustainable improvements.
- Reiterated the importance of hiring a CEO who understands the community and can navigate both financial and cultural complexities.
- Highlighted the need for more consistent, informed involvement in specific operational areas such as billing and IT.
- Noted that performance expectations for staff should be reinforced with Board support for the leadership team.
- Discussed rebuilding the orthopedics department as a visible and high-impact goal.

BOARD SELF-ASSESSMENT

SIGNIFICANT TRENDS THE BOARD MUST UNDERSTAND AND DEAL WITH IN THE NEXT YEAR

The Board discussed macro-level challenges that will shape governance priorities in the coming year. These included changes in reimbursement systems (Medicare, Medi-Cal, and private insurers), ongoing threats to financial stability, and the need for better long-range planning around service delivery and staffing.

Members emphasized that understanding cash flow, expense management, and billing trends will be critical for survival. There was recognition that decisions about which services can realistically be sustained or expanded locally need to be grounded in both financial and community access considerations.

Physician recruitment and retention were identified as ongoing concerns, particularly in specialized areas like labor and delivery and orthopedics. Members also discussed the importance of improving staff training—not only in clinical skills, but also in customer service and engagement.

Travel distances and rurality were noted as contextual realities that impact service decisions, patient volumes, and staff workload. There was also discussion about the need to better coordinate messaging and outreach among neighboring healthcare institutions across the Eastern Sierra region.

One key theme was the need to reconnect to long-term vision: What kind of hospital does NIHD want to be? Members acknowledged the need for deeper strategic planning to answer that question.

Board Questions & Comments

- Noted concern about NIHD's ability to stay financially viable if reimbursement continues to decline.
- Asked how to prioritize which services should be restored or introduced locally.
- Stressed that physician recruitment must be tackled with a long-term lens.
- Emphasized the importance of internal training for both staff competence and patient satisfaction.
- Asked that governance and strategy processes include vision-level questions—not just financial triage.

BOARD SELF-ASSESSMENT

CRITICAL FACTORS TO ADDRESS TO SUCCESSFULLY ACHIEVE GOALS

The Board discussed the importance of closely tracking financial trends affecting rural hospitals, particularly reimbursement changes from Medicare, Medi-Cal, and private insurance. Members emphasized the need to understand how these changes impact the hospital's cash flow, revenue opportunities, and long-term viability. Maintaining financial sustainability was described as a foundational concern underlying most other strategic efforts.

There was discussion about investing in specialized services locally and the need to evaluate which services can and should be delivered in Bishop versus referred out. This included references to labor and delivery, orthopedics, and other high-need clinical areas. Members expressed concern about the ability to recruit and retain physicians, particularly in specialized roles.

Operational capacity was also addressed, including ensuring staff are equipped with the training and customer service skills necessary to meet community expectations. The discussion included a desire to better understand what is realistically sustainable for the hospital and how to align services with both community needs and available resources.

Board Questions & Comments

- Raised concerns about unpredictable federal and state reimbursement trends and the need to plan for funding shifts.
- Expressed interest in improving local access to specialized services and assessing what can feasibly be delivered in-house.
- Acknowledged physician recruitment and retention as an ongoing challenge.
- Discussed the role of staff training in improving both care quality and patient experience.

- Noted the importance of having strategic conversations about which services NIHD should prioritize.

BOARD SELF-ASSESSMENT

DISCUSSION

Following the structured review of the Board Self-Assessment categories, the Board engaged in a brief wrap-up discussion. Members expressed appreciation for the openness of the dialogue and acknowledged the importance of continuing progress made during the session.

The group emphasized the need to carry forward the themes identified—particularly around CEO recruitment, communication, and alignment with the Executive Team. There was agreement that the Board should revisit the self-assessment results in a future meeting to assess progress and determine further actions.

Board members discussed the value of sustaining a tone of curiosity, mutual respect, and shared accountability, and noted this session as a potential turning point in improving governance culture.

The Board agreed that the Chair should conduct meetings in accordance with Robert's Rules of Order. For each agenda item, the designated presenter will first provide their report, followed by the Chair formally opening and closing the public comment period. Once public comment is closed, discussion will proceed to the Board only. Any additional comments or questions from the public—including staff—will not be accepted outside the designated comment period. Staff members attending the meeting were clarified to be participating as members of the public unless specifically listed as presenters, and should not raise their hand or call out during Board discussion. These steps are intended to promote consistent meeting structure, ensure fairness, and maintain compliance with the Brown Act.

ACTION ITEMS AND AGREEMENTS

Beta Liability Insurance

- Confirm D&O coverage for executive staff.
- Provide IHI governance materials.
- Share presentation slides with the Board.

Communication & Engagement

Board Communication Protocols

- Legal Counsel will schedule Brown Act training to support compliant Board Member to Board Member communication.
- Board Clerk will clarify the process for Board members to request agenda items.
- CEO will provide weekly email updates, use phone calls for urgent issues, and voice memos for non-urgent updates.

Agenda Preparation & Policy Review

- CEO and Executive Team will develop a vetting process to ensure agenda items generated by staff are reviewed by appropriate stakeholders for clarity and accuracy.

Internal Engagement

- COO will coordinate hospital tours or rounding opportunities for Board members.

External Engagement & Community Presence

- Marketing and Board Clerk will create a public-facing calendar of community events (e.g., Mule Days, Christmas Parade).
- Board and CEO will define the Board's role at community events.
- Board and Foundation will collaborate to host community events (such as provider recognition).
- Foundation and Auxiliary will present updates at future Board meetings.
- Board will participate in staff appreciation efforts that include employees, providers, volunteers, and other groups.

Board Culture & Communication Improvement

- Board will foster a consistent culture of collaboration, communication, and mutual accountability—carrying forward the positive tone modeled during recent challenges and working to build trust even outside of high-pressure situations.
- Board will explore ways to document and formalize how Board diversity and member strengths contribute to governance and decision-making.

Governance & Strategic Direction

Core Governance Tools

- Governance Committee will review the Mission, Vision, and Values alongside the Strategic Plan.
- Governance Committee will review and update the Board's Code of Conduct.

Onboarding & Self-Assessment

- Governance Committee will consider a structured onboarding plan for new Board members and the incoming CEO, incorporating board roles and strengths.
- Full Board will revisit Board self-assessment themes in a future meeting.

Board Leadership & Conduct

- The Chair will conduct meetings in accordance with Robert's Rules of Order, including clear sequencing of agenda item presentation, public comment, and Board discussion.
- CEO will inform staff that unless formally listed as presenters, they attend Board meetings as members of the public and should limit comments to the designated public comment period.

Strategic Planning

- Governance Committee will meet to discuss long-term vision and service line strategy.
- Board will sustain the collaborative tone demonstrated during recent challenges into routine governance.

- Board will actively incorporate individual member strengths into strategic and operational decision-making.
- Strategic discussions will include partnership opportunities with neighboring hospitals.

Financial Oversight & Operations

- Finance Committee will continue monitoring financial turnaround progress and share updates with the full Board.
- Finance Committee will review billing issues and report findings to the Board.
- CEO and IT Team will review IT infrastructure to ensure functionality is not compromised by excessive security.
- Board will remain actively involved in finalizing the CEO hiring process to ensure long-term alignment and stability.
- Board will support staff accountability through policy and governance, not operational intervention.

Partnerships & Regional Collaboration

- CEO and Board will continue exploring strategic relationships with Mammoth, Toiyabe, Southern Inyo, and Valley Health.
- CEO and Board will discuss NIHD's role in restoring healthcare access in Northern Mono County, including the Bridgeport Clinic.
- Board and CEO will collaborate with neighboring Eastern Sierra hospitals to align public messaging, reduce confusion, and support regional healthcare transparency.

Recruitment, Retention & Workforce Culture

- Executive Team and Board will address physician recruitment and retention as a long-term strategic issue.
- Executive Team will continue workforce development efforts, including customer service and clinical training.
- Board will engage with employees directly and invite SMEs to Board meetings to build trust and clarify information.
- Board will include service line strategy and physician recruitment in future strategic planning sessions.
- Board expressed interest in hearing more about staff development and training initiatives.

CEO Evaluation Process

- Board will refine the CEO evaluation process, including format, frequency, management responsibilities, and whether to incorporate 360-degree feedback from the Executive Team.
- Shared expectations for the incoming CEO will be documented and used to guide the final stages of hiring and onboarding.

ADJOURNMENT — Adjournment at 4:33 pm.

_____
Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
David Lent
Northern Inyo Healthcare District
Secretary

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Turner called the meeting to order at 5:00 pm.
PRESENT	Jean Turner, Chair Melissa Best-Baker, Vice Chair David Lent, Secretary David McCoy Barrett, Treasurer Laura Smith, Member at Large Christian Wallis, Interim Chief Executive Officer Allison Partridge, Chief Operations Officer / Chief Nursing Officer Alison Murray, Chief Human Resources Officer, Chief Business Development Officer Andrea Mossman, Chief Financial Officer Samantha Jeppsen, MD, Chief of Staff
ABSENT	Adam Hawkins, DO, Chief Medical Officer
TELECONFERENCING	Notice has been posted, and a quorum participated from locations within the jurisdiction.
PUBLIC COMMENT	Chair Turner reported that at this time, audience members may speak on any items not on the agenda that are within the jurisdiction of the Board. Public Comment: The Board received multiple public comments regarding the status of Dr. Bo Loy. Commenters expressed strong support for Dr. Loy's character, clinical expertise, and contributions to the hospital and community. They raised concerns about his suspension, citing a lack of transparency and its negative effects on staff morale, patient trust, and physician recruitment. Several emphasized personal experiences with Dr. Loy's exceptional care and questioned the fairness of the administrative actions taken. The Board was urged to improve communication and decision-making processes to retain qualified physicians and ensure accountability at all levels.
CONSENT AGENDA	Chair Turner called attention to the consent agenda. Motion to approve the Consent Agenda, including: The Emergency Management Plan was accepted with the proposed change of ensuring the full Board is notified of any changes. Motion to approve the consent agenda: Best-Baker 2nd: Lent Pass: 5-0
NEW BUSINESS	
	Chair Turner called attention to the CEO Report.

CHIEF EXECUTIVE OFFICER REPORT

CEO Report – Christian Wallis
Christian Wallis provided an update on recent organizational developments, including progress on the strategic plan and operational priorities. He acknowledged ongoing staffing and recruitment challenges and discussed efforts to stabilize leadership and clinical teams. Wallis also addressed concerns raised during Public Comment and stated that trust-building, transparency, and process improvements remain key goals. He concluded by thanking the board and staff for their support during a period of transition.

1. **Mammoth Orthopedic Institute Partnership – Information Item**
   An update was shared on collaborative efforts and cross-coverage between NIHD and Mammoth Hospital. Positive initial feedback was noted. No Board action taken.
2. **The Joint Commission Survey Update – Information Item**
   The District is preparing for the next survey. Internal readiness assessments are underway.
3. **Capital Equipment Purchase**
   a. Public comment: A speaker questioned the timing and justification of the equipment purchase, given recent administrative concerns.
   b. Staff emphasized the importance of these purchases, noting that investment in surgical infrastructure such as the Spider Shoulder Positioner and Hana Table is vital for retaining top clinical talent and ensuring high-quality patient care.

- Spider Shoulder Positioner – $29,200
- Hana Table – $150,000

Motion to approve the capital equipment purchase of Spider Shoulder Positioner and the Hana Table: Smith
2nd: Best-Baker
Pass: 5-0

CHIEF OF STAFF REPORT

Chair Turner called attention to the Chief of Staff Report

Motion to approve the Medical Staff Initial Appointments 2025-2026: Best-Baker
2nd: Barrett
Pass: 5-0

Motion to approve Medical Staff Initial Appointments 2025-2026 – Proxy Credentialing: Best-Baker
2nd: Lent
Pass: 5-0

Medical Executive Committee Meeting Report
1. Dr. Jeppsen reported that the committee had recently reviewed data on provider performance and peer review outcomes, focusing on opportunities for improvement and identifying educational needs. She noted that the

committee continues to monitor trends and address any emerging issues to support quality of care and patient safety. No unusual patterns or critical incidents were reported during this period.

CHIEF HUMAN RESOURCES OFFICER / CHIEF BUSINESS DEVELOPMENT OFFICER

Chair Turner called attention to the CHRO / CBDO Report

Alison Murray introduced her team.

Business Development Update

Community Engagement – Brittney Watson

1. NIHD is in early conversations with the City and other local organizations about potential wellness events to improve visibility and engagement.
2. Board members asked for clarification on what had been achieved during the past quarter.
    a. The team remained in a "listening and outreach" phase and had not yet finalized any formal initiatives.
    b. The Board requested a written community engagement strategy with clear outcomes and specific timelines, goals, and measurable results.

Grants – Brittney Watson

1. The team is beginning to identify potential funding sources to support outreach and engagement efforts. The FLEX and SHIP grants are opportunities under preliminary review.
2. Public comment: Who is the grant writer and how much funding has been secured to date?
    a. Carole Newark was identified as the grant writer
    b. The Board requested funding totals and grant outcomes.
3. NIHD is exploring endowments and foundation grants.
    a. The Board requested a timeframe for when grant-related deliverables or updates would be brought back.

Government Relations – Brittney Watson

1. NIHD is monitoring state and federal programs for potential funding or regulatory changes that could impact rural healthcare. General communication with regional contacts has occurred, no formal legislative engagement or coordinated advocacy efforts have occurred.
2. The Board requested a formal legislative strategy of active engagement with policymakers advocating for the District's priorities. The report should include current initiatives, contacts, and areas of policy focus.

Human Resources Plan – Marjorie Routt

1. There have been recent administrative transitions, and onboarding new department leaders is underway with a focus on stabilizing teams and aligning roles with District priorities.
2. Active recruitment for nursing, allied health, and specialty roles has been constrained by limited candidate pools and recruitment remains a top organizational priority.
3. Long-term housing solutions are needed to support workforce development, and the District is exploring partnerships to address this constraint.
4. The Board requested a report regarding:
    a. Which platforms are currently in use

b. A timeline for expansion to additional platforms such as Instagram
c. Metrics or milestones for evaluating impact

5. The Board requested that the District reach out to Cerro Coso and the **EMCC** (Emergency Medical Care Committee, so EMT students can be on boarded to obtain clinical hours.

Marketing – Barb Laughon

1. Recent marketing efforts, highlighting key accomplishments such as:
    a. Promoting NIHD's recognition as one of the top 100 critical access hospitals.
    b. Coverage of the new Behavioral Health Intensive Outpatient Program (IOP).
    c. A video and outreach campaign focused on mental health resources and suicide prevention.
    d. Internal campaigns supporting surgical services and Women's Health Week. She noted that these efforts aim to increase community trust, raise awareness, and reinforce NIHD's branding.
2. Backend updates, including refinement of the NIHD website layout, search engine optimization, and steps to improve digital engagement, are underway.
    a. The Board requested a marketing plan that includes concrete goals, a timeline for implementation, and clear metrics for evaluating effectiveness.
3. Senator Alvarado-Gil is scheduled to attend the Eastern Sierra Cancer Alliance event on September 27, 2025**,** which will take place at the Tri-County Fairgrounds. The District has extended an invitation for a visit to NIHD, but no formal meeting time has been confirmed by the Senator's office.
    a. NIHD will follow up with the Senator's staff and notify the Board if a meeting can be arranged.

CHIEF FINANCIAL OFFICER REPORT

Chair Turner introduced the CFO report

Financial and Statistical Report

1. The Board reviewed current financial performance, noting revenue and expense trends year-to-date.
    a. Financial updates will include:
        i. Days in accounts receivable (AR)
        ii. Denial rates
        iii. A timeline for improvements tied to new billing processes
2. NIHD will present the Board with a revised capital plan. It will include capital project expenditures, and long-term infrastructure planning.
3. NIHD will present the Finance Committee with an updated investment performance report and the process for aligning strategy with cash flow needs

Motion to accept the Financial and Statistical Reports: Smith
2nd: Best-Baker
Pass: 5-0

GENERAL INFORMATION FROM BOARD MEMBERS	Legal counsel will meet with Board members requesting information on retroactively changing their vote from a previous meeting. Legal counsel will advise the Board on how to request agenda items be added. The Board requested follow-up on three items raised at the previous meeting: • Conflicts of Interest. • A response to financial questions related to long-term infrastructure planning and retroactive approval of prior financial reports.
ADJOURNMENT	Adjournment at 8:23 pm.

_____
Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
David Lent
Northern Inyo Healthcare District Chair
Secretary

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Turner called the meeting to order at 2:35 pm.
PRESENT	Jean Turner, Chair Melissa Best-Baker, Vice Chair David Lent, Secretary David McCoy Barrett, Treasurer Laura Smith, Member at Large Alison Murray, Chief Human Resources and Business Development Officer
PUBLIC COMMENT	Chair Turner reported that at this time, audience members may speak on any items on the agenda that are within the jurisdiction of the Board. There were no comments from the public.
PUBLIC COMMENT ON CLOSED SESSION ITEMS	There were no comments from the public on closed session items.
ADJOURNMENT TO CLOSED SESSION	Adjournment to closed session at 2:36 pm, pursuant to Government Code §54957(b)(1), to discuss Public Employee Appointment: Chief Executive Officer candidate.
RETURN TO OPEN SESSION	Called back to order at 5:44 pm Chair Turner stated there were no reportable actions from the closed session
ADJOURNMENT	Adjournment at 5:44 pm.

_____
Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
David Lent
Northern Inyo Healthcare District Chair
Secretary

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Turner called the meeting to order at 1:00 pm.
PRESENT	Jean Turner, Chair Melissa Best-Baker, Vice Chair David Lent, Secretary David McCoy Barrett, Treasurer Laura Smith, Member at Large Alison Murray, Chief Human Resources and Business Development Officer
PUBLIC COMMENT	Chair Turner reported that at this time, audience members may speak on any items on the agenda that are within the jurisdiction of the Board. There were no comments from the public.
PUBLIC COMMENT ON CLOSED SESSION ITEMS	There were no comments from the public on closed session items.
ADJOURNMENT TO CLOSED SESSION	The meeting was adjourned to closed session at 1:02 PM pursuant to the following Government Code sections: **Public Employee Appointment / Discussion** *Government Code § 54957(b)(1)* Title: Chief Executive Officer Candidate **Conference with Labor Negotiators** *Government Code § 54957.6* Agency Designated Representative: Human Resources Unrepresented Employee: Chief Executive Officer
RETURN TO OPEN SESSION	Called back to order at 1:50 pm Chair Turner stated there were no reportable actions from the closed session
ADJOURNMENT	Adjournment at 1:50 pm.

_____
Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
David Lent
Northern Inyo Healthcare District
Secretary

CALL TO ORDER	Northern Inyo Healthcare District (NIHD) Board Chair Turner called the meeting to order at 8:05 am.
PRESENT	Jean Turner, Chair Melissa Best-Baker, Vice Chair David Lent, Secretary David McCoy Barrett, Treasurer Laura Smith, Member at Large
PUBLIC COMMENT	Chair Turner reported that at this time, audience members may speak on any items on the agenda that are within the jurisdiction of the Board.
PUBLIC COMMENT ON CLOSED SESSION ITEMS	Public Comment: Several members of the public expressed concern about the hospital's history of leadership instability, noting frequent turnover of both CEOs and Board members. They urged the Board to take a different approach in the current CEO search, emphasizing the need for a leader with 10–15 years of experience, a proven track record in larger and more complex organizations, and the ability to implement lasting organizational reform. Concerns were raised about the possibility of selecting the Interim CEO without fully considering other qualified candidates. Speakers stressed the importance of choosing someone capable of navigating political challenges, addressing corruption, and withstanding internal pressures, while ensuring the selection process is thorough and unbiased. The Board acknowledged the public comments, noting clarifying information on the turnover on the website. They thanked the speakers for their input and emphasized appreciation for the robust discussion.
ADJOURNMENT TO CLOSED SESSION	The meeting was adjourned to closed session at 8:14 am pursuant to the following Government Code sections: **Public Employee Appointment / Discussion** *Government Code § 54957(b)(1)* Title: Chief Executive Officer Candidate **Conference with Labor Negotiators** *Government Code § 54957.6* Agency Designated Representative: Human Resources Unrepresented Employee: Chief Executive Officer
RETURN TO OPEN SESSION	Called back to order at 6:32 pm Chair Turner stated there was no action to report.
ADJOURNMENT	Adjournment at 6:33 pm.

_____
Jean Turner
Northern Inyo Healthcare District
Chair

Attest: _____
David Lent
Northern Inyo Healthcare District
Secretary

NORTHERN INYO HEALTHCARE DISTRICT

ANNUAL PLAN

Title: Appointment of Infection Preventionist		
Owner: Compliance Officer	Department: Compliance	
Scope: District Wide		
Date Last Modified: 08/06/2024	Last Review Date: No Review Date	Version: 1
Final Approval by: NIHD Board of Directors	Original Approval Date:	

POLICY: The Northern Inyo Healthcare District Board of Directors shall appoint an individual who is qualified through education, training, experience, or certification in Infection Prevention and Control, based on the recommendations of the Medical Staff Executive Committee, the Nursing Executive Committee, and the NIHD Executive team.

Robin Christensen, BSRN, Healthcare Informatics Certified (HIC), is appointed as Infection Preventionist, supported by the Infection Prevention Committee Chair and Medical Director, CMO Adam Hawkins, D.O.

Ms. Christensen brings specialized education, training, and experience to NIHD's Infection Prevention and Control Program. She has demonstrated dedication and expertise in infection prevention and control since 2006 and has held a leadership role in Infection Prevention since 2016.

Ms. Christensen's education and training in the field of Infection Prevention and Control include significant involvement with the following organizations and institutions:

- The Association for Professionals in Infection Control and Epidemiology (APIC)
- California Department of Public Health (CDPH)
- The Centers for Disease Control and Prevention (CDC)
- The California Hospital Association (CHA)
- National Healthcare Safety Network (NHSN)
- Hospital Quality Institute
- The Joint Commission
- Sepsis Alliance
- National Emerging Special Pathogens Training & Education Center (NETEC).

Ms. Christensen's commitment to ongoing professional development is evident in her attendance at the APIC national conference and trainings, and the NHSN annual training, which keeps her abreast of the latest advancements and best practices in infection prevention and control. Her continuous engagement with these professional bodies and educational opportunities, and the resulting improvement in our infection prevention strategies, ensures that our hospital remains at the forefront of infection prevention strategies and maintains compliance with the highest standards.

REFERENCES:

1. TJC IP04.01.01 EP1 (2024)
2. CMS Conditions of Participation, Appendix W, C-1204 (Rev 200, Issued 02-21-2020, S485.840 (a) Standard: Infection prevention and control program organization and policies.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. Infection Prevention Plan

RECORD RETENTION AND DESTRUCTION:

This policy shall be maintained for 7 years following the last day of effectiveness.

Supersedes: Not Set

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

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: 07/30/2025	Last Review Date: 10/17/2024	Version: 5
Final Approval by: Board of Directors' NIHD	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. Pregnant patients with obstetric (OB) related symptoms (**low abdominal pain and/or back pain, vaginal discharge, pelvic pressure, headache**) at **24 weeks or greater** gestation will be sent to the Perinatal Department for evaluation.

   - The on-call OB provider will be consulted by the Perinatal RN after completing a medical screening exam (MSE), 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 discharged from the Perinatal Department by the OB provider and has non-obstetric complaints that were not addressed by the OB provider, the patient shall return to the ED to be evaluated by the ED provider. If it is determined by the OB provider that the patient needs further evaluation in the ED then the OB provider will directly contact the ED provider before the patient is transferred back down to the ED. This determination should only be made by the provider and is not at the discretion of the Perinatal RN, Emergency RN, or House Supervisor.

   - If a patient appears to be in **active labor** or delivery appears **imminent**, ED staff will notify the Perinatal Department to prepare for the patient and accompany patient to the Perinatal Department.

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

3. Pregnant patients **less than 24 weeks gestation with OB related symptoms** will be evaluated by the ED provider who will consult, as needed, with the OB provider on-call.

4. **All** pregnant patients presenting with **non-OB** related symptoms will be seen in the ED regardless of gestation.

    - For pregnant patients **24 weeks or greater** gestation who have a **non-OB** complaint, a Perinatal RN will be called to come to the ED to complete an NST. If a Perinatal RN is not free to come to the ED, the patient will be transferred to the Perinatal Department for an OB evaluation after the primary concern is addressed in the ED. The ED provider 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 provider.

5. Patients who are deemed clinically unstable regardless of gestation will not be transferred to the Perinatal Department until stabilized. The Emergency Department provider 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 Department before the on call OB provider arrives, the ED provider may be called to the Perinatal Department to assist in emergent stabilization of the patient.

6. The decision to admit or discharge a patient at 24 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 provider has taken place.

REFERENCES:

1. EMTALA; California Hospital EMTALA Manual; A guide to patient anti-dumping laws. Lipton, M.S. 2018.
2. ACOG Committee Opinion (2018 reaffirmed 2023). *Hospital-Based Triage of Obstetric Patients.*
3. Patient Safety Authority (2008. Triage of the Obstetric Patient in the Emergency Department: Is There Only One Patient?
4. AWHONN/ENA Conesus Statement (Revised and approved 2020). Emergency Care for Patients during Pregnancy and the Postpartum Period: Emergency Nurses Association and Association of Women's Health Obstetrics and Neonatal Nurses consensus statement.

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.4 Evaluation of Pregnant Patients in the Emergency Department

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY AND PROCEDURE

Title: Fall Prevention and Management		
Owner: Manager ICU and Acute Subacute	Department: Acute Subacute, ICU, OB, ED	
Scope: Inpatient Departments, Emergency Department		
Date Last Modified: 2/27/25	Last Review Date:	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 10/31/17	

PURPOSE:

A. Establish standards/criteria to identify patients who are at high risk of falling.
B. Identify methods to communicate high-risk status to staff, patient, and family.
C. Outline responsibilities of staff in relationship to the fall prevention program.
D. Outline procedures for documentation and communication.
E. Outline procedures after a fall has occurred.

POLICY:

A. Patients admitted to inpatient or observation services at Northern Inyo Hospital are assessed for being at risk of falling on admission reassessed every shift, and assessed as needed with changes in condition. Patients identified at risk for falling have a potential for physical injury. A Care Plan initiated and patients identified as high fall risk will have a Care Plan developed to meet their individualized needs.
B. Northern Inyo Hospital supports an interdisciplinary falls approach which facilitates:
   1. Developing/reviewing of the fall prevention protocol
   2. Assisting in implementation of fall prevention strategies
   3. Acting as a resource as needed
   4. Collecting and analyzing data on falls for common factors
   5. Development of recommendations to reduce falls and fall-related injuries
C. Universal Fall Precautions: Northern Inyo Hospital District recognizes that any individual has the potential to fall. All employees are to be aware of and follow Universal Fall Precautions. These precautions are developed to protect the patient, visitors, and employees. (Attachment B)
D. All departments caring for patients will follow Universal Fall Precautions.(Attachment B)
E. For Perinatal Services: Also view the Fall Risk Prevention perinatal policy
F. For Perioperative Services: Also view the Positioning of the Surgical Patient policy
G. The Emergency Department will follow Universal Fall Precautions. All Emergency Department patients are considered at risk for fall or injury.

DEFINITION:

A. A fall is a sudden, unintentional descent, with or without injury that results in the patient coming to rest on the floor or against some other person/surface/object as defined by the National Data Base of Nursing Quality Indicators (NDNQI).
B. Falls can be divided into four categories:

1. **Anticipated Physiological.** Patient's diagnosis or characteristics may predict their likelihood of falling (i.e. medications, unsteady gait, or post-surgery)
2. **Unanticipated Physiological.** No obvious risk factors identified on assessment; falls related to conditions that were not anticipated (i.e. syncope, medication reaction, or seizure)
3. **Accidental.** Environmental hazards, dropped infant
4. **Developmental (pediatric only)** Non-injurious falls for infants/toddlers as they are learning to walk, pivot, run

C. Types of falls can include:
1. Witnessed fall: Patient seen or in the presence of a staff member when the fall occurs.
2. Un-witnessed: Fall is not observed by staff, and maybe reported at a later time after the fall occurred
3. Assisted fall: Patient was assisted or lowered to the floor by staff
4. Unassisted fall: Patient found on the floor or fell in the presence of staff but not assisted or lowered to floor by staff.

Procedure:
INPATIENT FALL RISK ASSESSMENT AND PREVENTION:

A. Adult patients are assessed for fall risk using the Morse Fall Scale. (Attachment A).
B. Pediatric Patients are assessed for fall risk using the Humpty Dumpty scale. (Attachments E and F)
C. The RN assigned to the patient is responsible for assessing for fall risk. Risk assessments are completed:
1. On admission to the hospital
2. Every shift
3. Upon transfer from one unit to another within the hospital
4. Following a change in condition
5. Following a fall

D. Patients will be identified as:
a. Standard fall risk: Morse Falls Score of 0-44 or Humpty Dumpty Score of 7-11
b. High Fall Risk: Morse Score >45 or Humpty Dumpty Score >11
i. Any patient who has fallen during the current hospitalization
ii. A patient who in the nurse's judgment is high risk for falls

E. Fall Risk reduction interventions and the age appropriate Fall Prevention and Management Care Plan is initiated by the RN on patients identified as high risk for falls.
F. Patients who are impulsive, confused, have gait abnormalities or refuse to call for assist may receive additional interventions.

Fall Risk Reduction Interventions:

Standard Fall Risk Morse Score of <45 or Humpty Dumpty Score of 7-11:

The following will be initiated for all inpatients:

- Orient Patient and Family to environment and routines
- Place call light within reach, and remind Patient to use call light or bedrail call button to call for assistance
- Ensure that the Patient bed is in low position and the brake is on
- Place Patient’s necessary items within reach
- Provide non-skid footwear for Patient as needed
- Minimize environmental trip/slip hazards
- Round frequently and assess for safety and comfort (4 P’s: Potty, Position, Pain and Periphery)

- Provide necessary ambulatory aids
- A potential for physical injury care plan related to hospitalization will be initiated on all Patients
- Provide patients and families with a Fall Risk Brochure

High Fall Risk Interventions Morse Score >45 or Humpty Dumpty Score >11:

In addition to the Standard Fall Risk interventions listed above, more intensive interventions by the health care team are warranted for patients identified as high fall risk. They include but are not limited to the following:

- Upon completion of a nursing assessment, if the Morse Falls Scale is >45 or Humpty Dumpty Score >11, a Physical Therapy referral will be generated.
- Potential for injury from falls care plan will be initiated
- Relocate patient to an observation room near the nurse's station
- Activate the bed alarm and or chair alarm if indicated
- A gait belt will be used during transfers and ambulation for all high fall risk patients

1. The RN is responsible for initiating the Fall Risk Protocol and assuring the protocol implementation.
    a. High risk for falls is communicated in the following fashion:
        i. Falls risk yellow tile on the room plaque along with a yellow falling star sign
        ii. Yellow non-skid socks are given to the patient to wear during ambulation
        iii. Bed alarm signs are hung at the head of the patient's bed and on the door frame if indicated.
        iv. A yellow Fall Risk armband is applied at the time the patient is identified as high risk; (The armband application is documented in the EHR. Communication of the patients fall risk will be included during any handoff with an SBARQC handoff report regarding fall risk status.
        v. Shift huddle on the Acute/Sub Acute Services Department will include identification of High Fall Risk Patients.
        vi. Safety issues will be discussed daily at the interdisciplinary patient care conference.
2. Individualized Plan of Care interventions are chosen according to the patient's area of identified need.
    a. Identify the individual patient falls risk factors and implement interventions to decrease their risk of falling.
        i. RN will review medication for contributing to increase risk for falls Discuss any medication risk concern with the physician and provide education to patient regarding medications and falls risk.
            1. Some Medications on the EMAR will be flagged: "MAY INCREASE FALL RISK" including but not limited to:
                a. Antidepressants: amitriptyline, doxepin, imipramine
                b. Antiemetics: Compazine, Phenergan
                c. Antihistamines: Benadryl, Atarax
                d. Benzodiazepines: Ativan, Valium, Midazolam
        ii. If unsafe mobility is a risk factor consider:
            1. Physical Therapy referral
            2. Supervised transfers and toileting
            3. Ensure any walking aides and commode in reach
            4. Follow mobility plan to increase strength and balance
        iii. If frequent toileting is a risk factor consider:

1. Evaluate and discuss with physician any possible treatments/interventions regarding the increased frequency (i.e. infections, medications, incontinence)
2. Offer scheduled assisted toileting
3. Review medications that may increase toileting and try to not schedule near bedtime
4. Keep toileting aides near patient
5. If the patient is impulsive or confused consider the use of a safety attendant (Refer to Policy "Patient safety attendant or 1:1 staffing guidelines)

iv. If confusion is a risk factor consider;

1. Increased observation in a high visibility room with door open (Unless privacy needed)
2. Hall window shades to remain open (Unless privacy needed)
3. Frequently orient to surroundings
4. Avoid intercom usage or loud noises
5. If confusion is not the baseline, RN to assess for possible contributing factors (i.e. infection, medication, electrolyte imbalance. . .)
6. When patient is in a chair, a chair alarm will be used
7. When patient is in bed, a bed alarm will be used

b. Consider the use of a fall alarm under the following circumstances:
   i. Evidence of confusion or "sun-downing"
   ii. Impulsive behavior
   iii. Patient exhibits either of the above and are at higher risk for injury from anticoagulant therapy or bone related issues such as osteoporosis or bone metastasis, and/or
   iv. Repeated failure to remember to request help when getting up.
   v. If the patient/refuses the fall alarm, document this refusal in the EHR.

3. Care Plan includes patient/family education to assist the patient/family in understanding risk and steps to decrease the risk.
4. Patient's response to the Care Plan teaching is evaluated and documented.
5. Care Plan is updated as necessary based on the patient's condition and identified areas of risk for falling.
6. Family and patients receive the fall prevention brochure upon admission

MANAGEMENT OF THE IN-PATIENT POST FALL:

A. Post fall management is to be implemented on a witnessed fall, un-witnessed fall, assisted fall, or unassisted fall. (See Fall definition Page 1 & 2 / C 1 thru 4.)
B. The RN will initiate the Post Fall Care Phase of the Fall Prevention and Management.
C. The RN will complete an immediate post fall patient assessment and document the following information the EHR including but not limited to:
   a. Evaluation of the fall:
      a. Date and time of fall
      b. Patient assessment at time of fall:
         i. Assessment of injuries (Attachment C)
      c. Evaluation of patient injuries based upon interventions
   b. Patient vital signs
   c. Pain Assessment
   d. Physical assessment to include but not limited to the following systems:
      a. Neurological

b. Glascow coma scale
c. Musculoskeletal
d. Integumentary

e. Morse Fall risk re-assessment after the fall

D. Notification of the fall
The RN is responsible for:

a. Physician notification of fall
b. A physician is notified immediately when the patient has any injury identified, is unresponsive, has evidence of spinal cord injury, or significant injury (outlined in addendum C)
c. If no injury present a physician must be notified as soon as possible.
d. Documentation of the physician notification is to be completed in the EHR.

e. Notification of family/guardian or documentation that the patient did not want the family notified (If patient is alert and oriented)
f. Immediate notification to the shift charge if available
g. Immediate notification to the House Supervisor
h. Notification to the Department Manager

E. The RN caring for the patient in conjunction with the individual who discovered the patient is responsible for completing an Unusual Occurrence Report (UOR). The UOR should be completed at the time of the fall or by the end of the shift.
F. Document additional information regarding the patients fall in the EHR: Information may include but is not limited to:
a. Measures taken to provide patient safety (Initiation or adjustment to the plan of care)
b. Notification of family or documentation that the patient did not want the family notified (If the patient is alert and oriented)
G. The RN will complete the following:
a. Convene a "Post fall huddle debrief" to review the plan of care to assure appropriate interventions are in place and debrief the circumstances of the fall.
b. Assure that a UOR along with a Post Fall Huddle Debrief form is completed with all necessary information. Notify the nurse manager/director of the fall.
H. If the fall results in death or permanent functional injury, notify Performance Improvement who will initiate a Sentinel Event and CDPH Adverse Event Management and Reporting Plan. During non-business hours, notify the Administrator on call (AOC).

NORTHERN INYO HOSPITAL STAFF RESPONSIBILITIES:

A. All staff are responsible to:
1. Create and maintain a safe environment
2. Notify the proper individual of unsafe situations
3. Communicate high risk fall status
4. Comply with universal and high risk for fall precautions
5. Develop an individualized patient plan of care as appropriate to scope of practice.

B. Managers are responsible to:
1. Implement specific falls protocol on the unit level
2. Assure compliance with the falls protocol
3. Provide a safe environment
4. Maintain appropriate equipment in collaboration with facility equipment experts to aid in fall prevention

5. Ensure that staff receives education about fall prevention
6. Review falls data for the unit and provide feedback and coaching for fall prevention to staff

C. In-patient staff nurses are responsible for the implementation and oversight of individual patient fall prevention:
   1. Assess/reassess for fall risk
   2. Communicate when the patient is at high fall risk
   3. Collaborate with the interdisciplinary team in prevention of falls
   4. Develop the appropriate Care Plan for fall prevention.
   5. Educate the patient and family on the plan of care and fall risk prevention strategies
   6. Assure implementation of the high fall risk interventions by the team
   7. Evaluate the patient's response to the Care Plan teaching/interventions..
   8. Manage a patient after the fall.

D. Charge Nurse or nurse caring for the patient:
   1. Responsible for immediate post fall huddle and documentation in the Post Fall Debriefing form which will be attached to the UOR
   2. Assure post fall UOR is completed by the RN responsible for the patient
   3. Notify the house supervisor if a patient fell during off hours
   4. Notify the director, manager, or house supervisor of falls that results in significant injury such as fracture or death.
   5. Discuss the fall and other patient safety issues at the daily Interdisciplinary plan of care conference.

E. Clinical staff educators:
   1. Review of falls in assigned clinical areas
   2. Consultation on high fall risk patient as needed
   3. Review and analyze aggregated data
   4. Review and develop falls risk protocols
   5. Develop educational programs and competencies for nursing staff

REFERENCES:

- Bernick, L., Bretholz II,1999. Safe Mobility Program: A comprehensive falls prevention program for a multilevel geriatric setting. Perspectives 23 (3), 4-12.
- Corrigan, B.; Allen, K.; Moore, J., Samra, P; Stetler, C.; Thielen, J.; and NICHE Faulty;
- Chapter 7 Preventing Falls in Acute Care in Abraham, I.; Bottrell, M.; Fulmer, T.; and
- Mezèy, M.; (eds). Geriatric Nursing Protocols for Best Practice. (1999); Springer Publishing Company.
- Cumming, R. (lÞgS). "Epidemiology of Medication-Related Falls and Fractures in the Elderly."
- Drugs & Aging, 12(l):43-53
- Edelberg, ff.f. IZOO1). Falls and function. How to prevent falls and injuries in patients with impaired mobility. Geriatrics 56(3): 41-5.
- Fick, D. et al (2003) 'Updating the Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." Arch Intern Med, 163: 2716-2724.
- Joanna Briggs Institute, The (1998) Falls in Hospitals, Best Practice, 2 (2) l-6
- http ://joannabriggs.edu.au/pubs/best_practice/php
- Oliver, D. et al. (2004) Risk Factors And Risk Assessment Tools For Falls In Hospital In-patients: a systematic Review. Age and Aging (Vol 33 No. 2). Pg 122-130
- McFarlane-Kolb, H. (2004) Falls Risk assessment, Multitargeted Interventions and Impact on Hospital Falls. International Journal of Nursing Practice 10: 199-206
- Morse, J.M. (2002). "Enhancing the safety of hospitalization by reducing patient falls." Am J Infect Control 30 (6): 376-80.

- Morse, J. Preventing Patient Falls. 1997. Sage Publications.
- Mosley, 4., D. Galindo-Ciocon, et al. (1998). "Initiation and evaluation of a research based fall prevention program." Journal of Nursing Care Quality 13(2): 38-44.
- NCPS Falls Toolkit; 2004 National Center for Patient Safety.
- http://www.patientsafety.gov/SafetyTopics/fallstoolkit/notebook/completebooklet.pdf
- Patrick, L', LeLer, M., Scrim, C., Gendron, I., Elsener-Parsche, P. (1999). A standardized assessment and interventions protocol for managing risk for falls on a geriatric rehabilitation unit. Journal of Gerontological Nursing 25 (4): 40-47 .
- Rutledge, b., Donaldson, N., Pravikoff, D. (1998). Fall Risk Assessment and Prevention in Healthcare Facilities, Cinahl Information Systems. The Online Journal of Clinical Innovations 1 (9); l-33
- Tideiksaar, R. Falls in Older People Prevention and Management. 3rd edition. 2002. Health Professions Press.
- Tinetti, M.E. (2003) "Preventing falls in elderly persons" New England Journal of Medicine 348(1): 42-49
- Wilson, E.B. (1998). "Preventing patient falls." AACN Clin Issues 9(1): 100-8.

CROSS REFERENCE POLICIES AND PROCEDURES:

- Safety Policy for Perinatal Unit Patients
- Gait Belt Policy
- Functional Risk Assessment Criteria for Therapy referral
- Pediatric Standards of Care and Routines
- Positioning of the Surgical Patient

Supersedes: v.2 Fall Prevention and Management*

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL POLICY AND PROCEDURE

Title: Medical Ethics Referrals and Consultations		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: District Clinical Departments		
Date Last Modified: 06/14/2023	Last Review Date: 08/06/2025	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/21/2018	

PURPOSE:

The purpose of this document is to outline the procedure for medical ethics referrals to the Northern Inyo Healthcare District (NIHD) Medical Executive Committee. The Medical Executive Committee will serve as a forum to promote and clarify medical ethics practices throughout NIHD in order to enhance the quality of patient care.

POLICY:

1. The Medical Executive Committee shall serve as the Medical Staff Ethics Committee.
2. The activities of the Medical Executive Committee in relation to ethics include:
    a. Consultation – Consult with hospital staff regarding difficult clinical ethics cases, making recommendations when appropriate.
    b. Education – Identify educational opportunities to educate committee members, the hospital, and the community on medical ethics issues.
    c. Policy work – Review and create hospital policies and procedures to promote medical ethics practice guidelines and decrease future ethics conflicts.
3. Other healthcare professionals or members of the community may be asked to participate in the committee's activities when appropriate, including, but not limited to:
    a. Social workers
    b. Clergy
    c. Legal counsel

PROCEDURE:

1. Consultation Procedure (Referrals) – Inpatient or Outpatient
    a. Requests for consultation may be initiated by the patient, family, attending physician, other health care providers, or any person having a significant relationship with the patient.
    b. Requests for consultation are directed to the Medical Staff Office, the Chief of Staff, Vice Chief of Staff, or designee to initiate the referral.
    c. The Chief of Staff, Vice Chief of Staff, or designee reviews the request for appropriateness and urgency. If the request is appropriate, the Medical Staff Office will either:
        i. Add the referral to the next regularly scheduled Medical Executive Committee agenda for discussion in closed session, or
        ii. Convene a special meeting of the Medical Executive Committee if urgent.
    d. The committee reviews the case and proceeds as follows:
        i. Discusses issues that initiated the consultation including medical, family, psychosocial, spiritual, legal and ethical dilemmas.
        ii. Clarifies options, including the ethical justification or rationale for each option.

iii. Selects appropriate options to recommend. In this step, any providers that are directly responsible for the care of the patient will recuse themselves from voting on the committee's recommendations.

e. The Medical Executive Committee communicates its recommendation to the appropriate involved parties, either verbally or in writing.
f. A summary statement is placed in the patient's medical record by the Chief of Staff, Vice Chief of Staff, appropriate Chief or designee.

REFERENCES:

1. Nelson, William A. and Elliot, Barbara A. (2012) *Critical Access Hospital Ethics Committee Resource Guide*. Trustees of Dartmouth College, Hanover, New Hampshire.

RECORD RETENTION AND DESTRUCTION:

1. Minutes of the Medical Ethics Committee are confidential and are to be kept by the Medical Staff Office as official Medical Staff records. Retention will follow the same guidelines as other Medical Staff Committees.

CROSS REFERENCED POLICIES AND PROCEDURES:

1. None

Supersedes: v.2 Medical Ethics Referrals and Consultations

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Medical Records Delinquency Policy		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Medical Staff and Advanced Practice Providers (APPs)		
Date Last Modified: 07/08/2025	Last Review Date: 08/06/2025	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/19/2021	

PURPOSE:

To ensure compliant documentation and signatures on clinical documents and orders for patient's medical records.

POLICY:

1. For hospital-based medical records:
    a. History and Physical (H&P) shall be completed within 24 hours after admission.
    b. Discharge summary shall be completed within 7 days after discharge.
    c. The patient's complete medical records including H&P, progress notes, and discharge summary shall be completed within 14 days following discharge.
    d. Verbal or telephone orders need to be co-signed within 48 hours of order placement.
2. For clinic-based medical records:
    a. The patient's office visit note should be completed and signed at the time the office visit, or no later than 3 days following the visit.
    b. Verbal or telephone orders need to be co-signed within 48 hours of order placement.
3. For surgery-based medical records:
    a. For H&P requirements, refer to H&P Policy.
    b. An immediate postoperative note is required on all surgical patients.
    c. Complete operative reports shall be completed immediately after surgery or within 24 hours of surgery/operation.

PROCEDURE:

1. If documentation and/or signatures are delinquent, the Health Information Management (HIM) manager shall notify the Medical Staff member or Advanced Practice Provider (APP) by NIHD email and/or certified mail that his/her privileges to admit or attend to patients shall be suspended 7 days from the date of notice and that the Medical Staff member or APP shall remain suspended until records have been completed.
2. Ongoing care of patients already in the hospital may be continued. The suspended member shall not care for any patients other than those currently admitted under his/her own name and may not provide consults on Hospital or emergency room patients.
3. If the suspended member is on call, he/she is responsible for finding another physician to see any patients requiring care while he/she is on call.
4. Suspension of admitting privileges does not affect the Medical Staff or APP's privilege to provide patient care in emergency circumstances when the member is the only provider available to provide that necessary care.

5. Any member whose privileges have been suspended for failure to complete medical records in a timely fashion for a total of 30 (thirty) days or longer in a 12 (twelve) month period may be reported to the Medical Board of California by the Chief Executive Officer, pursuant to California Business and Professions Code section 805 and the National Practitioner Data Bank.
6. If the Medical Staff member or APP is unavailable for a prolonged period of time, that Medical Staff member or APP is able to designate a proxy of the same specialty to sign orders on their behalf.

REFERENCES:

1. California Code, Business and Professions Code – BPC 805
2. Title 22, California Code of Regulations, Section 70751
3. Title 22, California Code of Regulations, Section 74731
4. Title 22, California Code of Regulations, Section 70263

RECORD RETENTION AND DESTRUCTION:

1. As per the District's medical record retention and destruction policies.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Verbal and/or Phone Medical Staff Practitioner Orders
2. Medical Staff History and Physical (H&P) Policy
3. Northern Inyo Healthcare District Medical Staff Bylaws

Supersedes: v.1 Medical Records Delinquency Policy

NORTHERN INYO HEALTHCARE DISTRICT

CLINICAL POLICY

Title: Medical Staff History and Physical (H&P) Policy		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Medical Staff and Advanced Practice Providers (APPs)		
Date Last Modified: 08/08/2023	Last Review Date: 08/06/2025	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/19/2021	

PURPOSE:

To define the elements of a patient's history and physical (H&P) examination and medical history on admission or before any operative or interventional procedure.

POLICY:

1. An H&P examination must be performed by a qualified licensed practitioner who is credentialed and privileged by the medical staff to perform an H&P.
2. An H&P must consist of chief complaint, history of present illness, allergies and medications, relevant social and family history, past medical history, review of systems as needed and physical examination, and assessment and plan appropriate to the patient's age.
    a. For surgical procedures, the surgeon's documentation (H&P or consult note) should also include risks, benefits, and alternatives.
3. An H&P examination must be performed within twenty-four (24) hours after admission and prior to surgery or procedure requiring anesthesia services.
4. If a complete H&P examination was performed within thirty (30) calendar days before admission, an updated medical record entry must be completed and documented in the patient's medical record within twenty-four (24) hours after admission and prior to surgery or procedure requiring anesthesia services.
    a. The update note must document an examination for any changes in the patient's condition since the patient's H&P was performed that might be significant for the planned course of treatment. The physician or qualified licensed individual uses his/her clinical judgment, based upon his/her assessment of the patient's condition and comorbidities, if any, in relation to the patient's planned course of treatment to decide the extent of the update assessment needed as well as the information to be included in the update note in the patient's medical record.
    b. If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she may indicate in the patient's medical record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed (71 FR 68676).
5. If the practitioner finds that the H&P done before admission is older than thirty (30) days, incomplete, inaccurate, or otherwise unacceptable, the practitioner reviewing the H&P, examining the patient, and completing the update must document in the medical record a new or corrected H&P within twenty-four (24) hours after admission, but prior to surgery or a procedure requiring anesthesia.
6. If the H&P and the informed consent for the surgery or procedure are not recorded in the patient's medical record prior to surgery, the procedure shall not be performed unless the attending physician states in writing that such delay could lead to an adverse event or irreversible damage to the patient.

REFERENCES:

1. Centers for Medicare and Medicaid Condition of Participation: Medical Staff 482.22(c)(5)
2. "History and Physical." UCLA Health Medical Staff Policy. Effective Date 04/03/2017. Retrieved 01/25/2021. https://www.uclahealth.org/medical-staff/workfiles/policies-rrucla/MS%20200%20History%20and%20Physical%2004302017%20GH.pdf

RECORD RETENTION AND DESTRUCTION:

1. H&Ps are part of the patient's medical records and shall follow the District's record retention and destruction policies.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Informed Consent Policy - Practitioner's Responsibility

Supersedes: v.1 Medical Staff History and Physical (H&P) Policy

NORTHERN INYO HEALTHCARE DISTRICT

PLAN

Title: Medical Waste Management Plan		
Owner: Maintenance Manager	Department: Maintenance	
Scope: District Wide		
Date Last Modified: 07/02/2025	Last Review Date: No Review Date	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 08/01/2005	

PURPOSE: The purpose of this document is to outline and define safe and appropriate handling of medical waste, and to designate responsibilities of medical waste handling at this facility. It is also to assure compliance with all regulatory agencies and to provide a set of accepted definitions (if required.)

POLICY:

Medical Waste will be handled, stored, treated and disposed of in accordance with regulations as stated in the "Medical Waste Management Act" of the California Health and Safety Code. All human body parts and human tissue waste are stored in a multi-freezer (DAA) designated accumulation area. All other hazardous waste will undergo onsite treatment through the sterilization process. Chemo waste and Pharmaceutical waste are picked up Monthly by a medical waste transporter "

The Medical Waste Management Plan will be reviewed annually by the:

- Director of Facilities
- Maintenance leadership
- Maintenance team member
- Environmental Services leadership
- Director of Pharmacy
- Infection Preventionist Manager

The changes and review will be documented within policy management system via track changes and notes.

TYPES OF MEDICAL WASTE:

- Laboratory
- Blood and other potentially infectious materials (OPIM)
- Chemo Waste
- Contaminated Sharps
- Human Tissue Waste (Pathology)
- Recognizable Human Anatomical Parts
- Pharmaceutical
- Radioactive Waste
  - Resource Conservation and Recovery Act (RCRA)

- Biohazard waste from Small Quantity Generators (none at this time)
- Non-infectious waste

TYPE OF GENERATOR:

- Large Quantity Generator (greater than 600 lbs. per month)

TYPE OF ON-SITE TREATMENT:

- Steam Sterilization/Autoclave
  - This facility complies with the Medical Waste Management Act (MWMA) Treatment Permit Conditions.
  - Training for Operators will be conducted on an annual basis and documentation will be retained for a minimum of two years.
  - Monthly testing using a biological indicator (b.i.) will be performed and the results will be kept in the Maintenance office located in the Spore Testing Binder.

Autoclave/Steam Sterilizer Monthly Testing Protocol

Once per month, per HSC Section 118215(a)(2)(D), the biological indicator Geobacillus Stearothermophilus shall be placed at the center of a load processed under standard operating conditions to confirm the attainment of adequate sterilization conditions, (Temp. 275 degrees, 45 lbs. pressure psi, 45 minutes duration) and the results are maintained in the Maintenance Dept. for a minimum of two years.

- Test Vial 1262 for Steam Sterilization must be inserted into a retrievable vessel, in the center of a medical waste load.
- Run the autoclave at operating parameters and then retrieve the test vial in a safe manner
- Snap the vial like you are activating a glow stick (you will feel and hear a distinctive crack)
- Place the test vial in a 1262 incubator and take a fresh vial and snap it the same as above
- Place the Control vial or (fresh cracked vial) in the incubator next to the cooked vial (place a **C** on the fresh vial)
- Run incubator and check results in 48 hours.
- If fresh vial changes to yellow that means the box of test vials is good and the incubator is at the right temperature. (No color change means bad box of vials or malfunctioning incubator)
- If the cooked vial stays purple, then the autoclave is operating properly and all microbes were killed. (Yellow vial indicates not fully sterilizing the waste indicating live microbes changing the color to yellow)
- Document the results of both vials along with the date and initials of person conducting testing.

Annual Training for the Operators

- Annual training for the Operators shall be documented and be retained in the Maintenance Office for a minimum of two years.

MEDICAL WASTE MANAGEMENT ACT DEFINITIONS:

- **See attached**

I. CONTAINMENT, TRANSPORT, STORAGE:

- Medical waste is segregated and contained from other hospital waste at its point of origin.
- Sharps are disposed of into sharps containers for disposal.
- All biohazardous waste is red bagged, and when full bags are tied tightly.
- Radioactive waste will be handled in accordance with radioactive waste policy and regulations.
- Medical wastes are sterilized as specified in this policy.
- Medical waste will not be stored for longer than 7 days. (At room temperature,)
- All medical waste is transported daily in a covered transport cart to a locked storage dumpster. Once a month medical waste transporter picks up Medical & Pharmaceutical Waste.
- Bags of medical waste will not be placed on floors, in rooms, or corridors; bags are to be placed directly in transport carts
- Items such as broken glass, laboratory slides and sharps or pointed objects, which could puncture a plastic bag, will be placed in sharps containers.
- Bags of normal waste, soiled linens or other materials will not be placed in the transport cart used for transport of Biohazardous waste.
- Environmental Services employees will check the transport cart routinely to ensure it is in good condition, clean, and labeled properly. (Biohazardous Waste or the work Biohazard and the biohazard international symbol.)
- The transport cart must be leak proof, secured tightly with a cover, be labeled on sides and top "Biohazard" and Biohazard symbols.
- Appropriate P.P.E. is worn at all times for collecting and transporting.

II. MEDICAL/BIOHAZARDOUS WASTE AT THIS FACILITY MEANS ANY OF THE FOLLOWING:

- Items that are caked with dried blood or OPIM and are capable of releasing these materials.
- Waste compromised of human tissue, which has been fixed in formaldehyde or other fixatives.
- Waste contaminated with trace amounts of chemo agents.
- All contaminated sharps i.e.: needles, scalpel blades, glass pipettes.
- Any liquid or semi liquid blood or OPIM.

- A container, or inner liner removed from a container, which previously contained a Chemotherapeutic agent, is empty if the container or inner liner removed from the container has been emptied by the generator as much as possible, using methods commonly employed to remove waste or material from containers or liners, so that the following conditions are met:

A. If the material which the container or inner liner held is pourable, no material can be poured or drained from the container or inner liner when held in any orientation, including, but not limited to, when tilted or inverted.

B. If the material which the container or inner liner held is not pourable, no material or waste remains in the container or inner- liner that can feasibly be removed by scraping.

PHARMACEUTICAL WASTE PROCEDURE:
Refer to Safe Handling and Disposal of Occupationally Hazardous Drugs and Environmentally Hazardous Drugs in Policy Manager.

HANDLING AND DISPOSING OF SHARPS WASTE PROCEDURE:
Refer to Bloodborne Pathogen Exposure Plan

EDUCATION AND TRAINING:

- All employees who come in contact with blood and OPIM will receive initial and annual training on handling of biohazardous/medical waste as it pertains to job responsibilities. The education can be provided by the Infection Prevention team, Employee Health team or by online learning management system
- Maintenance leadership is responsible to ascertain safe and appropriate operation of sterilizer by qualified operators.

III. BIOHAZARDOUS WASTE DISPOSAL FROM SMALL QUANTITY GENERATOR (S.Q.G.) COMMUNITY CENTERS:
To assist medical offices in the disposal of medical (infectious) waste in order to:

- Comply with stringent federal and state regulations.
- Assure safety to hospital and office personnel.
- Prevent access by outside persons or animals.
- Reduce the amount of infectious waste generated.

POLICY:

- Infectious waste must be in red plastic bags and must be labeled “biohazardous” in writing or biohazard label.
- Bags must be labeled with office name.
- Bags must not be overfilled and must be tied securely to enable picking up by tied top.
- Double bagging is not necessary except for strength or if outside of bag is soiled.
- Used needles, syringes and sharps must be in biohazard sharps containers and will be sealed with puncture proof lid.
- Infectious waste must be delivered to the hospital maintenance building between the hours of 7:00 AM and 3:30 PM on weekdays only.

• Infectious waste **MUST NOT** be left outside the maintenance building, in the parking lot or the fenced off area near maintenance building.
• Offices must fill in the Medical Waste Treatment Record form located inside the maintenance building, medical waste container.

IV. CONTAMINATED SHARPS FROM THE COMMUNITY:

- Northern Inyo Healthcare District will accept contaminated needles from the community for disposal.
- Refer questions and persons with needles to the Manger of Infection Prevention/Employee Health
or Maintenance; ***USED NEEDLES OR NEEDLE CONTAINERS*** must not be accepted by anyone else.
- NIHD will accept contaminated needles from the community for disposal in the Red Kiosk located at the front entrance of the Main Hospital.
- Needle containers may not be supplied to patients or other individuals, for home use.
- All efforts are made to assure appropriate containers are used and will not be accepted otherwise.

V. CLEANING UP BLOOD SPILLS OR OTHER POTENTIALLY INFECTIOUS MATERIAL (OPIM):

- Blood spills are cleaned up as quickly as possible.
- Blood spills are cleaned up in a manner to prevent exposure to any person.
    1. Use hospital disinfectant or bleach solution.
    2. Wear gloves
    3. Use disposable rag, paper towel or mop.
    4. To avoid aero-soling, do not spray into spill.
    5. Dampen rag with cleaning solution, wipe up.
    6. Re-clean area with clean rag and solution.
    7. As an alternative, sprinkle spill with jelling powder, seep up with dustpan and broom.
    8. Red bag granules.
    9. Clean dustpan and broom by swishing in cleaning solution on cleaning cart or with rag.
    10. Wipe up as in steps 5 and 6.
    11. Blood spill kits are available

VI. BIOHAZARDOUS WASTE CARTS AND CLEANING:

- Large rigid, wheeled carts are used to transport biohazardous waste from the hospital units to locked storage dumpster.
- Environmental Services will check that carts are clean and in good condition at all times.
- Carts are lined with red bags; this bag is disposed of with biohazardous waste.
- Carts are cleaned on a regular basis.

VII. STEAM STERILIZER/COMPACTOR *Maintenance of Equipment:*

The steam sterilizer and compactor are maintained and inspected to ensure safe and proper operation and that infectious materials are fully sterilized in compliance with State and Federal regulations.

PROCEDURE/STERILIZER:

Daily:

Walk around the unit, check for damaged hoses and leaks. Remove any litter that may have accumulated around the sterilizer.

Open the sterilizer door and check the seal for damage and debris.

Clean drain screens (parts #41 and #45 on drawing #100A06.) Remove screens by lifting from the drain hole and check for the presence of debris and sediment that might restrict the flow of condensate (water.) Use a wire brush to loosen the debris, rinse thoroughly, and replace in the drain hole.

Clean "Y" strainers (Parts #6 and #39) with a crescent wrench (adjustable open end wrench) remove the large nut from the strainer. Carefully remove the internal strainer screen, clean and rinse the screen and replace, this should be done weekly.

Check the sterilizer carts for plastic residue or other debris and remove. Use a scraper if necessary.

Check the sterilizer door for alignment by slowly closing the door. If you hear scraping noises that might indicate misalignment, repair it immediately.

Weekly:

Clean wire strainers.

Recorder chart: Open the cover of the recorder with your fingers, unscrew the round knob in the center of chart. Replace with new chart. Release the pen holder; swing the arm out of the way. Gently pull the pen holder about ¼" away from the paper chart. Then remove the chart. Replace with a new chart. Release the pen holder, swing the arm back in place and gently tighten the center knob. (**Do not over tighten the knob.)**

Check the Roto-Wedge door.

a. Remove any debris from the wedges and gasket.
b. Lubricate the face of the wedges with high temperature grease.
c. Lubricate hinges and bearings, grease fittings are provided on the hinge and bearing housings.
d. Lubricate the gasket. Wipe off the gasket and the door with a clean rag to remove any debris. Spray a thin layer of high temperature Teflon based lubricant such as "Tri-Flow" on the gasket.
e. Check hydraulic hose fittings for damage and tighten the fittings if required.
f. The exterior of the sterilizer is thoroughly cleaned, primed and painted with a premium coating; however, rust may develop in certain areas due to the high moisture environment and frequent washing. Minor rust may develop due to scratches or other breaks in the coating. When rust develops, thoroughly dry the area, wire brush to remove any loose coating, and apply a recommended primer.

Primed areas can then be touched up with finish coating. Check hydraulic oil level and top off with approved hydraulic oil if necessary.

Monthly:

Perform biological indicator test monthly to confirm the attainment of adequate sterilization conditions.

Yearly:
Even though the hydraulic system is used on a limited basis (only when opening and closing the door), it is recommended that the hydraulic fluid be drained and replaced annually.

Thermometers are checked annually for calibration and records of the calibration checks are maintained as part of the maintenance files and records for a period of three years.

PROCEDURE/COMPACTOR:
Prior to performing any maintenance on the compactor or power unit, shut off the power at the disconnect switch and lock this switch in the "off" position. See power lockout procedure on page 3. Do not service the machine if it is possible for someone to start the machine while it is being serviced.

The self-contained compactor has grease zerts on the four cylinder pins, the four container wheels, and the container door hinges. These zerts must be greased monthly or more often depending on usage. Grease the cylinder pins until grease can be seen between the pin and pin plate.

Take the rear cover off the compactor, check for trash build up in the cylinder area, and clean when necessary.

The power units use a permanent type oil filter which may be reused after each cleaning. To keep down time at a minimum while cleaning the dirty filter, replace it with a spare clean filter. The dirty filter may then be cleaned as follows:

a. Soak the filter in kerosene or other solvent to loosen the contaminant.
b. Lightly scrub the filter with a soft bristle paint brush. **DO NOT USE A WIRE BRUSH.**
c. Remove embedded contaminants with clean, dry shop air. Direct the flow of air against the side of the filter with a perforated support.
d. Again, wash the filter in a solvent and blow with shop air, then inspect for damage. Holes in the filter cloth will leak dirt into the pump and valve which may cause malfunctions in the hydraulic system.

See chart below for recommended filter change frequency.
USAGE FILTER CHANGE OR CLEAN FREQUENCY

USAGE	FILTER CHANGE OR CLEAN FREQUENCY
Heavy: 6 hrs. per day	Initial change after 2 weeks, thereafter every 3 months
Medium: 2-6 hrs. per day	Initial change after 3 weeks, thereafter every 6 months
Light: up to 2 hrs. per day	Initial change after 4 weeks, thereafter every 12 months

INITIAL MAINTENANCE CHECK PROCEDURE:

1. The first maintenance check should take place with the first filter change and include the following:
    a. Check and tighten all electrical and hydraulic connections on the power unit, control head, and cylinder.
    b. Check and tighten all mechanical fasteners, nuts, bolts, set screws, etc.
    c. Drain some hydraulic fluid from the bottom of the reservoir by removing the ¾" plug from the half coupling under the oil level gauge. Inspect the fluid for the presence of water. Drain all water.
    d. Check the wear guide shoes, or Nylatron guide blocks, located on the rear of the ram, for looseness and unreasonable wear. Call a factory authorized representative if wear seems excessive or uneven.

Under normal conditions the fluid can be used for an indefinite time. If you suspect that the fluid has been contaminated or has otherwise lost its usefulness, drain off some of the fluid, take it to an oil distributor and have it analyzed.

The bottom of the reservoir should be inspected every 12 to 18 months for sludge deposits. If there is a detectable layer of sludge, the reservoir should be drained, flushed with kerosene or another suitable solvent, and then refilled with clean hydraulic fluid. Recommended oil may be used for all but extremely cold temperatures. An immersion oil heater is recommended for an area where temperatures are expected to frequently reach 0 degrees F or below.

Note: All records pertaining to onsite treatment shall be maintained for a period of not less than three years.

PROCEDURE/STERILIZER:

1. Put on Personal Protective Clothing, (i.e. gloves, eye protection, cover gown.) Any questions
regarding P.P.C. refer to your Infection Control Manual.
2. Safety door latch: Place handle in the open position.
3. Push **door open** button on control panel.
4. Lower loading ramp and remove sterilizer cart, place liner into sterilizer cart, and cut a few
holes in the liner to allow moisture to escape.
5. Push cart to Infectious Waste Bin and begin placing Red Bags and Sharp containers into the
cart, (this should be about 15-20 bags) do not load bags too high in the cart as the load should
be able to be placed into the sterilizer without any bags touching the inside of the vessel, using autoclave tape, tape the bag shut as much as possible. (does not require a tight seal.)
6. Close sterilizer door, push **door close** button on the control panel, place safety T handle into
the locked position.
7. Visually look around the sterilizer, steam lines, water lines, and drains, making sure these
areas are clear.
8. Turn water valve on.
9. Push **cycle start** button.
10. Check to assure sterilizer read out time is set for 45 minutes.
11. Cycle light on control panel will go off when load is done.
12. It is recommended to let vessel temperature drop to approximately 200 degrees before opening the door.
13. Be sure to put on welding gloves before opening door and unloading the cart, as the load will
be **hot**.
14. Before placing sterilized waste into compactor, be sure the chart on the control panel indicated 275 degrees' temperature for 45 minutes was achieved and the autoclave tape has turned brown. If the chart does not read 275 or the tape has not change color, re-run the load. If the second load fails, mark the load as not sterile, remedy the problem with the equipment and re-run the load.
15. Put cart on Compactor ram and dump the sterilized waste into the compactor (see procedure
for compactor.)
16. Place cart back into sterilizer; close the door, push **door closed** button until door locks, turn
water valve off.

PROCEDURE/COMPACTOR:

1. Assure that compactor ram is in the retracted position.
2. Place dumping container in dumper and secure.
3. Pull red "**Emergency Stop**" button to outer most position.

4. Set Compactor / Dumper switch to Dumper.
5. **Turn and hold** keyed "Start" switch to start position. (deadman operation) The dumper **will not** function unless the keyed switch is held in the start position.
6. Turn "**Up/Down**" switch to "**UP**" until dumper stops at the end of the dumper stroke.
7. When all refuse has emptied from container, turn and hold "**Up/Down**" switch to the "**Down**" position until dumper comes to rest in starting position and release key.
8. After the above process has been completed, set the "**Compactor/dumper**" switch to "**Compactor**".
9.. Assure that the red "**Emergency Stop**" button is pulled out to the outer most position.
10. Turn the "**Keyed Start**" switch to "**Start**" and release.

The compactor will cycle the pre-determined number of cycles and shut off automatically.
The process is now complete and ready to be repeated.

Caution: Make sure all personnel are clear of dumper before operation.
Make sure that all safety gates are closed and all inter-lock switches are functioning properly.
Do not switch to dumper operation until compactor has completed cycling and power unit shuts down.

Note: All records pertaining to onsite treatment shall be maintained for a period of not less than three years.

CLOSURE PLAN:

Should NIHD ever experience a termination of this treatment facility, we would have to hire an out of the area vendor to haul away our Medical Waste. The treatment facility would then be disassembled and disposed of properly.

TABLE 1: WASTE ITEMS AND APPROPRIATE DISPOSAL CONTAINERS

	DESIGNATED CONTAINER			
WASTE ITEM	**Sharps Box**	**Red Bag**	**Regular Bag**	**Other Designated Containers**
Needles/syringes	**X**			
Lancets	**X**			
Any other sharps	**X**			
Lab and microbiology used specimen tubes or media plates	**X**			
Broken glass	**X**			
Gloves, gowns, masks (dripping with blood)		**X**		

Any Dressings or Chucks (saturated with blood or other drainage)		**X**		
Foley catheters/bags with blood		**X**		
Any drainage receptacle with large amount of blood		**X**		
Any drainage tubes with large amount of blood		**X**		
Blood bags		**X**		
Peripads or tampons		**X**	**X**	
IV lines and bags (with blood)		**X**		
IV catheters			**X**	
IV lines and bags (no blood)			**X**	
Bedpans, urinals, emesis basins			**X**	
Ventilator tubing			**X**	
Foley catheters and bags			**X**	
Any dressings or chucks (minimal blood)			**X**	
Diapers			**X**	
ET tubes and suction catheters/Ng tubes			**X**	
Gloves, gowns, aprons, masks (no blood or slightly stained with blood)			**X**	
Tissues and paper towels			**X**	
Guiac and Gastro-occult cards			**X**	
Chemotherapy items Trace				**Yellow rigid container: chemo bucket**
Pharmaceutical Waste: Hazardous Drugs and Bulk Chemotherapy				**Black Bin**
Pharmaceutical Waste: General				**Blue and White Container**
Pharmaceutical Waste: Controlled Substance				**Opaque Green Bin**

Note: The general pharmaceutical waste, trace chemotherapy waste, and controlled substance will be picked up by a medical waste transporter vendor to be incinerated. These items will
be stored in EVS storage room until packaged and mailed out. When packaged the waste containers will be sent to Purchasing to be officially mailed out.

REFERENCES:

1. Association for Professionals in Infection Control and Epidemiology (APIC). (2023). Waste Management. Retrieved from https://text.apic.org/toc/infection-prevention-for-support-services-and-the-care-environment/waste-management#book_section_683912. California
2. Department of Public Health (2017). Medical Waste Management Plan Checklist. Retrieved from https://www.cdph.ca.gov/CDPH%20Document%20Library/ControlledForms/cdph8661.pdf
3. California Department of Public Health. (2022). Medical Waste Management Program. Retrieved from https://www.cdph.ca.gov/Programs/CEH/DRSEM/Pages/EMB/MedicalWaste/MedicalWaste.aspx
4. Occupational Safety & Health Administration) (accessed 11/6/2023). Standard Number 1910.1030 Feminine Products. Retrieved from https://www.osha.gov/laws-regs/standardinterpretations/1992-06-01

CROSS REFERENCE P&P:

1. Bloodborne Pathogen Exposure Control Plan
2. Hazardous Materials & Waste Management Plan
3. Hazardous Materials & Waste Inventory EC.02.02.01EP1
4. Opioids Waste Policy
5. Safe Handling and Disposal of Occupationally Hazardous Drugs and Environmentally Hazardous Drugs
6. Hazardous Materials & Waste Management Plan
7. Lippincott Procedures Personal Protective equipment (PPE), putting on
8 Lippincott Procedures Personal Protective equipment (PPE), removal
9. Hazardous Spill & Exposure EC.02.02.01EP3-4
10 Reporting Hazardous Materials & Waste Incident EC.04.01.01EP8
11. Management of Hazardous Chemicals EC.02.02.01EP5
12. Labeling Hazardous Material &Waste EC.02.02.01EP12
13. Hazardous Materials & Waste Management Plan
14. Formaldehyde EC.02.02.01EP9
15. Disposal of Radioactive Waste. Diagnostic Imaging - Radioactive Waste Storage and Disposal
16. Diagnostic Imaging - Disposal of radioactive sharps
17. InQuiseek – Medical Waste Handling and Disposal

Supersedes: v.2 MEDICAL WASTE MANAGEMENT PLAN

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Receiving Process		
Owner: Director of Purchasing	Department: Purchasing	
Scope: Purchasing Department		
Date Last Modified: 12/08/2022	Last Review Date: 07/08/2025	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 01/09/2015	

PURPOSE:
This policy outlines procedures for receiving most normal deliveries. See individual procedures for damaged goods, capital equipment, refrigerated items, hazardous materials, flowers, and after hour's deliveries.

POLICY:
Receiving will ensure that goods delivered to the institution are as ordered and undamaged. Receiving will document receipt of orders and ensure items are delivered internally.

PROCEDURE:

A. Unless otherwise noted on the purchase order, acceptance by the Receiving department completes the purchasing transaction and commits the hospital to payment. In cases where formal acceptance is delayed (usually for capital purchases), acceptance by the Receiving department still creates a bailment responsibility for items.
B. Except as otherwise noted or as outlined in supplements to this policy, all goods will be delivered to the receiving area and received by members of the Purchasing department. No receipt will be accepted by others or at times other than the established receiving times unless prior arrangements have been made by the Purchasing department.
    1. Pharmaceutical items will be delivered directly to the Pharmacy and be received by Pharmacy personnel.
    2. Food items will be delivered directly to Food Service and be received by Food Service personnel.
    3. Some engineering items will be delivered directly to the Engineering department; these items will be checked by Engineering personnel.
    4. Certain other supplies will be delivered directly to departments through various "stockless" programs. Receipt of these goods will be as established in the individual program.
C. It is the responsibility of the carrier to unload individual items from the truck into the Receiving department. Pallets will be unloaded by Receiving or Purchasing personnel and delivered to the Receiving department. Before signing to accept, the receiver will verify that all goods are the property of the hospital, that all packages and containers are free of signs of damage or contamination, and that the bill of lading agrees with the package count.
    1. After verification, the receiver will sign the bill of lading and accept the goods.
    2. In the event that the receiver is not given ample opportunity to ensure that all the goods are, in fact, property of the hospital and as noted on the bill of lading, the receiver shall make note of such on the shipper's receiving document. This comment might be, "signing for numbers of

packages only," for a UPS shipment or, "signing for numbers of pallets only," for a prime vendor shipment.

3. If there is apparent damage or contamination this fact will be noted on the shipper's receiving document. If the damage appears extensive, the Purchasing department should be notified immediately and a decision made whether to accept or refuse. See policy on receiving damaged goods.

D. Receiving documentation will normally start with the packing list.
   1. The packing list should be located and opened. The purchase order number should appear on this slip. If no purchase order number can be found, the purchase order number may be found by searching the MMIS. Alternately, contact Purchasing. If a purchase order cannot be found, the goods will be put into the holding area awaiting instructions from Purchasing.
   2. Once the purchase order has been identified, the actual goods present will be compared to those listed on the packing list. Any discrepancies including concealed damage will be noted on the packing slip.
   3. After the goods have been verified, the receipt information will be entered from the packing list into the MMIS. Any items received that are not on the purchase order or are in quantities larger than listed on the purchase order will be segregated. These over shipments will not be received but will be noted, along with other discrepancies, as in 2 above, in the comments section of the receiving screen.
   4. All discrepancies and/or over shipments will be reported to Purchasing.
   5. A receiving document will be generated for each department and/or inventory getting goods from the shipment. This document will accompany the goods to the ordering department.

E. The NIH Shipping/receiving system is reserved exclusively for hospital business. Employees and Medical Staff are not to receive/ship packages (i.e. "catalog orders, boxes, mailers etc.") of a personal nature through the Purchasing department. If the Purchasing Department receives a package via a carrier such as UPS, FedEx etc. of a personal nature, it will be handled in the following way:
   1. Addressee will be notified by email that a personal package has been received, and cannot be processed by the hospital.
   2. Package will be placed in a holding area.
   3. Addressee will be contacted, educated on the appropriate procedure for receiving personal property, and directed where to pick up the package. Failure to pick up the package will result in its return to shipper.

REFERENCES: N/A

RECORD RETENTION AND DESTRUCTION:
Maintain packing slips, bill of laden, other shipping documents and invoices for six (6) years.

CROSS REFERENCE POLICIES AND PROCEDURES:
1. Diagnostic Imaging – Radioactive Materials Delivery After-hours Policy/Procedure

Supersedes: v.2 Receiving Process

NORTHERN INYO HEALTHCARE DISTRICT
LABORATORY SERVICES DEPARTMENT
STANDARD OPERATING PROCEDURE

SOP #: HEM 017-2025		
Title: Spurious Cell Counts and Sample Interferences Workflow		
Owner: HEMATOLOGY LEAD		Department: Lab- Hematology
Scope: Laboratory Services Department		
Date Last Modified: 06/03/2025	Last Review Date: No Review Date	Version: 1
Final Approval by: Medical Director of Lab & Medical Executive Team		Original Approval Date:

I. PURPOSE:

The following procedures provide Clinical Laboratory Scientists (CLS) workflows for determining the appropriate response to sample abnormalities flagged on the automated hematology analyzer. These abnormalities range from high/low leukocyte counts, agglutination, turbidity, hemolysis etc.

II. BACKGROUND:

When CBC results are flagged with a positive result, it can mean many different things. Certain flags require a smear review and other flags require appropriate treatment of the sample. The first thing to be considered when encountering an abnormal flag is whether the CBC sample is compromised or not. In many cases, it is most appropriate to have a patient sample redrawn (i.e. clotting, excessive platelet clumping, or sample contamination). It may also be appropriate at times to simply rerun a patient sample on the hematology analyzer. There are a number of situations where re-drawing or re-running a sample will not suffice and results must be determined through manipulation of the sample or compensating the results through mathematical calculation. For example, when RBC agglutination is of concern, MCHC (mean corpuscular hemoglobin concentration) is often the most telling, but all of the RBC indices could be affected at the same time. Resolutions to this problem are pre-warming the sample, diluting the sample or performing a plasma replacement on the sample. Extreme cases of leukocytosis (>100K WBC) will raise the values of the red blood cells (RBC), the hemoglobin (HGB), and the hematocrit (HCT) as well. Other common causes of spurious CBC and reticulocyte results include: fragmented RBCs (schistocytes), microcytosis, erythroblasts, giant platelets, platelet aggregation, cryoglobulin, cryoprotein, malaria, sodium levels, glucose levels, and fibrin.

III. SPECIMEN REQUIREMENTS:

See SOP #: HEM-012 Sysmex XN-550 Automated Hematology Analyzer

IV. PROCEDURE:

1. Suspect Samples that need to be re-drawn
    a. Clotted samples or those containing clots, fibrin strands, or moderate to many platelet clumps.
    b. Grossly hemolyzed samples.
    c. Samples that are >24 hours old.

d. Samples drawn above an intravenous line or have become diluted or contaminated in any way.

2. Samples that need to be re-run on analyzer
   a. Any sample with a "*" or "—" in place of a numerical value on the report should be mixed thoroughly by hand before re-running.
   b. Samples with a thrombocytopenia flag after they have been checked for clots and vortexed for 60 seconds.
   c. Samples that result with "WBC abnormal scatter gram."
3. Performing a dilution
   a. Specimen reports with "@" next to a parameter are exceeding the reportable range and need to be diluted.
   b. Use Cellpack DCL diluent from container in cabinet to the right of the coagulation instruments. Saline from the Transfusion Services/Blood Bank may be used if no DCL is available.
   c. Find an Empty sample tube with a cap.
   d. Perform a 1:5 dilution using a pipette.
      -*Example*: (100 µL sample) + (400 µL DCL)
   e. Mix sample, then run on analyzer in manual mode.
   f. Correct results for dilution factor prior to reporting.
4. Performing a dilution with a microtainer

   -*Note:* using a microtainer for dilution is very useful when a very small amount of sample is submitted for testing. 20 µL of sample is the minimum amount required to use for this test method.
   a. Find a red top microtainer tube in the drawer below the primary hematology analyzer.
   b. Make sure analyzer is in manual analysis mode.
   c. Wait for instrument to enter ready state.
   d. Touch "mode" on the control menu.
   e. Select the radio button next to "Pre-dilution". Then touch "OK".
   f. Touch "Manual" on the right edge of the control menu.
   g. Touch "Dispense".
   h. Remove cap from the micro collection tube.
   i. Place the empty micro collection tube in the front position of the sample tube holder.
   j. Press the start switch. The sample will enter the analyzer and come back out with 120 µL of diluent.
   k. Touch "Cancel", the diluent dispensing function finishes and the instrument enters the analysis ready state.
   l. Dispense 20 µL of sample into the micro collection tube containing the diluent.
   m. Cap the tube and mix sample in micro collection tube.
   n. While remaining in the manual mode entry screen: scan barcode of sample, place the micro collection tube in the micro collection tube holder section of the sample tube holder and click "OK" (Analyzer should still be in "Pre-dilution" mode).
   o. Press the start switch next to the sample tube holder.
   p. The sample will run and the instrument will automatically correct all values for its report.
   q. It is important to know the distinction between a red top microtainer and EDTA raised bottom tube.

Red top microtainer

Raised bottom EDTA tube

5. Performing a plasma replacement
    a. Centrifuge an **aliquot** of blood from the primary tube to separate the cells from the plasma.
    b. Mark a line on the sample at the meniscus of the plasma and then remove plasma to the buffy coat. Refill to the line with DCL.
    c. Cap the tube and mix the sample by manual inversion until the cells are fully re-suspended in the Cellpack DCL
    d. Re-analyze the sample in manual mode.
    -*Note:* Warm DCL may be used for cold antibodies and room temperature DCL may be used for warm antibodies.
6. Samples with high WBC (>100 x 10^3 WBC/µL)
    a. Correct RBC Count
        - Subtract WBC (x10^3/µL) from RBC (x10^6/µL)

    -*Example:*

    Corrected RBC (cRBC) = RBC (5.1 x 10^6) – WBC (100 x 10^3) = 5.0 x 10^6 RBC/µL

    b. Correct Hemoglobin
        i. Follow procedure for dilution in IV.3.a. through e.
        ii. Hemoglobin value obtained from diluted specimen should be resulted.
7. Samples with low WBC counts
    a. Place the analyzer in manual mode.
    b. Touch "mode" on the control menu.
    c. Select the radio button next to "Low WBC". Then touch "OK"
    d. Touch then manual button on the right side of the screen. Enter accession number then select "OK"
    e. Press the start switch next to the sample tube holder.
    f. The sample will run with twice the count time of a normal whole blood sample.
    g. Prepare a slide from the sample for smear review.
    h. If absolute white count is less 0.6 x10^3/µL enter comment: "Absolute white count too low to perform manual differential."
8. Samples with "—" instead of report values
    a. Dashes (--) may appear in place of data on a report for several reasons.
        i. Repeat the sample after mixing by hand.
        ii. Perform manual differential if necessary.
    a. If dashes (--) are found on report for WBCs, then follow the workflow in section IV. 7 of HEM-013 Hematology Slide Review Work Flow, Criteria and Procedures WBC counts may only need to be confirmed with this method if an "*" is present.

b. If dashes are found on a report for platelets, then follow the workflow in section IV. 6 of HEM-013 Hematology Slide Review Work Flow, Criteria and Procedures .Platelet counts may only need to be confirmed with this method if an "*" is present.

9. Suspect RBC agglutination
   a. When RBC agglutination is present: an asterisk (*) may appear next to RBC, HCT or RBC indices on a hematology instrument report, the MCHC result may be >37.5 g/dL and a RBC agglutination flag may appear on the report.
   b. Check the sample for visible signs of agglutination.
   c. If agglutinated RBC are present then warm the sample at 37ºC for 15-30 minutes in the heating block located in the microbiology department. Mix the sample at least 10 times and promptly re-run the sample in manual mode on the analyzer.
   d. Some sample issues may not resolve from heating sample. If problem persists then make a slide with the warmed sample and view microscopically. Some situations such as, hereditary spherocytosis, various hemoglobin disorders and some rare RBC disorders may be responsible for the higher MCHC values.
   e. Using a plasma replacement procedure with DCL or saline may also help with unresolved agglutination issues.
      i. See section IV.5 for detailed instructions
      ii. Warm sample for 15-30 minutes after performing plasma replacement and before re-running on the analyzer.
   f. See Enclosure (2) for troubleshooting guide.
10. RBC turbidity/Hemoglobin interference

    Note: Samples with cold agglutinins, icteric or lipemic plasma, electrolytic imbalances or markedly high glucose may interfere with RBC, HGB or HCT measurement.
    a. Low Sodium
       i. Perform a 1:5 dilution of sample with CELLPACK DCL.
       ii. Allow the dilution to equilibrate 10-15 minutes.
       iii. Rerun after equilibration.
       iv. Correct results for dilution factor prior to reporting.
       v. MCV, MCH , MCHC, RDW-SD, RDW-CV, MPV, Ret-He IRF and differential percent results are unaffected by dilution and do not require correction.
    b. Severe Lipemia, Icterus, Abnormal Protein or Leukocytosis Affecting Hemoglobin Measurement or Hemolysis
       i. Perform a 1:5 dilution of sample with CELLPACK DCL.
       ii. Repeat diluted sample.
       iii. Correct results for dilution prior to reporting.
       iv. Perform a plasma replacement procedure for Lipemic or Icteric samples.
       v. Recollect severely hemolyzed specimens.
    c. See Enclosure (1) for troubleshooting guide.
11. Presence of *'s near Hemagram values
    a. An asterisk (*) next to RBC,PLT, HCT, MCH, MCHC or MCV results indicates that the results may be unreliable.
    b. Make a peripheral blood smear.
    c. Evaluate the smear using the guidelines in HEM-013Hematology Slide Review Work Flow, Criteria and Procedures.
    d. Circumstances that may cause *'s:
       i. Increased anisocytosis
       ii. Multiple RBC populations
       iii. Fragmented RBCs

iv. Poikilocytosis
v. Rouleaux or RBC agglutination (refer to Section IV. 9 for details on this workup)

12. Presence of RBC fragments
    a. The presence of fragmented RBCs in the sample may throw the "Fragments" flag.
    b. RBC fragments may be due to schistocytes or poikilocytosis.
    c. Make a peripheral blood smear.
    d. Evaluate the smear using the guidelines in HEM 013-2022 Hematology Slide Review Work Flow, Criteria and Procedures.
13. Presence of nucleated RBC
    a. If nucleated RBCs (NRBC) are present then a flag may appear on a sample report
    b. Make a smear and scan to see if there are NRBC on the smear.
    c. Perform a manual differential if necessary
    d. If >10 NRBC are seen per 100 WBC are counted, then a corrected WBC result needs to be calculated.
       -*Example:*
       Corrected WBC(x 10^3/µL) = (WBC x 100)/(NRBC + 100)
    e. Adjust absolute differential calculations as necessary.
    f. If no abnormalities are found when reviewing the smear, then results with asterisks may be reported.
14. Abnormal RET scattergram
    a. An asterisk may appear next to the Reticulocyte % when the instrument believes that the results are unreliable.
    b. Prepare a 1:5 dilution with CELLPACK DCL
    c. Run the sample in manual mode (not pre-dilute mode). Do not use dilutions greater than 1:5
    d. Check for errors in the dilution to make sure that it matches the original RBC count. Also check that the RBC value is not $<0.50 \times 10^6/\mu L$, if it is then make a lower dilution of the sample.
    e. If the RET flag is resolved, multiply the reticulocyte count by the dilution factor and correct the results
    f. If the flag is not eliminated:
        i. Review the peripheral smear for polychromasia, parasites, NRBCs, Howell-Jolly bodies or basophilic stippling. If present then report with a result comment. "Results may be affected by interfering substances."
        ii. Send the sample out to LabCorp for reticulocyte testing by another method.
12. Platelet interferences
    a. Platelet clumps flag
        i. Refer to section IV. 5 of HEM 013-2022 Hematology Slide Review Work Flow, Criteria and Procedures for general platelet clumping.
        ii. Refer to HEM 016-2023 EDTA-dependent pseudothrombocytopenia for how to work up patients with this specific condition.
    b. Abnormal platelet distribution
        i. Make a smear to examine for any possible causes of abnormal platelet distribution. These may include:
        - Large or giant platelets
        - Small platelets
        - Platelet clumps
        - Fragmented RBCs
        - Microcytic RBCs
        - Parasites

ii. Report abnormal morphological findings by ordering a ".Morphology (NIHD)" on the CBC and then go on to follow the guidelines from HEM-013 Hematology Slide Review Work Flow Criteria and procedures.
iii. If no abnormalities are found on the smear, then results from analyzer containing an (*) may be resulted.

c. Mean Platelet Volume (MPV) results with "- -" (dashes)
MPV tests may be resulted with dashes as long as samples have been checked for clots, remixed and re-ran on the analyzer.

V. RESULTS REPORTING:

1. Results that cannot be measured or calculated
   a. Change Cerner dropdown for result to "See Comment"
   b. Free write a result comment on proper field that explains
2. Calculations performed manually
   a. Show math for all manual calculations on sample printout.
   b. Have a second CLS check calculations, initial and date next to work.
   c. Store sample printout in banker's box in hematology department.

VI. LIMITATIONS:

1. Unsatisfactory specimens- In rare cases specimens may have unsatisfactory characteristics and run on the hematology analyzer without being flagged.
2. Manual dilutions- Manual dilutions are prone to human error.
3. Reportable ranges- See HEM-012 Sysmex XN-550 Automated Hematology Analyzer for reportable ranges.

VII. EQUIPMENT:

1. Sysmex XN-550 hematology analyzer
2. Microscope
3. Vortex
4. BD Microtainer Z (no additive/red top tubes)
5. EDTA tubes
6. Cellpack DCL
7. 12 X 75 mm Culture Tubes
8. Transfer pipette
9. MLA pipette
10. Superfrost slides
11. Wooden sticks

Commented [HP1]: Trying to make equipment less specific so we don't have to update when things change

Commented [MJ2R1]: Ok

VIII. QUALITY CONTROL PERFORMANCE:

Quality control is performed according to HEM-012Sysmex XN-550 Automated Hematology Analyzer § VIII.

IX. REFERENCES:

1. Sysmex America, Inc. Sysmex XN-L Series flagging interpretation guide, February 2019.
2. XN-550/XN-450/XN-350 General Information Instructions for Use (North America Edition), 2017

X. DISTRIBUTION:

1. Hematology Section

Supersedes: Not Set

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure - Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Nurse Practitioner, Certified Nurse Midwife		
Date Last Modified: 09/21/2023	Last Review Date: 08/06/2025	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/20/2019	

PURPOSE:
This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to cover the management of drugs and devices for patients of all ages

POLICY:
1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.
3. The NP or CNM may initiate, alter, discontinue, and renew medication included on, but not limited to the formulary referenced in Appendix A. Schedule I medications are excluded. NPs and CNMs will be required to have a current "Furnishing Number" which has been obtained from the Board of Registered Nursing. All NP & CNM providers will be required to have a DEA certificate and will prescribe within the constraints of this certification.

PROCEDURE:
1. Database – Nursing Practice
    a. Subjective data information will include but is not limited to: Relevant health history to warrant the use of the drug or device, no allergic history specific to the drug or device, and no personal and/or family history which is an absolute contraindication to use the drug or device.
    b. Objective data information will include but is not limited to: Physical examination appropriate to warrant the use of the drug or device and laboratory tests or procedures to indicate/contraindicate use of drug or device if necessary.
    c. Assessment: Subjective and objective information consistent for the use of the drug or device. No absolute contraindications of the use of the drug or device.
2. Treatment – Common Nursing Functions
    a. Medications/devices furnished by the NP or CNM may be either over-the-counter or medications/devices requiring a prescription.
    b. Medications/devices may be furnished directly to the patient, or the patient's direct care giver, by the NP or CNM (section 2725.1 of the NPA).

c. Medications may be furnished by transmittal. The NP or CNM may write and sign "transmittal orders" of any prescription personally stated or written by the physician. This is in accordance with the Pharmacy Law, Business and Professions Code, Section 34021

d. Office samples may be dispensed per NIHD policy.
e. The drug or device will be appropriate to the condition being treated:
    i. Dosage will be in the effective range per formulary references
    ii. Not to exceed upper limit dosage per formulary references.
    iii. Indications or uses as specified by the formulary references.
    iv. No absolute contraindications of the use of the drug or device.

f. Medication history has been obtained including other medications being taken, medication allergies, and prior medications used for current condition.
g. All medications/devices furnished shall be documented in the patient's medical record. The effectiveness of the medication/device shall be documented in the patient's medical record.

3. Patient Education
    a. Provide the patient with information and counseling in regard to the drug or device. Caution the patient regarding potential side effects or complications with chosen drug or device. Document the education process in the medical record.
4. Physician consultation is to be obtained under the following circumstances:

    a. Non-responsiveness to appropriate therapy and/or unusual or unexpected side effects and as indicated in general policy statement.
    b. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
    c. Acute decompensation of patient situation.
    d. Problem which is not resolving as anticipated.
    e. History, physical, or lab finding inconsistent with the clinical picture.
    f. Upon request of patient, nurse, or supervising physician.

5. Documentation
    a. A current drug list will be maintained in the patient's record. All medications furnished, changes in medications, and renewals will be documented on this list.
    b. The name and furnishing number of the NP or CNM is written on the transmittal order.

REFERENCES:

1. UpToDate-evidence-based, Physician-authorized clinical decision support resource
2. (2021) Title 16, California Code of Regulations, Section 1474. Standardized Procedure Guidelines.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years.

Supersedes: v.3 Standardized Procedure - Furnishing Medications/Devices Policy for the Nurse Practitioner or Certified Nurse Midwife

APPENDIX A:

FORMULARY SPECIFICATIONS for

Furnishing Medications/Devices Policy for the Nurse Practitioner/Physician Assistant

STANDARDIZED PROCEDURE/PROTOCOL

Formulary: Lexicomp drug database as accessed through UpToDate online reference, current as published and updated online.

Deletions: None.

APPROVALS

Chair, Interdisciplinary Practice Committee	Date
Administrator	Date
Chief of Staff	Date
Chair, Board of Directors	Date

ATTACHMENT 1 – LIST OF AUTHORIZED NP's or CNM's

1. _____ _____
   NAME DATE

2. _____ _____
   NAME DATE

3. _____ _____
   NAME DATE

4. _____ _____
   NAME DATE

5. _____ _____
   NAME DATE

6. _____ _____
   NAME DATE

7. _____ _____
   NAME DATE

8. _____ _____
   NAME DATE

9. _____ _____
   NAME DATE

10. _____ _____
    NAME DATE

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure – Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Nurse Practitioner, Certified Nurse Midwife		
Date Last Modified: 09/21/2023	Last Review Date: 08/06/2025	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/20/2019	

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines for the ordering of laboratory and diagnostic tests.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. Laboratory and diagnostic tests may be ordered by the NP or CNM under the following conditions:
    a. As an appropriate adjunct to the determination of diagnosis.
    b. When necessary, to implement, monitor or adjust treatment.
3. Circumstances:
    a. Patient population: neonatal, pediatric, adult and geriatric patients – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROCEDURE:

1. Conditions
    a. The following diagnostic tests can be initiated by the NP or CNM without prior consultation with M.D.:
        i. Any blood work
        ii. Urine: any urine test
        iii. Cultures: any culture
        iv. Radiologic/Sonographic: any radiologic/sonographic exam including CT scans and MRI examinations
        v. Audiometric testing/speech evaluation
        vi. Pregnancy Tests
        vii. Cardiac Testing
    b. All other diagnostic tests will be ordered by the NP or CNM in consultation with the physician, including:
        i. When diagnostic test of choice is in doubt.

REFERENCES:

1. (2021) Title 16, California Code of Regulations, Section 1474. Standardized Procedure Guidelines.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.3 Standardized Procedure – Laboratory and Diagnostic Testing Policy for the Nurse Practitioner or Certified Nurse Midwife

APPROVALS

_____ _____

Chair, Interdisciplinary Practice Committee Date

_____ _____

Administrator Date

_____ _____

Chief of Staff Date

_____ _____

Chair, Board of Directors Date

ATTACHMENT 1 – LIST OF AUTHORIZED NP's or CNM's

1. _____ _____
   NAME DATE

2. _____ _____
   NAME DATE

3. _____ _____
   NAME DATE

4. _____ _____
   NAME DATE

5. _____ _____
   NAME DATE

6. _____ _____
   NAME DATE

7. _____ _____
   NAME DATE

8. _____ _____
   NAME DATE

9. _____ _____
   NAME DATE

10. _____ _____
    NAME DATE

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure – Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Nurse Practitioner, Certified Nurse Midwife		
Date Last Modified: 09/21/2023	Last Review Date: 08/06/2025	Version: 4
Final Approval by: NIHD Board of Directors	Original Approval Date: 06/20/2018	

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines that will allow the NP or CNM to medically manage acute illness and conditions.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. This standardized procedure covers the medical management of acute illness, allergies, symptomatic complaints, minor trauma and emergencies in children and adults in the ambulatory care setting.
3. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations.
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROCEDURE:

1. Data Base
    a. Subjective:
        i. Historical information relevant to the acute illness.
        ii. Historical information regarding concurrent problems.
        iii. Historical information regarding relevant past medical problems.
        iv. Patient's/family's efforts to treat the illness/condition.
        v. History of allergic/adverse reactions to medications.
        vi. Status of patient's functional and instrumental abilities.
    b. Objective:
        i. Perform physical exam pertinent to presenting symptoms.
        ii. Evaluate severity of complaint (i.e., vital sign changes, level of consciousness, unusual or unexpected symptoms).
        iii. Order laboratory testing and diagnostic procedure as indicated.
    c. Assessment
        i. Diagnosis consistent with subjective and objective findings.
        ii. Record data on appropriate areas on patient's chart.

d. Plan
    i. Medications as indicated (see *Furnishing of Medications/Devices Standardized Procedure*).
    ii. Order further diagnostic testing as indicated.
    iii. Patient education appropriate to acute illness and any procedures, diagnostic testing, or medications ordered.
    iv. Order/perform therapeutic procedures as appropriate.
    v. Order medical supplies and necessary equipment for treatment.
    vi. Consult with and/or refer to supervising M.D. for:
        1. Presence of unexpected or ambiguous historical, physical or diagnostic findings.
            a. Signs of sepsis/toxic patient.
            b. Alteration in level of consciousness (i.e., seizure, etc.).
            c. Emergency situations which may be life threatening.
            d. Any patient whose condition warrants hospitalization.
            e. Unresolving problems.
            f. Any needs of the NP or CNM requiring information/confirmation of management plans.
            g. Upon request of patient/family.
    vii. Refer as indicated to other services/specialties.
    viii. Follow-up as indicated.

REFERENCES:

1. (2021) Title 16, California Code of Regulations, Section 1474. Standardized Procedure Guidelines.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years.

Supersedes: v.3 Standardized Procedure – Management of Acute Illness Policy for the Nurse Practitioner or Certified Nurse Midwife

APPROVALS

_____ _____

Chair, Interdisciplinary Practice Committee Date

_____ _____

Administrator Date

_____ _____

Chief of Staff Date

_____ _____

Chair, Board of Directors Date

ATTACHMENT 1 – LIST OF AUTHORIZED NP's or CNM's

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

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROTOCOL

Title: Standardized Protocol – Management of Chronic Illness for the Physician Assistant		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Physician Assistants		
Date Last Modified: 01/02/2024	Last Review Date: 01/18/2024	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/20/2019	

PURPOSE:

1. This standardized protocol is designed to establish guidelines that will allow the Physician Assistant (PA) to manage chronic illnesses.

POLICY:

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

PROTOCOL:

1. Definition: this protocol covers the management of chronic illness in children and adults at NIHD and affiliated locations.
2. Data Base:
    a. Subjective:
        i. Pertinent history including symptoms related to the chronic illness.
        ii. Present state of chronic illness (patient's perception).
        iii. Historical information regarding relevant past medical problems.
        iv. Effects of chronic illness on activities of daily living, psychological, physical and financial status.
        v. Patient's attitude and behaviors regarding the chronic illness.
        vi. Patient's physical, social, financial support systems.
        vii. Documentation of complete history updated minimally on an annual basis.
    b. Objective:
        i. Complete pediatric Well Child Care (WCC) or adult Health Maintenance Exam (HME) annually.

ii. Physical assessment pertinent to chronic illness.
iii. Laboratory/diagnostic testing as indicated.

c. Assessment:
   i. Qualification/quantification of chronic illness status.
   ii. Record appropriately on patient chart.

d. Plan:
   i. Medications as indicated (see Practice Agreement)
   ii. Laboratory/diagnostic testing as indicated.
   iii. Patient education appropriate to chronic illness and any procedures, diagnostic testing, or medications ordered.
   iv. Order/perform therapeutic procedures as appropriate.
   v. Order medical supplies and necessary equipment for treatment.
   vi. Refer as indicated to other specialists/services/school programs.
   vii. Follow-up as indicated.

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

REFERENCES:

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

ATTACHMENTS:

1. List of Authorized Physician Assistants and Supervising Physicians

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years

Supersedes: v.2 Standardized Protocol – Management of Chronic Illness for the Physician Assistant

NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure – Management of Minor Trauma Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Nurse Practitioner, Certified Nurse Midwife		
Date Last Modified: 09/21/2023	Last Review Date: 08/06/2025	Version: 3
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/20/2019	

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines that will allow the NP or CNM to manage minor trauma.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. This standardized procedure is designed to establish guidelines that will allow NP and CNM to manage ambulatory clients presenting with minor traumatic injuries.
3. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROCEDURE:

1. Data Base
    a. Subjective:
        i. Obtain pertinent history related to the injury or traumatic event.
        ii. Collect appropriate information, including past medical history, review of systems, allergies, immunizations, and medications.
    b. Objective:
        i. Perform limited physical examinations pertinent to the injury, including any possible involved organ system.
        ii. Obtain appropriate evaluative studies, including but not limited to, lab work and x-rays (see *Laboratory and Diagnostic Testing Standardized Procedure*).
    c. Assessment
        i. Formulate a working diagnosis consistent with date base collected.
    d. Plan
        i. If indicated, develop or initiate a therapeutic regimen including, but not limited to, the following:
            1. Physician consultation prior to management as per policy statement or in the following cases:
                a. Any injury threatening to life or limb.

   b. Any laceration requiring complicated suture closure (see *Minor Surgical Procedures – Standardized Procedure*).
   c. Any fracture or injury requiring immobilization by full casting.
   d. Complicated or extensive burns.
   e. Injury that may involve litigation or compensation.
   f. Any case where surgical intervention may be needed.
2. Further diagnostic tests.
3. Skin/wound care appropriate to injury.
4. Apply or furnish appropriate medications and/or immunizations.
5. Refer to appropriate support services which may include Rehabilitative services.
6. Develop appropriate follow-up care plan to maximize healing and rehabilitation.
   a. Provide appropriate health education materials including, but not limited to, cast care and precautions, head trauma, suture care, and use of oral or topical medications.
   b. Schedule follow-up appointments as appropriate.
7. Update problem list.

REFERENCES:

1. (2021) Title 16, California Code of Regulations, Section 1474. Standardized Procedure Guidelines.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years.

Supersedes: v.2 Standardized Procedure – Management of Minor Trauma Policy for the Nurse Practitioner or Certified Nurse Midwife

APPROVALS

Chair, Interdisciplinary Practice Committee	Date
Administrator	Date
Chief of Staff	Date
Chair, Board of Directors	Date

ATTACHMENT 1 – LIST OF AUTHORIZED NP's or CNM's

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NORTHERN INYO HEALTHCARE DISTRICT
CLINICAL STANDARDIZED PROCEDURE

Title: Standardized Procedure – Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife		
Owner: Medical Staff Director	Department: Medical Staff	
Scope: Nurse Practitioner, Certified Nurse Midwife		
Date Last Modified: 08/06/2025	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 02/20/2019	

PURPOSE:

This standardized procedure developed for the use by the Nurse Practitioner (NP) and the Certified Nurse Midwife (CNM) is designed to establish guidelines that will allow the NP or CNM to manage minor surgical procedures.

POLICY:

1. This standardized procedure and those authorized to work through this standardized procedure will meet all guidelines as outlined in the *General Policy for the Nurse Practitioner or Certified Nurse Midwife.*
2. This standardized procedure is designed to establish guidelines that will allow NP and CNM to perform minor surgical procedures incidental to the provision of routine primary care to ambulatory patients presenting to the listed settings.
3. Circumstances:
    a. Patient population: neonates, pediatrics, adults and geriatrics – as appropriate for specialty.
    b. Settings: Northern Inyo Healthcare District (NIHD) and affiliated locations
    c. Supervision: Physicians indicated in the supervisory agreements for the NP or CNM.

PROCEDURE:

1. Conditions
    a. After appropriate training and experience (which includes a minimum of 5 proctored procedures each by a supervising physician), minor surgical procedures that can be performed by the NP or CNM without direct physician supervision include:
        i. Pessary placement
        ii. Electrocautery of external, non-malignant lesions, e.g. warts
        iii. Epidermal cyst removal
        iv. Incision and drainage of abscess (excluding peri-rectal abscesses)
        v. Suture laceration without nerve or tendon involvement
        vi. Mole removal (non-facial)
        vii. Punch or shave biopsy
        viii. Toe nail removal
        ix. Cryotherapy
        x. IUD insertion and removal
        xi. Excision of simple lesions

xii. Simple foreign body removal
xiii. Endometrial biopsy
xiv. Arthrocentesis/Steroid joint injection
xv. Excision of hemorrhoid thrombus
xvi. Nexplanon insertion/removal
xvii. Circumcision of newborn
xviii. Insertion of implantable loop recorder

2. Data Base
    a. Subjective
        i. Obtain pertinent history including involved organ system, injury, trauma, dermatology problems, etc.
        ii. Obtain information regarding review of system, risk taking behaviors, prior surgery, allergies, and immunizations.
    b. Objective
        i. Perform physical examination pertinent to assessment of the problem.
        ii. Collect appropriate diagnostic/radiological studies.
    c. Assessment
        i. Formulate diagnosis consistent with the above data base.
    d. Plan
        i. Develop therapeutic regimen
        ii. Provide informed consent. Utilize universal protocol "Time Out" prior to all invasive procedures.
        iii. Perform appropriate procedure utilizing standard aseptic technique.
        iv. Obtain additional diagnostic studies as indicated.
        v. Physician consultation/assistance in performing the procedure as per policy statement or above conditions.
        vi. Patient education and self-care techniques.
        vii. Development of appropriate follow-up care plan.
        viii. Update problem list.

REFERENCES:

1. (2021) Title 16, California Code of Regulations, Section 1474. Standardized Procedure Guidelines.

RECORD RETENTION AND DESTRUCTION:

1. Life of policy, plus 6 years.

Supersedes: v.4 Standardized Procedure – Minor Surgical Procedures Policy for the Nurse Practitioner or Certified Nurse Midwife

APPROVALS

_____	_____
Chair, Interdisciplinary Practice Committee	Date
_____	_____
Administrator	Date
_____	_____
Chief of Staff	Date
_____	_____
Chair, Board of Directors	Date

ATTACHMENT 1 – LIST OF AUTHORIZED NP's or CNM's

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NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

Title: Utilization of Personnel From Outside Agencies		
Owner: Interim CEO, COO, CNO	Department: Nursing Administration	
Scope: Nursing Department, Human Resources		
Date Last Modified: 06/10/2025	Last Review Date: No Review Date	Version: 2
Final Approval by: NIHD Board of Directors	Original Approval Date: 03/16/2016	

PURPOSE:
To delineate the process for providing additional nursing staff to cover open positions and temporary staff vacancies.

To outline the process for validating professional license and/or certificates, providing orientation to work environment, assessing competency and evaluating performance of personnel from outside agencies.

DEFINITIONS:
Traveler: A Registered Nurse (RN) hired through a Travel agency to work in a temporary nursing position.

Interim Contract: An experienced RN hired to provide interim management resources and skills for a specialized area usually from an outside agency.

POLICY:
1. Approval by Executive Team prior to hiring is required for RN Travelers and Interim Nursing Management positions.

2. Human Resources (HR) coordinates the hiring of personnel from outside agencies.

3. RN Traveler will attend general District orientation and complete general nursing orientation and nursing department specific orientation.

4. Personnel from outside agencies will perform within the requirements of the job description, California Scope of Practice, and meet the policies and procedures of Northern Inyo Healthcare District (NIHD).

5. Documentation of performance by department manager utilizes, 'Shift Evaluation Tool for the RN Traveler' form.

6. The Traveler RN will attend District and nursing meetings pertinent to the job hired.

7. The Traveler RN may complete required certification classes that are expiring prior to the end of the contract, such as BLS, ACLS, etc. The Traveler RN must have the required certification prior to employment.

8. The Traveler RN may receive annual vaccinations from the Employee Health Specialist.
    a. The Traveler RN must have the required vaccinations and physical exam prior to employment.

PROCEDURE: RN Traveler

1. Nursing Management will notify the Chief Nursing Officer (CNO) of Traveler RN position requests and complete HR paperwork.
    a. The CNO will request approval for RN Travelers through Senior Leadership and notify the Nursing Manager of approval or not.

2. HR will contact Traveler RN Oversight Company of NIHD RN needs.
    a. HR will notify the Nursing Manager of potential candidates.
    b. The Nursing Manager will follow the HR hiring practices.
    c. HR will maintain the HR file for the Traveler.

3. Prior to starting, the Travel agency will provide required documentation to HR/Employee Health including current physical exam, criminal background check, vaccination history, California RN licensure, RB Skills Checklist, etc.
    a. The Employee Health Specialist will review the physical exam and lab tests results prior to starting.
    b. The Traveler RN must follow NIHD immunization requirements including flu vaccinations.

4. The Nurse Manager will oversee the orientation, 90-day release, and annual evaluation of any hired traveler (depending on length of the contract).
    a. The RN Traveler is evaluated weekly during the first month of hire then monthly using the 'Traveler RN Shift Evaluation tool'.
    b. The department staff will make appropriate patient care assignment based on the Traveler Skills Profile and NIHD Skills Assessment.

5. If the performance of a Traveler RN is determined to be unsatisfactory, the following actions are taken:
    a. The Nursing Director or manager completes an investigation.
    b. The Nursing Director or manager will collaborate with HR and the CNO regarding the RN Traveler performance investigation. It will be determined if the RN Traveler's contract will be continued.

6. Manager will assign all RN Travelers a preceptor who will assist as needed and evaluate the RN Traveler skill level and general performance.
    a. Orientation will include check off on the department's physical layout (egress, supply room, etc.) and department specific equipment.
    b. Attendance at General Nursing Orientation and completion of Learning Management System (LMS) assigned courses specific to RN Traveler position hired.
    c. Review the RN Traveler's skills profile and position hired skills checklist and skills confirmed on the NIHD skills checklist.
    d. The RN Traveler Nurse Manager is responsible to assure completion all paperwork prior to independently assigning the Traveler.

REFERENCES:

1. California Code of Regulations Title 22 Division 5. Licensing and Certification of Health Facilities 70217 Nursing Service Staff (N)(0). Hospitals, which utilize temporary agencies, shall have and adhere to a written procedure to orient and evaluate personnel from these sources. Such procedures shall require that personnel from temporary nursing agencies be evaluated as often, or more often, that staff employed directly by the hospital.
2. TJC (2023) CAMCAH Functional Chapter Human Resources Standard HR01.04.01 EP 2,3,4,5,6.

CROSS REFERENCE POLICIES AND PROCEDURES:

1. Contracts administration policy and procedure
2. 02-03 Orientation
3. Orientation to nursing departments

RECORD RETENTION AND DESTRUCTION:

Supersedes: v.1 Utilization of Personnel From Outside Agencies*

Northern Inyo Healthcare District
One Team. One Goal. Your Health.

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

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

TO: NIHD Board of Directors
FROM: Samantha Jeppsen, MD, Chief of Medical Staff
DATE: August 5, 2025
RE: Medical Executive Committee Report

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

A. Medical Staff Initial Appointments 2025-2026 (*action item*)
    1. Michael Karch, MD (orthopedic surgery) – Active Staff
    2. Stephen Knecht, MD (orthopedic surgery) – Active Staff
    3. Jennifer Boni, MD (obstetrics/gynecology) – Courtesy Staff
    4. Alexandra Moss, PMHNP (psychiatric mental health nurse practitioner) – Advanced Practice Provider Staff

B. Medical Staff Initial Appointments 2025-2026 – Proxy Credentialing (*action item*)
    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
    1. Feras Jalab, MD (teleradiology) – Telemedicine Staff (Direct Radiology)

C. Medical Staff Reappointments 2025-2026 (*action item*)
    1. Justin Levy, MD (hospitalist) – Courtesy Staff

D. Additional Privileges (*action item*)
    1. Bartlett White, PA-C (orthopedic physician assistant) – additional privileges in inpatient rounding and ED consultations

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

INTRODUCTION

- **PURPOSE**: TO PROVIDE AN OVERVIEW OF NIHD'S POLICY FRAMEWORK AND PROCEDURES FOR MANAGING CONFLICTS OF INTEREST (COI).
- **SCOPE**: APPLIES TO ALL WORKFORCE MEMBERS (EMPLOYEES, CONTRACTED STAFF, PROVIDERS, ETC.)

WHAT IS A CONFLICT OF INTEREST?

- **DEFINITION:** A SITUATION WHERE PERSONAL, FAMILY, OR FINANCIAL INTERESTS COULD IMPROPERLY INFLUENCE PROFESSIONAL JUDGMENT OR ACTIONS.
- **COMMON TYPES:**
  - FAMILY MEMBERS IN THE WORKPLACE
  - EMPLOYEES WITH SECONDARY HEALTHCARE EMPLOYERS
  - EMPLOYEE OR FAMILY MEMBER WITH OWNERSHIP, DECISION-MAKING ROLE, OR BUSINESS INTEREST IN VENDOR, SUPPLIER, OR COMPETITIVE HEALTHCARE ORGANIZATION

REQUIRED DISCLOSURES

- CONFLICT OF INTEREST QUESTIONNAIRE
  - AT TIME OF HIRE
  - ANNUALLY THEREAFTER
  - UPON CHANGE IN RELATIONSHIP/EMPLOYMENT STATUS
- REVIEWED BY BUSINESS COMPLIANCE TEAM
  - SUBCOMMITTEE OF THE COMPLIANCE TEAM
  - INCLUDES: CHIEF HUMAN RESOURCES OFFICER, COMPLIANCE OFFICER, CHIEF MEDICAL OFFICER (AD HOC)

FACTORS THAT AFFECT THE DETERMINATION

- DIRECT REPORTING RELATIONSHIP WITH A FAMILY MEMBER OR RELATIVE.
- RELATIVES OR FAMILY MEMBERS WORKING IN THE SAME DEPARTMENT.
- ANTICIPATED INFLUENCE ON WORKPLACE PROCESSES ON EITHER EMPLOYEE'S ROLE.
- FINANCIAL INTERESTS THAT COULD AFFECT DECISION-MAKING.
- DECISION-MAKING ROLE WITH NIHD, SECONDARY EMPLOYER, OR BOTH.

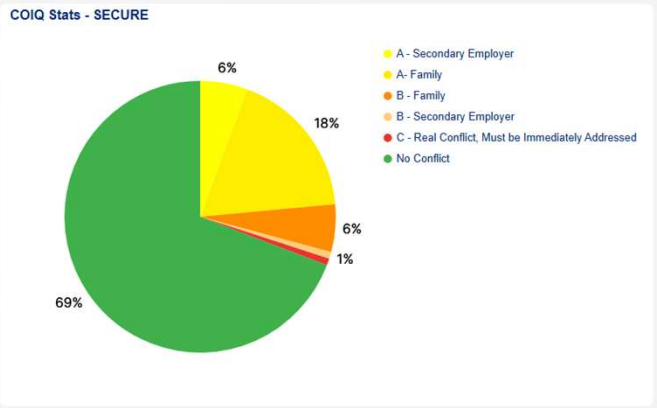
DETERMINATION & REMEDIATION

- CATEGORY A: NOT SIGNIFICANT AND GENERALLY PERMISSIBLE ACTIVITIES.
  - THESE SITUATIONS MAY CONTINUE WITHOUT SPECIAL SAFEGUARDS OR OVERSIGHT.
- CATEGORY B: POTENTIAL OR PERCEIVED CONFLICT OF INTEREST, BUT IN MANY CASES WOULD BE PERMITTED TO GO FORWARD AFTER DISCLOSURE AND A MANAGEMENT PLAN.
  - FOLLOWING DISCLOSURE, APPROPRIATE SAFEGUARDS ARE IMPLEMENTED, INCLUDING NON-DISCLOSURE AGREEMENTS AND MANAGEMENT PLANS AS NECESSARY. RECUSAL FROM BUSINESS DEALS OR POSITIONS OF INDIRECT INFLUENCE MAY BE PART OF THE MANAGEMENT PLAN.
- CATEGORY C: ACTUAL CONFLICTS OF INTEREST.
  - FAMILY IN DIRECT SUPERVISORY ROLE IN SAME DEPARTMENT: ONE WORKFORCE MEMBER MUST CHANGE ROLES, POSITIONS, OR JOBS.
  - FAMILY IN INDIRECT SUPERVISORY ROLE (DIFFERENT DEPARTMENT): MANAGEMENT PLAN FOR RECUSAL. OVERSIGHT BY THE CHIEF IN THE CHAIN OF COMMAND.

STATISTICS

- APPROXIMATELY 30% OF THE STAFF HAVE SOME RELATIONSHIP TO ANOTHER STAFF MEMBER
- THERE ARE TWO EMPLOYEES WITH A CATEGORY C "ACTUAL CONFLICT OF INTEREST"
  - BOTH HAVE MANAGEMENT PLANS IN PLACE
- NOTE: PERCENTAGES DO NOT EQUAL 100%, AS SOME EMPLOYEES HAVE MORE THAN ONE TYPE OF CONFLICT

STATISTICS CONTINUED



Conflict Categories:

1. Category A: Not significant and generally permissible activities.
2. Category B: Potential or perceived conflict of interest, but in many cases would be permitted to go forward after disclosure and a management plan.
3. Category C: Actual conflicts of interest.

Remediation:

1. Category A: These situations may continue without special safeguards or oversight.
2. Category B: Following disclosure, appropriate safeguards are implemented, including Non-Disclosure Agreements and Management Plans as necessary. Recusal from business deals or positions of indirect influence may be part of the management plan.
3. Category C: Family in direct supervisory role in same department. One workforce member must change roles, positions, or jobs.
4. Category C: Family in indirect supervisory role (different department): Management plan for recusal. Oversight by the chief

POLICY FRAMEWORK

DOCUMENTS INCLUDED:

- **CODE OF BUSINESS ETHICS AND CONDUCT**
- **CONFLICT OF INTEREST MANAGEMENT PLAN**
- **FAMILY MEMBERS IN THE WORKPLACE POLICY**
- **WORKFORCE NON-DISCLOSURE AGREEMENT (NDA)**

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

DATE: August 2025

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Christian Wallis, Interim Chief Executive Officer

RE: Review and Update of Purchasing Threshold Limits

MEMORANDUM

Background

- The District's current purchasing approval thresholds are as follows:
  - Managers: up to $500
  - Directors: up to $2,500
  - Chiefs: up to $5,000
  - CEO: up to $40,000
  - Above $40,000 requires Board approval.
- This structure centralizes nearly all significant purchasing decisions with the CEO.
- Limiting authority at other leadership and division levels reduces accountability and responsibility for budget management by Chiefs and Directors who oversee specific cost centers.

Discussion
Updating the purchasing thresholds would better align financial authority with operational responsibility and improve accountability at the department and division levels.

Opportunities:

- Empower leaders to make timely financial decisions within their approved budgets.
- Hold Chiefs and Directors more directly accountable for staying within their cost center budgets.
- Reduce unnecessary escalations of routine purchases to the CEO, allowing focus on strategic priorities.

Current vs. Proposed Thresholds:

Role	Current Limit	Proposed Limit
Managers	up to $500	up to $3,000
Directors	up to $2,500	up to $10,000
Director of Facilities	up to $2,500	up to $25,000

Role	Current Limit	Proposed Limit
Director of Supply Chain	up to $2,500	up to $25,000
Director of Pharmacy	up to $2,500	up to $25,000
Chiefs	up to $5,000	up to $25,000
CEO	up to $40,000	no change
Board approval	>$40,000	no change

These updated thresholds are reflected in the attached redlined version of the District's Purchasing Policy.

Recommendation

- Approve and forward to the full Board the recommendation to update purchasing approval limits as outlined above and as shown in the attached redlined policy.

NORTHERN INYO HEALTHCARE DISTRICT
NON-CLINICAL POLICY AND PROCEDURE

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Title: Purchasing and Signature Authority		
Owner: Chief Financial Officer	Department: Fiscal Services	
Scope: District Leadership		
Date Last Modified: 08/14/2025	Last Review Date: No Review Date	Version: 5
Final Approval by: NIHD Board of Directors	Original Approval Date: 04/20/2016	

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PURPOSE:
To control the commitment of healthcare District funds, including purchasing and signing activities. Goods and services purchased with District funds must be necessary and relevant to the District's business and the advancement of its mission. District funds include Local District Taxing Authority revenues and carry with them fiduciary responsibilities. Proper stewardship of District funds is the responsibility of all employees involved in procurement transactions.

POLICY:
1. Established purchase levels are tiered in low, mid, and high value purchasing authority. All purchases including purchase orders and check requests will follow these guidelines as outlined in the procedure below. The only exception made is for emergency purchases as outlined in the Emergency Purchases Policy.
2. The Board of Directors delegates and approves authority for purchases to the Chief Executive Officer (CEO).
3. The CEO delegates purchasing authority to the Chief Financial Officer (CFO), Chief Medical Officer (CMO), Chief Nursing Officer (CNO), Chief Operating Officer (COO), Chief Human Resource Officer (CHRO), Administrator on Call (AOC), directors (and equivalent level positions), and managers at the approval levels defined in the procedure below.
2.4. Only those employees given explicit written authority by the Northern Inyo Healthcare District (NIHD) Board of Directors, currently the Chief Executive Officer (CEO) or CEO's designee may execute the procedure agreements. ~~. (Written procurement agreements contractually bind the District and a supplier to a purchasing obligation.) Such written authority includes terms and conditions, typically including a review by the Compliance Officer and all such terms and conditions are legally binding.~~
3.5. Group Purchasing Organization (GPO) contracts, approved by the CEO, allow Directors to work within the terms stipulated. Various departments utilize GPO contracts without requiring new signatures per the established purchasing levels.

PROCEDURE:
1. District leadership may authorize purchases at the levels defined below for cost centers associated with their leadership position.
1.2. Purchase authorization and approval ~~L~~levels ~~-~~are established in the following manner:
   i. Manager – up to $3,000
   ii. Director or equivalent position – up to $10,000
   iii. Director of Facilities - up to $25,000

iv. Director of Purchasing - up to $25,000
v. Director of Pharmacy - up to $25,000
vi. Chief - up to $25,000
vii. CEO - up to $40,000

~~i. Authorization of Purchases up to $1,000 $3,000 require the signature of manager level (or higher) associated with the cost center.~~

~~ii. Purchase requests over $1,000 $3,000 and below $2,500 $10,000 require the signature of a director level (or higher) member of the NIHD Management team associated with the cost center.~~

~~Purchase requests by the Director of Facilities, Director of Supply Chain, or Director of Pharmacy up to $25,000 may be approved by that Director.~~

~~iii. Purchase requests above $2,500 $10,000 and below $5,000 $25,000 require the signature of an executive level member of the NIHD team.~~

~~iv. Over $5,000 $25,000 and below $40,000 require the signature of the CEO or in his/her absence the Administrator On Call (AOC) for emergency purchases.~~

viii. All purchase requests above $40,000 require the approval of the NIHD Board of Directors with the exception of Capital Approved purchases that were part of the NIHD Board Budget approval process and purchases authorized in the approved District operational budget. See Capitalization of Asset policy for specific information on capital purchase limits.

3. Check signing

i. All checks will be electronically signed by a chief who has a signature card on file with the appropriate financial institution.

~~v. Printed checks over $10,000 will be hand-signed by a second chief who has a signature card on file with the appropriate financial institution.sig~~

ii.

~~vi. All checks for payments based on any paid invoices are subject the Check Signing Policy regardless of purchase approval level.~~

~~2.~~4. Materials Management via Purchasing Department with Predetermined Catalog items

i. Board of Directors approves the annual District budget, which includes materials supplied via the Purchasing Department.
ii. Pre-established Periodic Automated Replenishing (PAR) levels based on department needs are built into the District's information system.
iii. Upon documented use of items, District Information System reorders the items necessary to maintain PAR stock.
iv. Items reordered within the PAR do not fall into the need for purchase orders or signature requirements listed within procedure #1.
v. Special order items, not routinely requested or on the PAR, do fall under the purchase signature requirements listed within procedure #1.

~~3.~~5. Reporting violations for complaints or concerns regarding compliance with the above, please contact the Chief Finance Officer (CFO) or the Compliance Officer.

REFERENCES:

1. The Joint Commission (CAMCAH Manual) January 2022. Standard LD.01.04.01 EP 1.

RECORD RETENTION AND DESTRUCTION:

Maintenance of Fiscal records, including documents associated with procurement contracts and purchase orders is for fifteen (15) years.

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CROSS REFERENCE POLICIES AND PROCEDURES:

1. Capitalization of Assets
2. ~~Check Signing~~
3. ~~2.~~Emergency Purchases

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Supersedes: v.4 Purchasing and Signature Authority

NORTHERN INYO HEALTHCARE DISTRICT
DISTRICT BOARD RESOLUTION 25-03
Appropriations

WHEREAS, the Northern Inyo Healthcare District is required to establish an annual appropriations limit in accordance with Article XIIIB of the California Constitution; and

WHEREAS, using data provided by the State of California Department of Finance, letter dated July 2024, the Board of Directors of Northern Inyo Healthcare District established an appropriations limit of $837,676.40 for the July 1, 2024 to June 30, 2025 fiscal year; and

WHEREAS, using data provided by the State of California Department of Finance and the County of Inyo, an appropriations limit of $830,263.00 has been calculated for the July 1, 2025 to June 30, 2026 fiscal year.

NOW, THEREFORE, BE IT RESOLVED by this Board of Directors of Northern Inyo Healthcare District, meeting in regular session this 20th day of August, 2025 that an appropriations limit of $830,263.00 be established for the Northern Inyo Healthcare District for the 2025-2026 fiscal year; and

BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting; and this Resolution shall take effect immediately after its adoption on the date hereof.

PASSED, APPROVED, AND ADOPTED by the Northern Inyo Healthcare District this 20th day of August 2025 by the following vote:

AYES: _____

NOES: _____

ABSTAIN: _____

ABSENT: _____

By: _____
Jean Turner, Chair of the Board
Northern Inyo Healthcare District

ATTEST: _____
Clerk of the Board
Northern Inyo Healthcare District

NORTHERN INYO HEALTHCARE DISTRICT
RECOMMENDATION TO THE BOARD OF DIRECTORS
FOR ACTION

Date: 08/20/2025

Title: **BOARD RESOLUTION 25-03 APPROVAL OF APPROPRIATIONS LIMIT**

Synopsis: It is recommended that the Board of Directors approve and adopt the Resolution to establish an annual appropriations limit in accordance with Article XIIIB of the California Constitution. As a government entity, NIHD is to receive funds from property taxes in the form of State Appropriations. These funds are for operating expenses and are not restricted as to use.

Prepared by: _____
Andrea Mossman
Chief Financial Officer

Approved by: _____
Christian Wallis
Interim Chief Executive Officer

ATTACHMENT A
STATEMENT OF INYO COUNTY GANN LIMIT CALCULATIONS
FOR THE TAX YEAR 2025-2026

	2023-2024 Limit	Population Change	Per Capita Change	2024-2025 Limit	Population Change	Per Capita Change	2025-2026 Limit
Big Pine Lighting	70,857	0.99840	1.0362	73,305	0.997	1.002	73,231
Independence Lighting	70,639	0.99840	1.0362	73,079	0.997	1.002	73,006
Lone Pine Lighting	101,608	0.99840	1.0362	105,118	0.997	1.002	105,012
Big Pine Fire	458,277	0.99840	1.0362	474,107	0.997	1.002	473,630
Bishop Fire	719,935	0.99840	1.0362	744,803	0.997	1.002	744,054
Independence Fire	314,589	0.99840	1.0362	325,455	0.997	1.002	325,128
Lone Pine Fire	392,039	0.99840	1.0362	405,581	0.997	1.002	405,173
Big Pine Cemetery	97,223	0.99840	1.0362	100,581	0.997	1.002	100,480
Independence Cemetery	224,816	0.99840	1.0362	232,582	0.997	1.002	232,348
Mt. Whitney Cemetery	156,353	0.99840	1.0362	161,753	0.997	1.002	161,591
Pioneer Cemetery	582,027	0.99840	1.0362	602,132	0.997	1.002	601,526
Tecopa Cemetery	16,318	0.99840	1.0362	16,882	0.997	1.002	16,865
Darwin CSD	23,942	0.99840	1.0362	24,769	0.997	1.002	24,744
Olancha CSD	194,234	0.99840	1.0362	200,943	0.997	1.002	200,741
Westridge CSD	121,984	0.99840	1.0362	126,197	0.997	1.002	126,070
	-			-			-
Southern Inyo Emergency	162,825	0.99840	1.0362	168,449	0.997	1.002	168,280
Northern Inyo Hospital	803,350	0.99840	1.0362	831,099	0.997	1.002	830,263
INYO COUNTY	56,348,310	0.99840	1.0362	58,294,698	0.997	1.002	58,236,053
				-			
				-			

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

DATE: August 12, 2025

TO: Finance Committee, Northern Inyo Healthcare District

FROM: Christian Wallis, Interim Chief Executive Officer

RE: Evaluation of Alternative Banking Options

MEMORANDUM

Background

The fundamental guide to managing public funds is based on safety, liquidity and yield. The District currently holds over $20 million dollars in public funds in accounts at Eastern Sierra Community Bank.

- Safety: Accounts are insured up to $250,000 per depositor, per institution (FDIC/NCUA). The amounts over $250,000 must be collateralized per state policy. This has been verified with a letter from Eastern Sierra Community Bank (ESCB).
- Liquidity: The money in ESCB is available (liquid) for use by NIHD should the District need this money for immediate needs.
- Yield: The District funds appear to have yielded little to no interest over the years with ESCB. There are banks that have specialized government services who offer safe product that yield over 4% return on the investment while still keeping the money safe and liquid.

Discussion

The District's current approach has prioritized liquidity and safety which is good however, there is an opportunity cost to avoiding better interest bearing products. The current relationship with ESCB is good for providing local access to the full liquidity of NIHD funds. Using ESCB also provides a good banking relationship with a local company that provides minimal administrative complexity. ESCB also verifies safety through collateralization of NIHD funds.

The District should generate as much interest as possible while maintaining appropriate safety and liquidity. Current funds do not earn interest, leaving potential income unrealized. This is an opportunity cost that will help the District gain better financial status. There are banks that do specialize in the management and investment of public money. Specifically, Five Star Bank currently works with over 100 unique public entity clients all throughout the state with the vast majority being special districts (approximately 90 special districts). In the healthcare district space, Five Star Bank works with are:

- Eden Township Healthcare District
- Fallbrook Regional Health District
- Mark Twain Healthcare District

- Camarillo Healthcare District

Recommendation:

Authorize the NIHD Interim CEO to move District funds for investment with Five Star Bank ensuring enough funds are left with ESCB for day to day banking.

PUBLIC MONEY MARKET ACCOUNT PROPOSAL

PREPARED FOR

Northern Inyo Healthcare District

FIVE STAR BANK

www.fivestarbank.com

NASDAQ: FSBC

August 7, 2025

Mr. Christian Wallis, Interim CEO
Northern Inyo Healthcare District
150 Pioneer Ln.
Bishop, CA 93514

Dear Mr. Wallis:

Thank you for the opportunity to present this proposal to the Northern Inyo Healthcare District.

We are very excited about the opportunity to partner with the Northern Inyo Healthcare District. We believe you deserve nothing less than exceptional customer service, reliability, competitive pricing, efficient means of managing your accounts electronically, and direct access to a team of qualified banking professionals who are keenly knowledgeable with public funds and public entities.

Given our staff experience working with special districts, cities, and counties, we believe Five Star Bank is the perfect partner for the Northern Inyo Healthcare District. We are offering a Public Money Market Account (PMMA) that matches the most recently published monthly rate at LAIF (Local Agency Investment Fund). The current rate on our Public Money Market Account is 4.258% as of 8/7/2025.

Five Star Bank Public Money Market Account Overview:

- **Funds are collateralized as per state law, GC 53652. All deposits are either fully insured by the FDIC or fully collateralized as per state statute.**
- **Withdrawals must be initiated by 2:30 PM PST for same day wire transfer.**
- **The rate is reset each month to match the most recently published monthly LAIF rate.**
- **Interest is compounded daily and will be paid monthly on the last day of the month.**
- **The Public Money Market Account must maintain an average daily collected balance of $25,000.00 to waive the $15.00 monthly service charge.**
- **The maximum deposit amount in the Public Money Market Account must not exceed the Shareholder Equity Value of Five Star Bank, as of 6/30/2025, this was $416 million.**
- **Account terms are subject to change at any time at the discretion of Five Star Bank.**

Five Star Bank is very active within the special district community and serves the banking needs of public entities all throughout the state of California. In fact, we have over $850 million in public funds on deposit as of August 5, 2025. One of the notable associations we partner with is the Association of California Healthcare Districts. We are a Bronze Sponsor for ACHD and an active participant at their Annual Meeting. Furthermore, we have sponsored scholarships to the California Special District Association GM Summit since 2018. These scholarships provide funding for those who may not have had the resources to attend the GM Summit otherwise and receive training on policies, procedures, and best practices. We believe that being a good community bank means supporting your community.

This opportunity to develop a partnership with the Northern Inyo Healthcare District is very important to our Bank and, as always, we will take every measure possible to ensure your success. I can assure you that I will personally oversee the entire transition to Five Star Bank. Please let us know if you have any questions or need clarification on anything in this proposal. Five Star Bank is offering to provide these banking services to the Northern Inyo Healthcare District at a very competitive price with unparalleled customer service and support. We can discuss the opportunity in greater detail and plan the next steps to move forward. Thank you once again for this opportunity. We are committed to providing the Northern Inyo Healthcare District with the absolute best customer service experience and look forward to building a long and sustainable relationship together.

Sincerely,

REAGAN BALLO, CTP
SVP/Managing Director of Government Banking

t: 916.660.5752 | **m:** 805.305.1882
e: rballo@fivestarbank.com
a: 3100 Zinfandel Drive, Suite 650
Rancho Cordova, CA 95670

Bank Information

BANK OVERVIEW

ORGANIZATIONAL OVERVIEW

Five Star Bank is a $4.4 Billion community business bank serving customers nationwide, with branch locations in the Capital Region, North State, and San Francisco Bay Area. Five Star Bank has a high-tech and high-touch approach to business banking where customers have direct access to their banker at all times.

A HISTORY OF ORGANIC GROWTH

Five Star Bank was founded in 1999 by a group of local entrepreneurs who wanted to create the kind of personalized banking services they desired themselves – services provided by industry experts who were committed to partnerships grounded in shared vision and goals. Today, Five Star Bank is a community business bank guided by purpose-driven banking, community stewardship, regional and industry expertise, and a commitment to economic development. In May 2021, we completed our initial public offering. Prior to this achievement, and for over twenty years, we focused on organic growth by strategically and thoughtfully expanding our reach in Northern California (and beyond) and by developing our team, banking groups, internal processes, community partnerships and brand. In 2023, we expanded into the San Francisco Bay Area.

Today, we provide a broad range of banking products and services to small and medium-sized businesses, professionals, and individuals primarily in Northern California through eight branch offices, and the internet with our mobile banking applications. Our primary loan products are commercial real estate loans, commercial loans, commercial land and construction loans, and farmland loans. Our principal geographic market is the Capital Region (Rancho Cordova, Roseville, Sacramento and Elk Grove), the North State (Chico, Redding, and Yuba City), and the nine-county San Francisco Bay Area.

The geographies we serve have profitable and productive economies driven by the governmental, education, technology, healthcare, agricultural, and manufacturing sectors. Since 2016, our market share of the total deposits in the Greater Sacramento Area has increased significantly, according to the Federal Deposit Insurance Corporation (FDIC) Deposit Market Share Reports. We believe our market growth confirms the quality of the integrity-centered banking we strive to deliver to clients. Our mission is to become the top business bank in the markets we serve through exceptional service, deep connectivity, and client empathy.

REGIONS WE SERVE

Five Star Bank serves clients through branch locations in Northern California, including the Capital Region, North State and San Francisco Bay Area.

VERTICALS WE SERVE

Government
Food, Agribusiness & Diversified Industries
Commercial Real Estate & Construction
Enterprise (Businesses & Associations)
Manufactured Housing, RV & Self Storage
Private Practice & Professional Services
Venture Banking, Technology & Start-up
Small Business Administration (“SBA”)
Manufacturing & Distribution
Faith Based Community
Healthcare
Non-profit

AWARDS & RECOGNITION

TOP 3
S&P Global Market Intelligence
Top 3 Best-Performing Community Banks
2024

TOP 10%
Raymond James Community
Bankers Cup Winner
2024
Ranked in top 10% of Community Banks in the Nation

Piper Sandler's Sm-All Stars
2024

Bauer Financial	5 Stars (out of 5)
Findley Report	Super Premier Performing Bank
IDC	Superior Rating
Sacramento Business Journal	2023 Best Places to Work & 2025 Fastest Growing Businesses

YOUR FIVE STAR BANK TEAM

FIVE STAR SERVICE

Five Star Bank prides itself on being an entrepreneurial organization with white glove service for our clients. We are happy to discuss any specific accommodations that would help create a better overall banking experience for Northern Inyo Healthcare District. Listed below is your Five Star Bank relationship team.

REAGAN BALLO, CTP
SVP / Managing Director of Government Banking
rballo@fivestarbank.com
805.305.1882

Reagan is your primary point of contact at Five Star Bank, serving as your internal advocate and managing every product, service, and team member involved in your banking experience.

EDDIE GROGG
AVP / Relationship Manager
egrogg@fivestarbank.com
916.306.1348

Eddie will be your day-to-day banker setting up your accounts and your "go-to" for any operational questions.

BRITTANY SILVEIRA
AVP / Treasury Solutions Advisor
bsilveira@fivestarbank.com
530.924.5127

Brittany is your expert in treasury solutions and will ensure your onboarding is swift, seamless and efficient.

"We are genuinely grateful for our 15-year relationship with Five Star Bank. Their commitment to customer service, responsiveness, community focus, and trustworthiness sets them apart in the banking industry."

JENNIFER NEWMAN
Senior Vice President & CEO
California Hospital Association

Thank You

Thank you for the opportunity to share Five Star Bank's story and extensive capabilities with you. It would be our privilege to serve you.

Please contact SVP / Managing Director of Government Banking, Reagan Ballo, CTP directly at 805.305.1882.

FIVE STAR BANK

www.fivestarbank.com

NASDAQ: FSBC

MEMORANDUM OF UNDERSTANDING
Between
NORTHERN INYO HEALTHCARE DISTRICT and INYO COUNTY HEALTH AND HUMAN SERVICES

This Memorandum of Understanding (MOU) is made and entered into this ___ day of _____, 2025, by and between **Northern Inyo Healthcare District**, a public healthcare district organized under California Health & Safety Code § 32000 et seq. ("District"), and **Inyo County Health and Human Services** ("County").

PURPOSE The purpose of this MOU is to establish a collaborative relationship under which the County and District Maternal Mental Health Program staff and volunteers will use District meeting room space at the Birch Street Building for their meetings in support of the Maternal Mental Health classes, which promote maternal and infant health within the District's service area.

TERM This MOU shall become effective upon execution by both parties and shall remain in effect until **September 30, 2026**, unless terminated earlier in accordance with **Termination Section** of this MOU.

DISTRICT RESPONSIBILITIES

The District agrees to:

a. Provide use of its Boardroom located at 2957 Birch Street, Bishop, CA, 93514, on a recurring schedule, which does not affect the duties and responsibilities of the Northern Inyo Healthcare District Board of Directors.
b. Ensure the space is available, clean, and in reasonable working condition.
c. Allow County staff access to restrooms and basic utilities during use.

COUNTY RESPONSIBILITIES

The County agrees to:

a. Coordinate maternal health program activities, including scheduling and community outreach.
b. Ensure proper supervision of participants.
c. Leave the meeting room in a clean and orderly condition after each use.
d. Maintain liability insurance covering its operations and provide proof upon request.

MUTUAL UNDERSTANDINGS

a. No exchange of funds is contemplated under this MOU.
b. Each party shall be responsible for its own employees, volunteers, and participants.

c. Both parties agree that this MOU serves a governmental purpose consistent with their respective missions.

INSURANCE AND LIABILITY Each party shall maintain liability insurance or self-insurance in accordance with California law. Nothing in this MOU shall be construed as creating a joint venture or shared liability.

TERMINATION This MOU may be terminated by either party with thirty (30) days' written notice to the other party.

ENTIRE AGREEMENT This MOU contains the full understanding of the parties and may only be modified in writing signed by both parties.

IN WITNESS WHEREOF, the parties hereto have executed this MOU as of the date first written above.

Northern Inyo Healthcare District	Inyo County Health and Human Services
By: _____	By: _____
Name: _____	Name: _____
Title: _____	Title: _____
Date: _____	Date: _____

NORTHERN INYO HEALTHCARE DISTRICT

BOARD RESOLUTION NO. 25-02

A RESOLUTION OF THE BOARD OF DIRECTORS OF THE NORTHERN INYO HEALTHCARE DISTRICT APPROVING A MEMORANDUM OF UNDERSTANDING WITH THE INYO COUNTY HEALTH AND HUMAN SERVICES FOR USE OF DISTRICT MEETING SPACE.

WHEREAS, the Northern Inyo Healthcare District ("District") is a public healthcare district organized under California Health & Safety Code § 32000 et seq.; and

WHEREAS, the Inyo County Health and Human Services ("County") seeks to utilize District meeting room space for maternal mental health-related programs that benefit residents within the District's service area; and

WHEREAS, the District supports community health improvement initiatives and finds that this collaboration promotes the public interest and supports its mission;

NOW, THEREFORE, BE IT RESOLVED by the Board of Directors of the Northern Inyo Healthcare District as follows:

1. The Board hereby approves the Memorandum of Understanding (MOU) with the Inyo County Health and Human Services Agency, substantially in the form attached hereto.
2. The Chief Executive Officer or designee is authorized to execute the MOU and take any and all actions necessary to carry out its provisions.

PASSED AND ADOPTED this ___ day of _____, 2025, by the following vote:

AYES:
NOES:
ABSENT:
ABSTAIN:

Chair, Board of Directors

ATTEST:

Secretary, Board of Directors

Northern Inyo Healthcare District

150 Pioneer Lane
Bishop, CA 93514
(760) 873-5811
www.nih.org

DATE: August 13, 2025

TO: Northern Inyo Healthcare District Board of Directors

From: Patty Dickson, Compliance Officer

RE: 2025 Quarter 3 Compliance Report Highlights

This is a brief overview of some of the ongoing work in the Compliance Department.

Auditing
To confirm ongoing compliance and ensure we would detect fraud, waste, and abuse if it occurred, the following audits are currently in progress: Language Access Services Use and Documentation Audit, Non-Physician Vendor Audit, Imaging Report Compliance Follow-up Audit, Health Information Management (HIM) Scanning Accuracy Audit, Active Directory Access and Accuracy Audit, and Employee Access Audits.

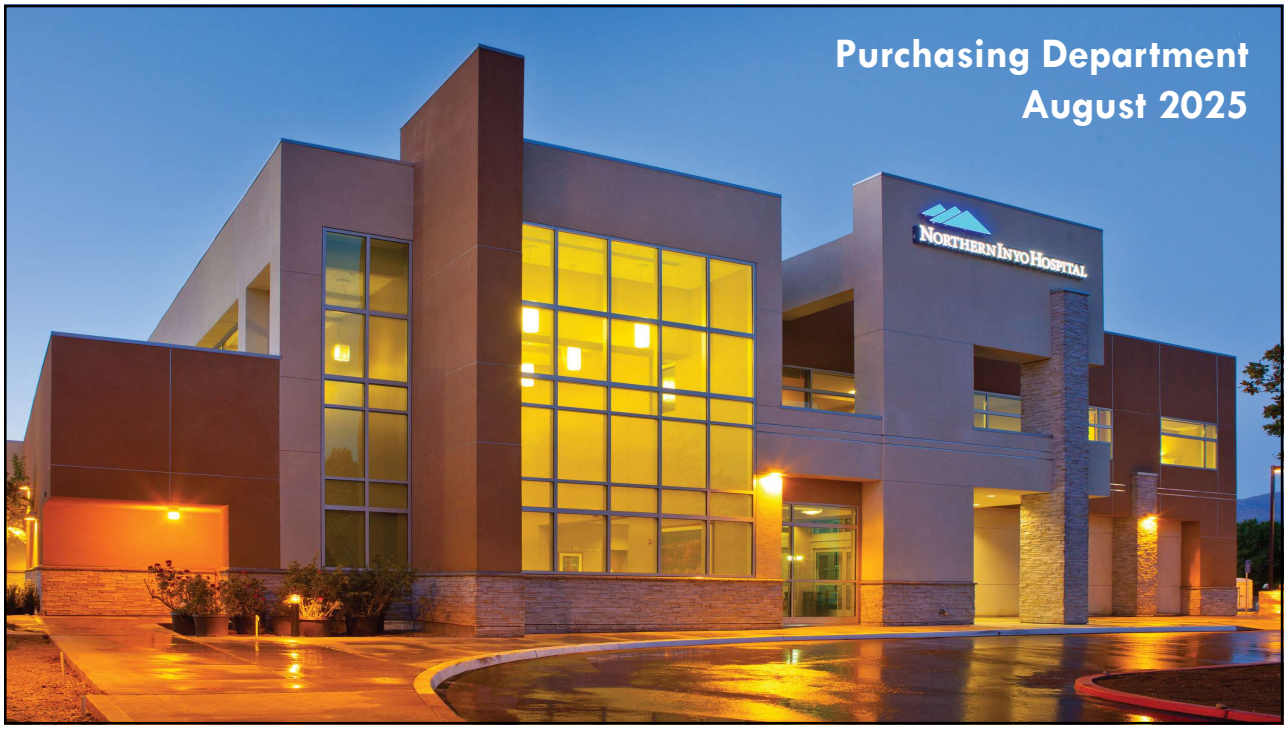
Unusual Occurrence Reports (UORs)
The total volume of UORs trended down over the second quarter of 2025. Patient complaints and review requests continue to trend higher than other areas. Patient complaint response letters were sent within seven days 96% of the time.

Investigations
Currently, there are six ongoing privacy investigations. This year, NIHD has had two reportable privacy breaches. There are six ongoing investigations related to non-privacy compliance concerns.

Risk Assessments
Informatics and Compliance have completed the annual SAFER ((Safety Assurance Factors for EHR (Electronic Health Record) Resilience)) for 2025.

Public Records Requests
The Compliance Office has reviewed and released documents, as appropriate, for eight public records requests.

Regulatory Updates
Compliance has reviewed approximately 60 new regulations released by state and federal government agencies to ensure NIHD leadership teams are aware and take appropriate actions to maintain compliance with current and new requirements.



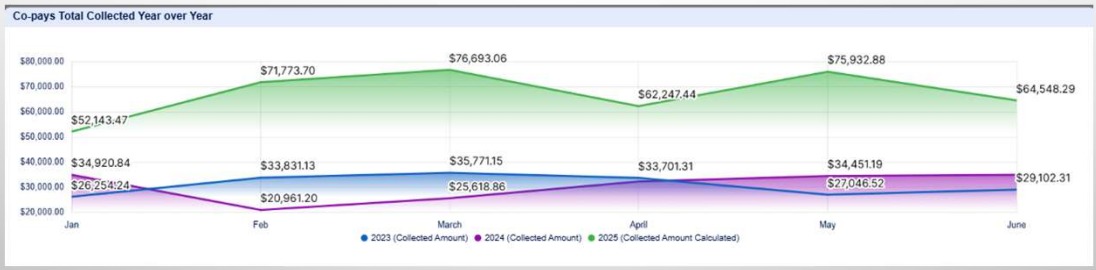
PURCHASING DEPARTMENT

- INITIATED VALUE ANALYSIS COMMITTEE MEETINGS WITH CONSISTENT BI-WEEKLY CADENCE
- IMPLEMENTED NEW CAPITAL REQUEST HTML FORM FOR IMPROVED WORKFLOW EFFICIENCY
- DEVELOPED ROI & TOTAL-COST-OF-OWNERSHIP SMARTSHEET TOOL FOR MEDICAL EQUIPMENT EVALUATIONS

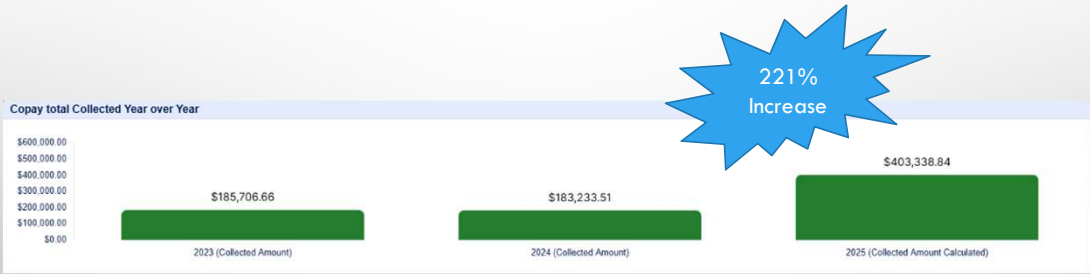
PATIENT ACCESS
POINT OF SERVICE COLLECTIONS

- INITIATIVE BEGAN ON JANUARY, 2025
- UTILIZE THE PRICE ESTIMATOR TOOL AND PATIENT INSURANCE WEBSITES TO IDENTIFY PATIENT RESPONSIBILITY.
- TRAINING STAFF ON THE ABOVE TOOLS AND PROPER CONVERSATIONS WITH PATIENTS.
- DISTRICT EDUCATIONS TO INFORM COMMUNITY OF PRACTICE CHANGE IN REGARDS TO POINT OF SERVICE COLLECTIONS.

POINT OF SERVICE COLLECTIONS
MONTHLY COLLECTION AMOUNTS



POINT OF SERVICE COLLECTIONS
2023-2025



POINT OF SERVICE COLLECTIONS DEPARTMENT ACHIEVEMENTS

RHC 2024 VS 2025

DIAG. IMAGING 2024 VS 2025

POINT OF SERVICE COLLECTION ACKNOWLEDGEMENTS

- SHOUT OUT TO LYNDA VANCE FOR HELPING US PULL THIS DATA FROM A VERY EXTENSIVE SMART SHEET
- A BIG THANK YOU TO ANDREA FOR GUIDING US IN THIS CHANGE INITIATIVE
- AND LAST BUT DEFINITELY NOT LEAST, THIS COULD NOT HAVE BEEN DONE WITHOUT OUR PATIENT ACCESS TEAM MEMBERS IF THEY HAD NOT EMBRACED THIS CHANGE

Questions?

REVENUE CYCLE UPDATE

ACROSS THE REVENUE CYCLE WE ARE ENGAGING IN INTERDEPARTMENTAL COLLABORATION TO IDENTIFY AND ADDRESS OPPORTUNITIES TO IMPROVE OPERATIONAL EFFICIENCY, FINANCIAL PERFORMANCE, AND THE OVERALL PATIENT EXPERIENCE.

WE ARE ESTABLISHING WORKGROUPS TO DRIVE PROGRESS ON ACTION ITEMS.

- SOME OF THE CURRENT PRIORITIES INCLUDE:
  - STRENGTHENING ELIGIBILITY VERIFICATION PROCESSES
  - STREAMLINING PRIOR AUTHORIZATION WORKFLOWS
  - IMPROVING CODING WORKFLOWS
  - OPTIMIZING REIMBURSEMENT STRATEGIES
  - INTERNAL AND EXTERNAL COMMUNICATION EFFORTS

REVENUE CYCLE UPDATE

- JORIE UPDATE:
  - BILLING IS IMPROVING EVERY WEEK, RECORD COLLECTIONS IN JUNE OF JUST UNDER $11M, NET AR HAS DECREASED EVERY MONTH SINCE JORIE WENT LIVE FROM $25M TO $19M
  - ELIGIBILITY IS LIVE AND WE ARE ALREADY SEEING A 2% DECREASE IN ELIGIBILITY RELATED DENIALS
  - AUTHORIZATIONS FOR HOSPITAL PATIENTS ON THE MEDICAL FLOOR IMPLEMENTATION HAS GONE VERY SMOOTHLY, JORIE INITIATED AUTHORIZATION FOR 124 VISITS IN JULY
  - NEXT IMPLEMENTATION WILL BE FOR OUTPATIENT PRIOR AUTHORIZATIONS

DEPARTMENT'S CURRENT PROJECTS

- REMOVING FYE 2024 INVENTORY AUDIT FINDING
- REMOVING FYE 2024 BALANCE SHEET AUDIT FINDING
- IMPLEMENTATION OF LUDI
  - INTEGRATED PHYSICIAN COMPENSATION & CONTRACT MANAGEMENT
    - PHASE 1 – DOCTIME
      - CONTRACT MANAGEMENT & COMPENSATION PHASE
    - PHASE 2 – wRVU
      - IMPLEMENTATION OF "WORK RELATIVE VALUE UNIT" CALCULATION

DEPARTMENT'S CURRENT PROJECTS

- PAYROLL360 INTEGRATION
  - INTEGRATION (AUTOMATION) OF ADP (PAYROLL SYSTEM) DATA INTO MULTIVIEW (ACCOUNTING)
- BAI INTERFACE
  - AUTOMATING THE IMPORT OF BANK TRANSACTIONS INTO MULTIVIEW
- BUSINESS REPORTS AND KPI'S
  - EARLY STAGE DEVELOPMENT WITHIN MULTIVIEW REPORTING MODULE
- RECRUITMENT OF 2 TEAM MEMBERS
  - ONGOING PROCESS

UPCOMING PROJECTS

- FINAL BALANCE SHEET RECONCILIATIONS
  - WRAPPING UP THE GOAL OF 100%
- PBC DOCUMENT PREPARATION FOR INITIAL AUDIT REQUESTS
  - PROVIDING INITIAL DOCUMENT REQUEST FROM AUDITOR FOR FYE 2025 AUDIT
- CONTINUED RECRUITMENT OF 2 NEW TEAM MEMBERS
- REFINING MONTH END PROCESS FOR A 5 TO 7 DAY CLOSE

THANKS AND GRATITUDE FOR NIHD'S FINANCE/ACCOUNTING/PAYROLL TEAM

"THANK YOU!!!"

REUBEN, KAREN, NICK, BECKI, PAUL, LINDSAY, ALFREDO, ALDINA AND NAI

QUESTIONS … ???

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

DATE: August 2025

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Andrea Mossman, Chief Financial Officer

RE: Financial Summary and Operation Insights FYE 2025 Preliminary (unaudited)

Financial Summary

1. Net Income: June's net income was $2.4M, which was $1.6M higher than last June was. This was due to a $3.2M favorable other income item related to covid related employee retention credit from the IRS. We received approval from the IRS and are awaiting the check but accrued for the earnings this fiscal year.

   For the year, net income was $5.2M, which was $626k higher than last year. This was due to an increase in other income driven by higher supplement (IGT) funds and the employee retention credit.
2. Operating Income: June's operating loss was $(6.7M), which was $(7.1M) lower than last June due to lower revenue and higher expenses. Revenue was lower due to slower volumes in most areas along with reimbursement rate decreases. We also had $4M due to Medicare from last year's cost report that was reserved this month. For expenses, we were over prior year due a $2M unfavorable entry in salaries related to prior periods along with an unfavorable inventory adjustment of $1M.

   For the year, operating loss was $(16.5M) which was $(8.2M) lower than last year due to lower surgical volume and reimbursement rate declines along with higher professional fee expenses for legal costs, physician fees, and billing company fee increases.

   Action Plan: The Mammoth Orthopedic Institute hit the ground running in July. We anticipate recouping the lost surgical volumes and increasing our revenue. Additionally, we are educating leaders to be the "CEO of their own cost center" and manage their expenses to budgets FYE 2026.

Stats Summary

1. Admits (excluding Nursery): For June, admits were -8% lower due to lower surgical cases. For the year, admits were -1% lower than last fiscal year due to lower surgical cases.
2. Inpatient Days (excluding Nursery): For June, inpatient days were -11% lower. For the year, inpatient days increased 13%.
3. Average Daily Census: For the fiscal year, census increased by 10% due to medical admits.
4. Average Length of Stay (ALOS): For the year, average length of stay increased 10% compared to last year but was still below the maximum for a critical access hospital.
5. Deliveries: For the year, Deliveries were 4% higher than last year.
6. Surgical Procedures: For June, surgeries were (14%) lower than last June due to orthopedics. For the year, surgical procedures were (4%) lower with decreases in orthopedics and gynecology.
7. Emergency Department (ED) Visits: For the year, ED visits were 1% higher than last year.
8. Diagnostic Imaging (DI) Exams: For the year-to-date, DI exams 2% higher than last year.
9. Rehab Visits: For the year, rehab visits were up 27% for the year.
10. Outpatient Infusion / Injections / Wound Care Visits: These visits were higher by 57% compared to last year-to-date.
11. Observation Hours: Observations hours were down (20%) compared to last year-to-date due to change in observation methodology in the women and surgical service lines along with less surgical volume.
12. Rural Health Clinic (RHC) Visits: For the year, RHC visits were higher than last year by 1%.
13. Other Clinics: For June, clinic volumes were slow in orthopedics, pediatrics, bronco, and virtual care with increases in specialty and surgery. For the year, pediatrics and orthopedics are lower than last year with increases in specialty, surgery and virtual care due to new providers.

Action Plan: The Mammoth Orthopedic Institute started in July to help recoup orthopedic clinic and surgical volumes. We are working on reviewing operational efficiency including space utilization reviews to maximize patient flow and care. Additionally, we have formed an OR Utilization Task Force and are implementing a deliberate service line strategy.

Revenue Summary

1. While we achieved and increase of $4.9M in gross charges by increasing inpatient medical admissions and deliveries along with increased clinic revenue, our surgical volume decreased negatively impacted net revenue. This is due to surgeries having higher reimbursement rates compared to other types of admissions and outpatient services.

Action Plan: The Mammoth Orthopedic Institute hit the ground running in July. We anticipate recouping the lost surgical volumes and increasing our revenue.

Deductions Summary

1. Deductions increased due to unfavorable rate changes from Medicare. Deductions as a % of gross revenue declined by 4% in FYE 2025 compared to FYE 2024, which is the amount our Medicare reimbursement decreased.

Action Plan: We have switched billing companies for Medicare and Commercial payors to help facilitate a thorough and efficient billing process. This should expedite our cash flow timing and decrease our billing errors. We have hired two new contingency-based companies to help us dispute medical necessity denials and to ensure insurance companies are paying us the full amount committed to in the contract.

Salaries

1. Total Salaries: For the year, salaries were 8% higher than last year due to 14 more full-time equivalents along with annual merit increases. The increase in full-time equivalents (FTEs) was partially offset by decreases in contract labor full-time equivalents.
2. Average Hourly Rate: For the year, average hourly rate was 5% higher than last year due to merits.

Action Plan: We have developed reports to monitor our largest expense better including overtime, missed meal and rest breaks, and call pay to ensure we are staffing effectively. Leaders will be educated in August on how to review these reports, which will be sent out each pay period.

Benefits

1. Total Benefits: For June and year-to-date, benefits were lower than prior year due to pension and medical expenses. We saved $3.6M in benefits costs for this fiscal year compared to last year.
2. Benefits % of Wages: For the year, we were at 40% of wages, which was lower than prior year by (13%).

Industry standard has this metric at 25-30% if wages.

Action Plan: We will continue to review opportunities with our benefits broker to save money while still offering quality benefits to our employees.

Total Salaries, Wages and Benefits (SWB)

1. Salaries, Wages and Benefits (SWB) / Adjusted Patient Day: For the year, we were (17%) under budget and (5%) under prior year-to-date. This was due to lower benefit costs and higher patient days / volumes.
2. Salaries, Wages and Benefits (SWB) % of Total Expenses: For the year, we were lower relatively flat to prior year. While wages increased, they were offset by decreases in benefits. For the year, we were at 50% of total expenses, which is our goal. However, when you include contract labor, we are at 55%.

Contract Labor

1. Contract Labor Expense: For the year, contract labor was (11%) lower than prior year due to employment increases. Employed FTEs increased and contract labor FTEs decreased.
2. Contract Labor Rates: Rates are higher than budgeted by 47% and higher than prior year by 3%. Contract Labor Full-Time Equivalents (FTEs): For the year, contract labor was (13%) lower than prior year.

   Action Plan: We have made progress hiring permanent employees instead of contractors, which saves us 32% on average. We have completed trainings with leaders on reports to monitor premium pay including overtime for our contractors.

Other Expenses

1. Physician Expense / Adjusted Patient Day: While physician expenses increased 4% compared to last year due to new physicians and higher contracts, our volume has also increased in most areas. Our physician expense per patient has decreased by 1%.
2. Other Professional Fees: For the year, these expenses increased $1.4M due to higher legal expenses for complex employee and physician related advisement along with higher billing fees from our new AI vendor, Jorie.
3. Supplies: For the year, supplies were higher than prior year-to-date due to a $1M unfavorable inventory adjustment. We had less inventory on hand this year during the count, which increases expenses.
4. Total Expenses: For the year, expenses were under budget by (3%) yet over prior year by 2% or $1.8M. This was due to unfavorable inventory adjustment of $1M along with higher professional fees. However, total expenses per patient was (4%) lower than prior year.

Action Plan: We are educating leaders to be the “CEO of their own cost center” and manage their expenses to budgets FYE 2026.

Cash Summary

1. Days Cash on Hand: For the year, days cash on hand was at 94 days, which is 10 days higher than last June. Our bond requirement is 75 days.
2. Estimated Days until Depletion (excluding supplement/IGT): For the year, estimated days until depletion (excluding IGT) is 858 days, which is 411 days higher than last June. This excludes supplement money such as grants and IGT. When considering those funds, we are no longer depleting. We grew cash by over $2M or $6,000 per day this year. We recently hit record collections due to the new AI billing vendor. We estimated that we have approximately $3-5M in IGT at risk due to federal Medicaid cuts. The impact of these cuts should start with calendar year 2027.
3. Unrestricted Cash: Unrestricted cash balance is now $29M. While this is higher than where we ended FYE 2024, we have depleted cash $26M since July 1, 2021. During FYE 2023 and FYE 2024, we averaged a depletion of $6M annually in cash.

   Action Plan: The cash flow action team is working to improve processes in all aspects of billing and collections. We have hired a new AI-based billing company, Jorie, and have hit record cash collections the past few months. The automation is now live in several areas. Additionally, we have hired two contingency-based companies that will help us recoup money from insurance companies by disputing denials and holding insurance companies accountable for underpayments on claims. Lastly, we will evaluate moving money to take advantage of better interest rates along with reviewing early payment of capital appreciation bond to save on interest payments.

Northern Inyo Healthcare District

June 2025 – 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)	2,400,606	(244,289)	2,644,895	(1,083%)	785,068	1,615,538	(206%)	5,231,102	105,595	5,125,507	(4,854%)	4,604,662	626,440	14%
Operating Income (Loss)	(6,735,735)	(611,590)	(6,124,145)	1,001%	356,735	(7,092,470)	1,988%	(16,501,349)	(13,154,621)	(3,346,728)	(25%)	(8,237,332)	(8,264,016)	100%
EBIDA (Loss)	2,890,704	119,289	2,771,415	2,323%	1,224,650	1,666,054	(136%)	10,317,883	4,468,531	5,849,352	(131%)	10,102,686	215,196	2%
IP Gross Revenue	3,271,065	3,058,994	212,071	7%	2,799,611	471,454	17%	44,044,886	42,071,740	1,973,145	5%	41,353,814	2,691,071	7%
OP Gross Revenue	14,026,215	14,099,737	(73,522)	(1%)	13,848,705	177,510	1%	166,541,415	170,813,816	(4,272,401)	(3%)	166,032,671	508,744	0%
Clinic Gross Revenue	1,655,734	1,535,631	120,104	8%	1,665,622	(9,888)	(1%)	21,078,588	19,602,952	1,475,636	8%	19,388,997	1,689,590	9%
Total Gross Revenue	**18,953,014**	**18,694,362**	**258,652**	**1%**	**18,313,938**	**639,076**	**3%**	**231,664,888**	**232,488,508**	**(823,620)**	**(0%)**	**226,775,482**	**4,889,406**	**2%**
Net Patient Revenue	**4,449,499**	**9,315,722**	**(4,866,223)**	**(52%)**	**8,529,089**	**(4,079,589)**	**(48%)**	**100,607,508**	**107,518,418**	**(6,910,910)**	**(6%)**	**107,115,424**	**(6,507,916)**	**(6%)**
Cash Net Revenue % of Gross	*23%*	*50%*	*(26%)*	*(53%)*	*47%*	*(23%)*	*(50%)*	*43%*	*46%*	*(3%)*	*(6%)*	*47%*	*(4%)*	*(8%)*
Admits (excl. Nursery)	65	71	(6)	(8%)	71	(6)	(8%)	849	856	(7)	(1%)	856	(7)	(1%)
IP Days	199	223	(24)	(11%)	223	(24)	(11%)	2,887	2,562	325	13%	2,562	325	13%
IP Days (excl. Nursery)	167	192	(25)	(13%)	192	(25)	(13%)	2,485	2,265	220	10%	2,265	220	10%
Average Daily Census	5.6	6.4	(0.8)	(13%)	6.4	(0.8)	(13%)	6.8	6.2	0.6	10%	6.2	0.6	10%
ALOS	2.6	2.7	(0.1)	(5%)	2.7	(0.1)	(5%)	2.9	2.6	0.3	11%	2.6	0.3	11%
Deliveries	18	19	(1)	(5%)	19	(1)	(5%)	205	197	8	4%	197	8	4%
OP Visits	3,824	3,229	595	18%	3,229	595	18%	47,767	42,374	5,393	13%	42,374	5,393	13%
Rural Health Clinic Visits	2,159	2,225	(66)	(3%)	2,225	(66)	(3%)	27,720	28,213	(493)	(2%)	28,213	(493)	(2%)
Rural Health Women Visits	558	471	87	18%	471	87	18%	6,335	5,704	631	11%	5,704	631	11%
Rural Health Behavioral Visits	212	471	(259)	(55%)	471	(259)	(55%)	2,505	2,238	267	12%	2,238	267	12%
Total RHC Visits	**2,929**	**3,167**	**(238)**	**(8%)**	**3,167**	**(238)**	**(8%)**	**36,560**	**36,155**	**405**	**1%**	**36,155**	**405**	**1%**
Bronco Clinic Visits	-	13	(13)	(100%)	13	(13)	(100%)	394	403	(9)	(2%)	403	(9)	(2%)
Internal Medicine Clinic Visits	-	-	-	-%	-	-	-%	-	201	(201)	(100%)	201	(201)	(100%)
Orthopedic Clinic Visits	238	351	(113)	(32%)	351	(113)	(32%)	4,038	4,176	(138)	(3%)	4,176	(138)	(3%)
Pediatric Clinic Visits	473	559	(86)	(15%)	559	(86)	(15%)	6,928	7,364	(436)	(6%)	7,364	(436)	(6%)
Specialty Clinic Visits	641	530	111	21%	530	111	21%	6,778	5,042	1,736	34%	5,042	1,736	34%
Surgery Clinic Visits	196	144	52	36%	144	52	36%	1,887	1,578	309	20%	1,578	309	20%
Virtual Care Clinic Visits	51	66	(15)	(23%)	66	(15)	(23%)	678	641	37	6%	641	37	6%
Total NIA Clinic Visits	**1,599**	**1,663**	**(64)**	**(4%)**	**1,663**	**(64)**	**(4%)**	**20,703**	**19,405**	**1,298**	**7%**	**19,405**	**1,298**	**7%**
IP Surgeries	3	14	(11)	(79%)	14	(11)	(79%)	129	232	(103)	(44%)	232	(103)	(44%)
OP Surgeries	139	134	5	4%	134	5	4%	1,546	1,516	30	2%	1,516	30	2%
Total Surgeries	**142**	**148**	**(6)**	**(4%)**	**148**	**(6)**	**(4%)**	**1,675**	**1,748**	**(73)**	**(4%)**	**1,748**	**(73)**	**(4%)**
Cardiology	-	-	-	-%	-	-	-%	7	2	5	250%	2	5	250%
General	76	65	11	17%	65	11	17%	854	848	6	1%	848	6	1%
Gynecology & Obstetrics	23	12	11	92%	12	11	92%	151	184	(33)	(18%)	184	(33)	(18%)
Ophthalmology	30	25	5	20%	25	5	20%	295	271	24	9%	271	24	9%
Orthopedic	1	29	(28)	(97%)	29	(28)	(97%)	206	304	(98)	(32%)	304	(98)	(32%)
Pediatric	-	-	-	-%	-	-	-%	1	-	1	-%	-	1	-%
Plastics	-	-	-	-%	-	-	-%	2	-	2	-%	-	2	-%
Podiatry	-	1	(1)	(100%)	1	(1)	(100%)	6	2	4	200%	2	4	200%
Urology	11	14	(3)	(21%)	14	(3)	(21%)	149	135	14	10%	135	14	10%
Diagnostic Image Exams	2,134	1,814	320	18%	1,814	320	18%	25,216	24,825	391	2%	24,825	391	2%
Emergency Visits	889	879	10	1%	879	10	1%	10,219	10,080	139	1%	10,080	139	1%
ED Admits	44	38	6	16%	38	6	16%	515	427	88	21%	427	88	21%
ED Admits % of ED Visits	5%	4%	1%	14%	4%	1%	14%	5%	4%	1%	19%	4%	1%	19%
Rehab Visits	615	670	(55)	(8%)	670	(55)	(8%)	10,060	7,941	2,119	27%	7,941	2,119	27%
OP Infusion/Wound Care Visits	604	715	(111)	(16%)	715	(111)	(16%)	6,935	4,431	2,504	57%	4,431	2,504	57%
Observation Hours	1,196	1,064	132	12%	1,064	132	12%	17,469	21,806	(4,338)	(20%)	21,806	(4,338)	(20%)

Provided by: Chief Financial Officer
Report Name: June 2025 Financial Summary

Northern Inyo Healthcare District

June 2025 – 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 %
PAYOR MIX														
Blue Cross	27.1%	22.4%	4.7%	20.9%	22.4%	4.7%	20.9%	26.7%	19.0%	7.7%	40.5%	19.0%	7.7%	40.5%
Commercial	5.5%	3.1%	2.3%	74.5%	3.1%	2.3%	74.5%	6.7%	3.7%	3.0%	79.7%	3.7%	3.0%	79.7%
Medicaid	17.3%	24.7%	(7.4%)	(30.0%)	24.7%	(7.4%)	(30.0%)	21.7%	24.6%	(2.9%)	(11.7%)	24.6%	(2.9%)	(11.7%)
Medicare	45.4%	40.8%	4.6%	11.3%	40.8%	4.6%	11.3%	41.0%	47.7%	(6.7%)	(14.0%)	47.7%	(6.7%)	(14.0%)
Self-pay	1.5%	1.3%	0.1%	7.9%	1.3%	0.1%	7.9%	1.7%	3.4%	(1.6%)	(48.6%)	3.4%	(1.6%)	(48.6%)
Worker's Comp	0.6%	-%	0.6%	-%	-%	0.6%	-%	1.0%	0.4%	0.6%	141.9%	0.4%	0.6%	141.9%
Other	2.7%	7.6%	(5.0%)	(65.2%)	7.6%	(5.0%)	(65.2%)	1.1%	1.2%	(0.1%)	(6.9%)	1.2%	(0.1%)	(6.9%)
DEDUCTIONS														
Contract Adjust	(17,009,328)	(8,297,884)	(8,711,444)	105%	(9,150,988)	(7,858,339)	86%	(118,159,553)	(110,305,575)	(7,853,978)	7%	(112,228,375)	(5,931,178)	5%
Bad Debt	284,638	(568,882)	853,520	(150%)	(271,822)	556,460	(205%)	(6,686,608)	(7,793,650)	1,107,042	(14%)	(1,935,492)	(4,751,116)	245%
Write-off	(444,054)	(511,874)	67,820	(13%)	(362,039)	(82,015)	23%	(8,730,569)	(6,870,866)	(1,859,703)	27%	(5,503,223)	(3,227,346)	59%
CENSUS														
Patient Days	167	192	(25)	(13%)	192	(25)	(13%)	2,485	2,265	220	10%	2,265	220	10%
Adjusted ADC	31	42	(11)	(26%)	42	(11)	(26%)	37	34	3	9%	34	3	9%
Adjusted Days	968	1,256	(288)	(23%)	1,256	(288)	(23%)	13,070	12,420	650	5%	12,420	650	5%
Employed FTE	382.1	353.0	29.1	8%	353.0	29.1	8%	370.8	356.6	14.1	4%	356.6	14.1	4%
Contract Labor FTE	20.4	26.0	(5.5)	(21%)	26.0	(5.5)	(21%)	23.9	27.6	(3.7)	(13%)	27.6	(3.7)	(13%)
Total Paid FTE	402.6	379.0	23.6	6%	379.0	23.6	6%	394.7	384.2	10.5	3%	384.2	10.5	3%
EPOB (Employee per Occupied Bed)	2.4	2.0	0.4	22%	2.0	0.4	22%	1.9	2.1	(0.1)	(7%)	2.1	(0.1)	(7%)
EPOC (Employee per Occupied Case)	0.4	0.3	0.1	43%	0.3	0.1	43%	0.0	0.0	(0.0)	(6%)	0.0	(0.0)	(6%)
Adjusted EPOB	14.0	12.9	1.1	8%	12.9	1.1	8%	10.2	11.3	(1.2)	(10%)	11.3	(1.2)	(10%)
Adjusted EPOC	2.5	2.0	0.5	27%	2.0	0.5	27%	0.2	0.2	(0.0)	(9%)	0.2	(0.0)	(9%)
SALARIES														
Per Adjust Bed Day	5,695	2,744	2,951	108%	2,415	3,279	136%	3,210	3,377	(167)	(5%)	3,114	96	3%
Total Salaries	5,511,992	3,446,459	2,065,533	60%	3,033,481	2,478,511	82%	41,959,974	41,939,782	20,192	0%	38,674,815	3,285,160	8%
Average Hourly Rate	84.14	56.95	27.19	48%	50.12	34.02	68%	54.26	56.38	(2.13)	(4%)	51.85	2.41	5%
Employed Paid FTEs	382.1	353.0	29.1	323.9	353.0	29.1	8%	370.8	356.6	14.1	4%	356.6	14.1	4%
BENEFITS														
Per Adjust Bed Day	615	1,629	(1,014)	(62%)	1,159	(544)	(47%)	1,287	2,009	(722)	(36%)	1,642	(355)	(22%)
Total Benefits	595,293	2,046,554	(1,451,262)	(71%)	1,456,281	(860,988)	(59%)	16,821,936	24,956,580	(8,134,644)	(33%)	20,389,997	(3,568,061)	(17%)
Benefits % of Wages	11%	59%	(49%)	(82%)	48%	-37%	(78%)	40%	60%	(19%)	(33%)	53%	(13%)	(24%)
Pension Expense	(288,661)	497,683	(786,344)	(158%)	760,350	(1,049,012)	(138%)	4,054,888	5,974,666	(1,919,778)	(32%)	5,777,673	(1,722,785)	(30%)
MDV Expense	510,871	748,612	(237,741)	(32%)	360,144	150,727	42%	8,790,515	8,983,344	(192,829)	(2%)	10,773,145	(1,982,631)	(18%)
Taxes, PTO accrued, Other	373,083	800,260	(427,177)	(53%)	335,787	37,296	11%	3,976,533	9,998,570	(6,022,036)	(60%)	3,839,179	137,354	4%
Salaries, Wages & Benefits	6,107,285	5,493,013	614,272	11%	4,489,762	1,617,523	36%	58,781,911	66,896,362	(8,114,452)	(12%)	59,064,812	(282,901)	(0%)
SWB/APD	6,310	4,373	1,936	44%	3,575	2,735	77%	4,497	5,386	(889)	(17%)	4,756	(258)	(5%)
SWB % of Total Expenses	55%	55%	(1%)	(1%)	55%	(0%)	(1%)	50%	55%	(5%)	(9%)	51%	(1%)	(2%)

Provided by: Chief Financial Officer
Report Name: June 2025 Financial Summary

Northern Inyo Healthcare District

June 2025 – 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 %
PROFESSIONAL FEES														
Per Adjust Bed Day	2,978	1,756	1,222	70%	2,427	551	23%	2,457	2,157	301	14%	2,477	(19)	(1%)
Total Physician Fee	1,621,674	1,463,822	157,852	11%	1,621,499	175	0%	19,350,587	17,564,267	1,786,320	10%	18,551,493	799,094	4%
Total Contract Labor	537,390	343,860	193,530	56%	774,264	(236,874)	(31%)	5,369,335	4,209,291	1,160,044	28%	6,024,606	(655,271)	(11%)
Total Other Pro-Fees	723,591	397,634	325,957	82%	652,578	71,013	11%	7,398,030	5,012,217	2,385,813	48%	6,182,386	1,215,644	20%
Total Professional Fees	2,882,655	2,205,317	677,338	31%	3,048,342	(165,687)	(5%)	32,117,952	26,785,776	5,332,176	20%	30,758,485	1,359,467	4%
Contract AHR	153.33	77.29	76.04	98%	174.03	(20.71)	(12%)	107.77	73.25	34.51	47%	104.56	3.21	3%
Contract Paid FTEs	20.4	26.0	(5.5)	(21%)	26.0	(5.5)	(21%)	23.9	27.6	(3.7)	(13%)	27.6	(3.7)	(13%)
Physician Fee per Adjust Bed Day	1,675	1,165	510	44%	1,291	384	30%	1,481	1,414	66	5%	1,494	(13)	(1%)
PHARMACY														
Per Adjust Bed Day	84	367	(283)	(77%)	692	(608)	(88%)	329	446	(117)	(26%)	470	(141)	(30%)
Total Rx Expense	81,516	461,460	(379,944)	(82%)	869,201	(787,686)	(91%)	4,297,639	5,537,516	(1,239,876)	(22%)	5,832,893	(1,535,253)	(26%)
MEDICAL SUPPLIES														
Per Adjust Bed Day	1,289	341	948	278%	(1,345)	2,634	(196%)	461	414	47	11%	281	181	64%
Total Medical Supplies	1,247,647	427,743	819,904	192%	(1,689,273)	2,936,920	(174%)	6,027,806	5,146,455	881,351	17%	3,485,151	2,542,656	73%
EHR SYSTEM														
Per Adjust Bed Day	45	107	(62)	(58%)	108	(62)	(58%)	33	130	(97)	(75%)	32	1	4%
Total EHR Expense	44,018	135,000	(90,982)	(67%)	135,492	(91,474)	(68%)	431,744	1,620,000	(1,188,256)	(73%)	393,606	38,138	10%
OTHER EXPENSE														
Per Adjust Bed Day	343	670	(327)	(49%)	700	(357)	(51%)	793	831	(38)	(5%)	831	(38)	(5%)
Total Other	332,015	841,201	(509,186)	(61%)	879,248	(547,233)	(62%)	10,365,024	10,323,994	41,030	0%	10,319,786	45,238	0%
DEPRECIATION AND AMORTIZATION														
Per Adjust Bed Day	506	289	217	75%	350	156	45%	389	351	38	11%	443	(53)	(12%)
Total Depreciation and Amortization	490,098	363,578	126,520	35%	439,581	50,517	11%	5,086,781	4,362,936	723,845	17%	5,498,024	(411,244)	(7%)
TOTAL EXPENSES	11,185,234	9,927,312	1,257,922	13%	8,172,354	3,012,880	37%	117,108,857	120,673,039	(3,564,182)	(3%)	115,352,756	1,756,100	2%
Per Adjust Bed Day	11,556	7,904	3,652	46%	6,507	5,049	78%	8,960	9,716	(756)	(8%)	9,288	(328)	(4%)
Per Calendar Day	372,841	330,910	41,931	13%	272,412	100,429	37%	320,846	330,611	(9,765)	(3%)	315,171	5,675	2%

Provided by: Chief Financial Officer
Report Name: June 2025 Financial Summary

Key Financial Performance Indicators	Industry Benchmark	Jun-23	FYE 2023 Average	Jun-24	FYE 2024 Average	Mar-25	Apr-25	May-25	Jun-25	Variance to PM	Variance to FYE 2024 Average	Variance to PYM
Volume												
Admits	41	83	68	71	71	60	51	87	65	(22)	(6)	(6)
Deliveries	n/a	17	17	22	17	14	8	19	18	(1)	1	(4)
Adjusted Patient Days	n/a	1,105	977	1,145	1,035	511	907	1,399	968	(431)	(67)	(177)
Total Surgeries	153	81	120	148	146	117	157	123	142	19	(4)	(6)
ER Visits	659	851	810	879	840	825	794	899	889	(10)	49	10
RHC and Clinic Visits	n/a	4,381	4,353	4,554	4,607	4,734	5,193	4,911	4,528	(383)	(79)	(26)
Diagnostic Imaging Services	n/a	2,051	2,020	1,814	2,069	2,057	2,081	2,210	2,134	(76)	65	320
Rehab Services	n/a	896	762	670	662	860	1,161	865	615	(250)	(47)	(55)
AR & Income												
Gross AR (Cerner only)	n/a	$ 50,668,396	$ 53,638,580	$ 54,287,686	$ 52,823,707	$ 48,628,722	$ 51,510,454	$ 49,751,818	$ 45,165,161	$ (4,586,657)	$ (7,658,547)	$ (9,122,525)
AR > 90 Days	$ 7,001,767.65	$ 25,752,910	$ 23,387,686	$ 22,959,460	$ 24,488,432	$ 16,111,701	$ 18,527,180	$ 20,779,018	$ 18,682,553	$ (2,096,465)	$ (5,805,879)	$ (4,276,907)
AR % > 90 Days	15%	51.55%	45.3%	43.0%	46.7%	33.1%	36.0%	41.8%	41.4%	-0.4%	-5.3%	-1.6%
Gross AR Days (per financial statements)	60	93	98	89	85	70	85	84	71.49	(13)	(14)	(17)
Net AR Days (per financial statements)	30	47	73	63	58	45	103	83	126.0	43	68	63
Net AR	n/a	$ 9,351,360	$ 17,800,084	$ 17,964,704	$ 16,938,200	$ 18,641,177	$ 12,663,338	$ 24,454,016	$ 18,225,043	$ (6,228,973)	$ 1,286,843	$ 260,339
Net AR % of Gross	n/a	18.5%	33.1%	33.1%	31.9%	38.3%	24.6%	49.2%	40.4%	-8.8%	8.4%	7.3%
Gross Patient Revenue/Calendar Day	n/a	$ 543,011	$ 546,652	$ 610,465	$ 619,457	$ 699,090	$ 606,428	$ 589,849	$ 631,767	$ 41,919	$ 12,310	$ 21,303
Net Patient Revenue/Calendar Day	n/a	$ 198,702	$ 243,317	$ 284,303	$ 292,759	$ 354,409	$ 179,938	$ 250,736	$ 148,317	$ (102,420)	$ (144,442)	$ (135,986)
Net Patient Revenue/APD	n/a	$ 5,395	$ 7,622	$ 7,449	$ 8,757	$ 21,500	$ 5,952	$ 5,557	$ 4,597	$ (960)	$ (4,160)	$ (2,852)
Wages												
Wages	n/a	$ 5,954,820	$ 3,281,173	$ 3,033,481	$ 3,285,431	$ 3,511,824	$ 3,803,369	$ 3,599,495	$ 5,511,992	$ 1,912,497	$ 2,226,561	$ 2,478,511
Employed paid FTEs	n/a	364.62	384.63	353.75	353.69	368.66	383.03	375.45	382.15	6.70	28.46	28.39
Employed Average Hourly Rate	$55.50	$ 95.27	$ 49.86	$ 50.02	$ 53.32	$ 53.92	$ 58.08	$ 54.27	$ 84.37	$ 30.10	$ 31.05	$ 34.35
Benefits	n/a	$ 1,610,167	$ 1,907,194	$ 1,456,281	$ 1,640,216	$ 1,667,467	$ 1,415,779	$ 1,155,616	$ 595,293	$ (560,323)	$ (1,044,923)	$ (860,988)
Benefits % of Wages	30%	27.0%	58.7%	48.0%	50.3%	47.5%	37.2%	32.1%	10.8%	-21.3%	-39.5%	-37.2%
Contract Labor	n/a	$ 803,281	$ 808,284	$ 774,264	$ 518,351	$ 283,021	$ 452,748	$ 392,345	$ 537,390	$ 145,045	$ 19,039	$ (236,874)
Contract Labor Paid FTEs	n/a	39.55	40.27	25.95	23.49	22.16	21.29	19.69	20.45	0.75	(3.05)	(5.51)
Total Paid FTEs	n/a	404.17	424.90	379.71	377.18	390.82	404.32	395.14	402.59	7.46	25.42	22.89
Contract Labor Average Hourly Rate	$ 81.04	$ 118.48	$ 112.84	$ 174.03	$ 126.74	$ 72.30	$ 124.38	$ 112.79	$ 153.75	$ 40.96	$ 27.01	$ (20.28)
Total Salaries, Wages, & Benefits (including contract labor)	n/a	$ 8,368,268	$ 5,996,651	$ 5,264,026	$ 5,443,998	$ 5,462,313	$ 5,671,896	$ 5,147,456	$ 6,644,675	$ 1,497,219	$ 1,200,677	$ 1,380,649
SWB% of NR	50%	140.4%	79.8%	61.7%	63.2%	49.7%	105.1%	66.2%	149.3%	83.1%	86.2%	87.6%
SWB/APD	2,572	$ 7,573	$ 5,909	$ 4,597	$ 5,346	$ 10,689	$ 6,254	$ 3,680	$ 6,865	$ 3,185	$ 1,519	$ 2,268
SWB % of total expenses	50%	92.2%	66.0%	64.4%	56.7%	53.1%	57.0%	50.2%	59.4%	9.2%	2.7%	-5.0%

Physician Spend	Industry Benchmark	Jun-23	FYE 2023 Average	Jun-24	FYE 2024 Average	Mar-25	Apr-25	May-25	Jun-25	Variance to PM	Variance to FYE 2024 Average	Variance to PYM
Physician Expenses	n/a	$ 1,428,974	$ 1,400,634	$ 1,621,499	$ 1,507,510	$ 1,809,889	$ 1,656,184	$ 1,878,965	$ 1,621,674	$ (257,291)	$ 114,164	$ 175
Physician expenses/APD	n/a	$ 1,293	$ 1,451	$ 1,416	$ 1,478	$ 3,542	$ 1,826	$ 1,343	$ 1,675	$ 332	$ 197	$ 259
Supplies												
Supply Expenses	n/a	$ (985,032)	$ 544,557	$ (820,071)	$ 776,504	$ 1,059,159	$ 616,123	$ 579,458	$ 1,329,163	$ 749,705	$ 552,659	$ 2,149,234
Supply expenses/APD		$ (891)	$ 579	$ (716)	$ 780	$ 2,073	$ 679	$ 414	$ 1,373	$ 959	$ 593	$ 2,089
Other Expenses												
Other Expenses	n/a	$ 268,236	$ 1,138,604	$ 2,106,900	$ 1,891,477	$ 1,963,696	$ 2,012,839	$ 2,652,181	$ 1,589,722	$ (1,062,459)	$ (301,755)	$ (517,178)
Other Expenses/APD	n/a	$ 243	$ 1,178	$ 1,840	$ 1,878	$ 3,843	$ 2,219	$ 1,896	$ 1,642	$ (254)	$ (235)	$ (198)
Margin												
Net Income	n/a	$ (5,031,592)	$ (1,448,727)	$ 785,068	$ 383,722	$ 764,746	$ (3,722,346)	$ (2,134,682)	$ 2,400,606	$ 4,535,288	$ 2,016,884	$ 1,615,538
Net Profit Margin	n/a	-84.4%	-20.8%	9.2%	3.0%	7.0%	-69.0%	-27.5%	54.0%	81.4%	51.0%	44.8%
Operating Income	n/a	$ (5,308,483)	$ (2,495,327)	$ 356,735	$ (686,444)	$ 691,628	$ (4,558,891)	$ (2,485,229)	$ (6,735,735)	$ (4,250,506)	$ (6,049,290)	$ (7,092,470)
Operating Margin	2.9%	-89.1%	-33.0%	4.2%	-10.9%	6.3%	-84.5%	-32.0%	-151.4%	-119.4%	-140.5%	-155.6%
EBITDA	n/a	$ (5,370,917)	$ (1,789,289)	$ 1,224,650	$ 841,891	$ 1,173,910	$ (3,313,182)	$ (1,725,518)	$ 2,890,704	$ 4,616,223	$ 2,048,814	$ 1,666,054
EBITDA Margin	12.7%	-90.1%	-22.6%	14.4%	8.7%	10.7%	-61.4%	-22.2%	65.0%	87.2%	56.2%	50.6%
Debt Service Coverage Ratio	3.70	(5.8)	(5.8)	3.9	3.3	6.6	4.2	3.1	3.9	0.8	0.6	(0.0)
Cash												
Avg Daily Disbursements (excl. IGT)	n/a	$ 489,123	$ 363,636	$ 332,307	$ 355,328	$ 314,837	$ 321,662	$ 359,335	$ 295,398	$ (63,937)	$ (59,931)	$ (36,910)
Average Daily Cash Collections (excl. IGT)	n/a	$ 482,340	$ 340,919	$ 291,820	$ 299,110	$ 363,569	$ 391,697	$ 359,285	$ 343,912	$ (15,373)	$ 44,802	$ 52,092
Average Daily Net Cash		$ (6,783)	$ (22,716)	$ (40,487)	$ (56,218)	$ 48,733	$ 70,035	$ (50)	$ 48,514	$ 48,564	$ 104,732	$ 89,002
Upfront Cash Collections				$ 34,997	$ 36,146	$ 78,395	$ 71,226	$ 81,100	$ 64,886	$ (16,214)	$ 28,740	$ 29,889
Upfront Cash % of Gross Charges	1%	0.0%	0.0%	0.2%	0.2%	0.4%	0.4%	0.4%	0.3%	-0.1%	0.1%	0.2%
Unrestricted Funds	n/a	$ 31,636,319	$ 25,185,410	$ 25,138,815	$ 23,536,438	$ 23,918,889	$ 27,688,938	$ 27,908,135	$ 28,996,641	$ 1,088,506	$ 5,460,203	$ 3,857,825
Change of cash per balance sheet	n/a	$ 4,895,725	$ 204,360	$ (2,649,693)	$ (541,459)	$ 113,019	$ 3,770,050	$ 219,197	$ 1,088,506	$ 869,309	$ 1,629,964	$ 3,738,198
Days Cash on Hand (assume no more cash is collected)	196	105	83	84	72	80	92	92	94	2	22	10
Estimated Days Until Depleted (operating cash only)		4,664	1,109	447	406	411	610	676	858	182	452	411
Years Until Cash Depletion (operating cash only)		12.78	3.04	1.23	1.11	1.13	1.67	1.85	2.35	0.50	1.24	1.12

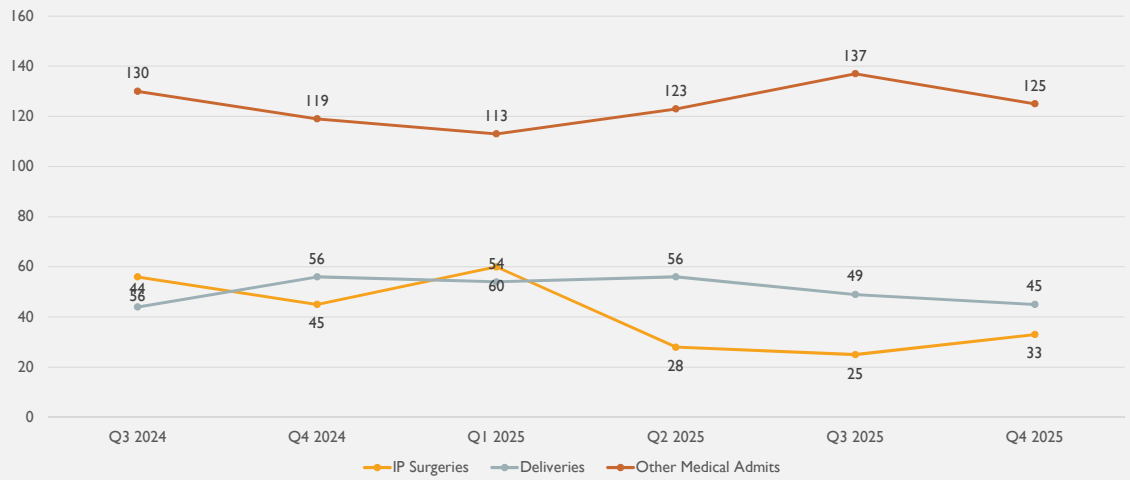
NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

NIHD FINANCIAL UPDATE

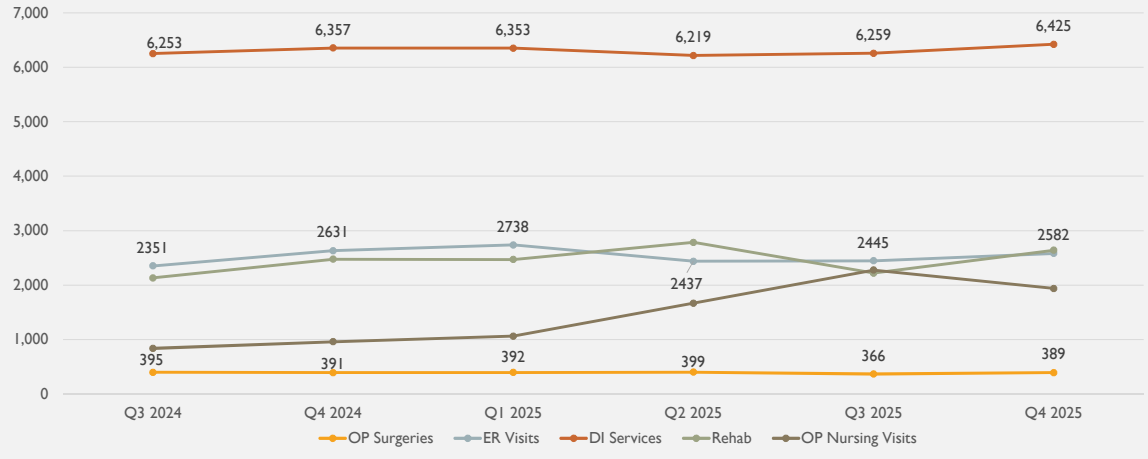
June 2025

VOLUMES & INCOME

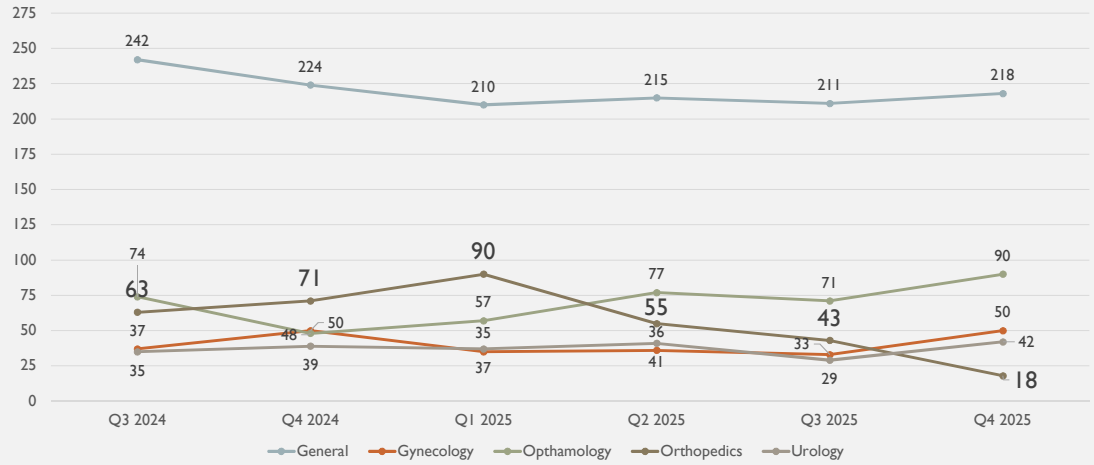
INPATIENT VOLUME PERFORMANCE



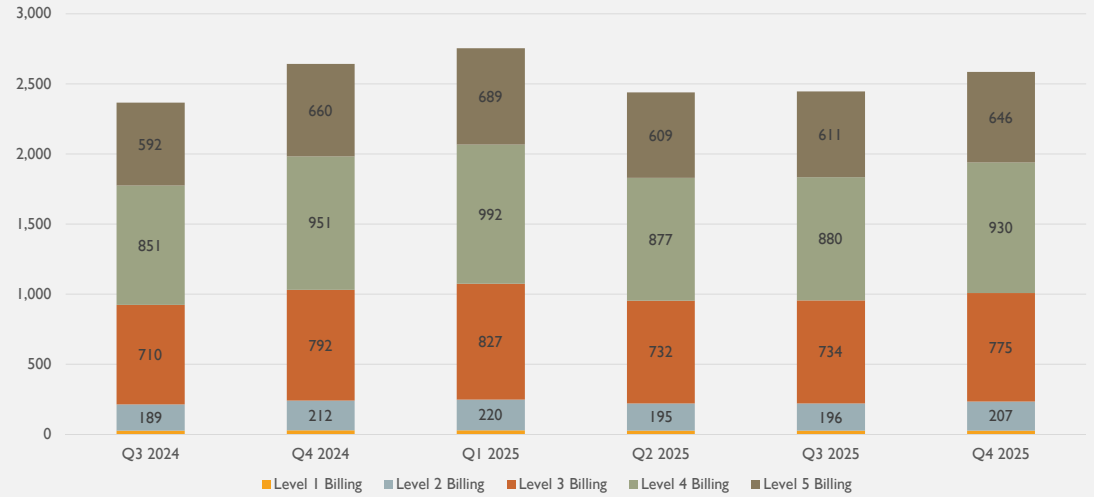
OUTPATIENT VOLUME PERFORMANCE



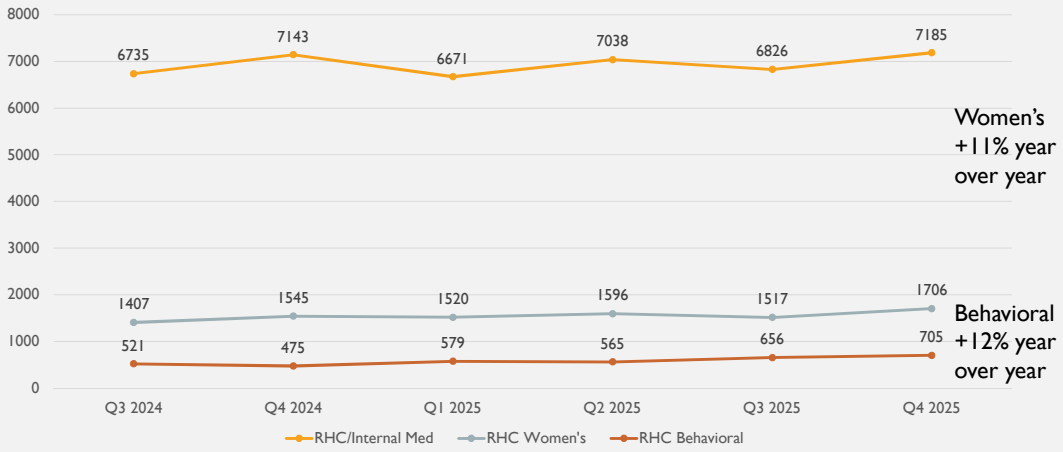
SURGERIES BY SPECIALTY



ER VISITS



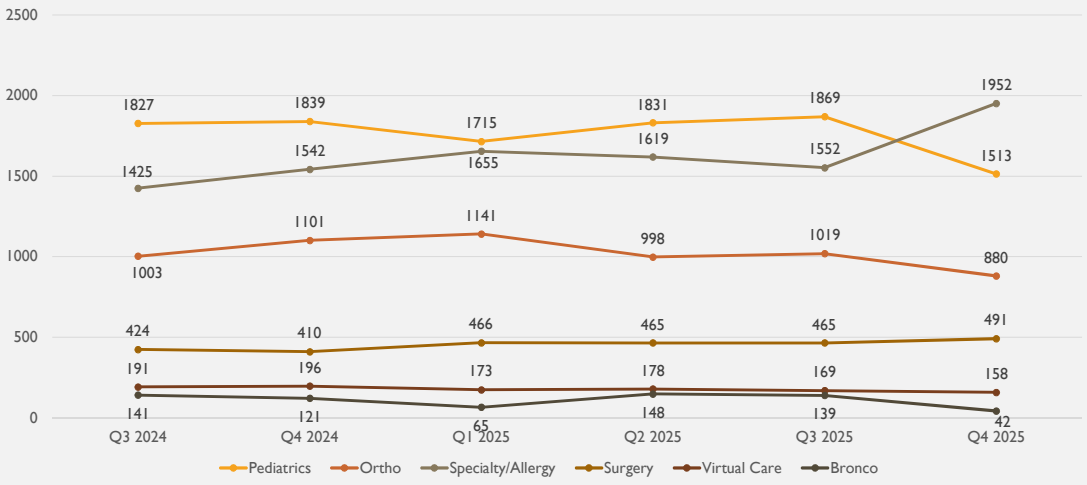
RHC VISITS



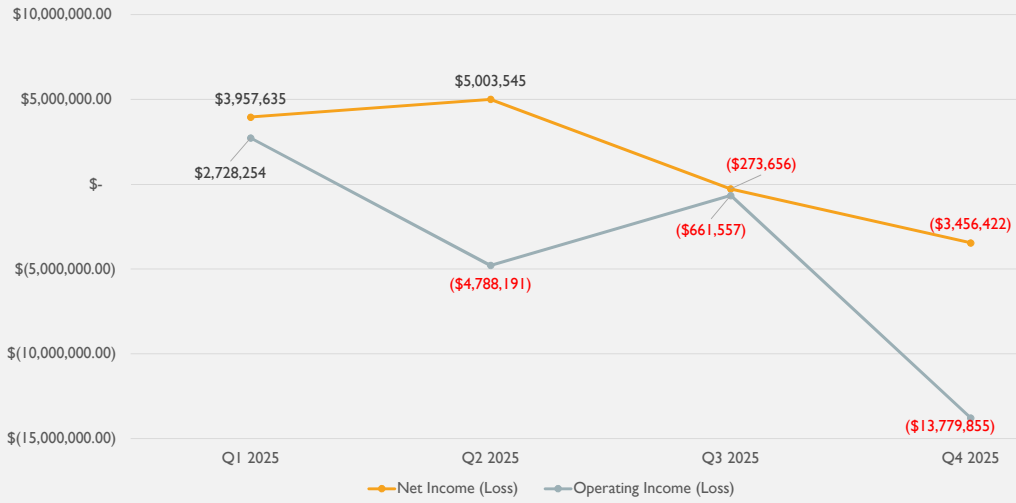
Women's +11% year over year

Behavioral +12% year over year

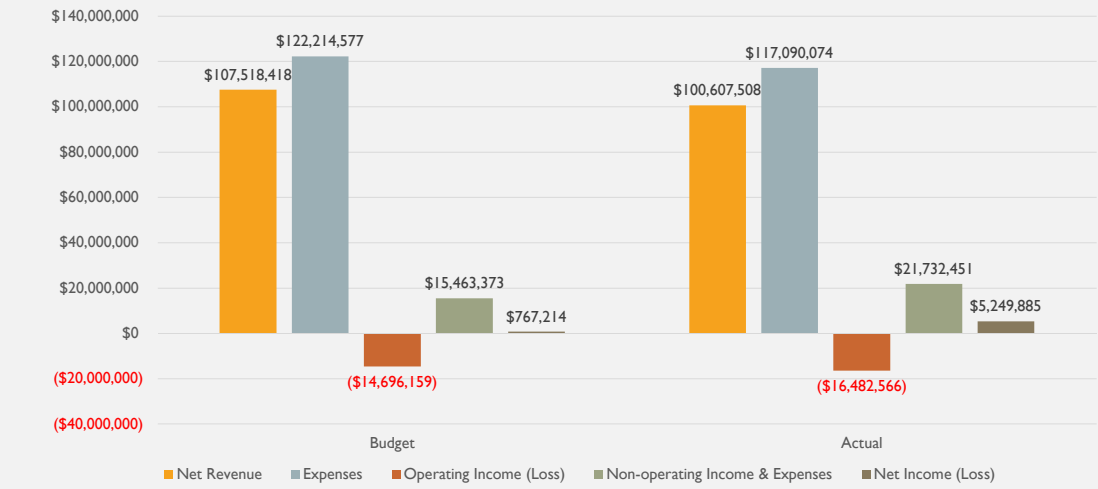
CLINIC VOLUME PERFORMANCE



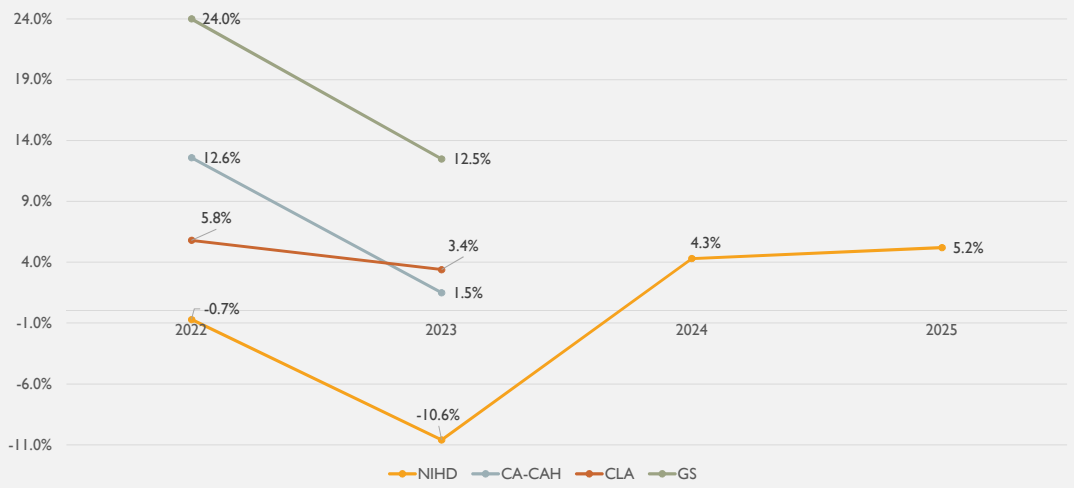
FYE 2025 INCOME TREND



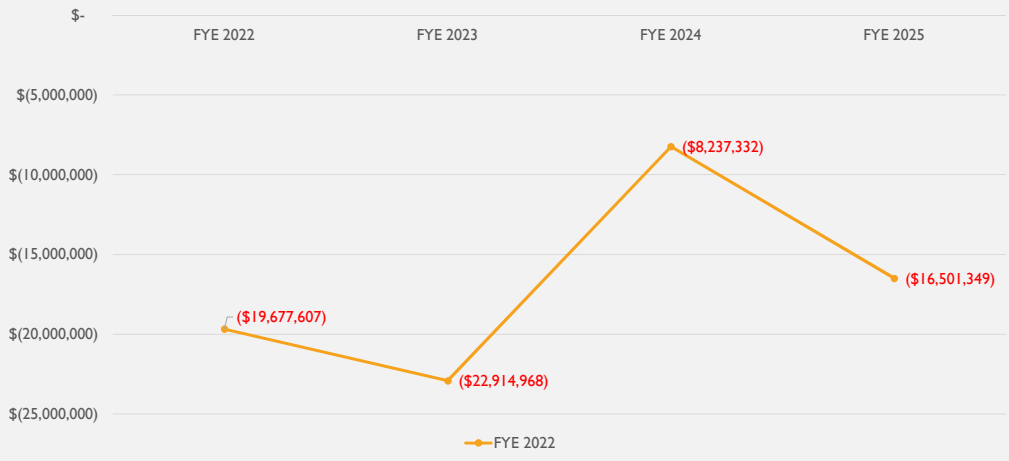
FYE 2025 INCOME TO BUDGET



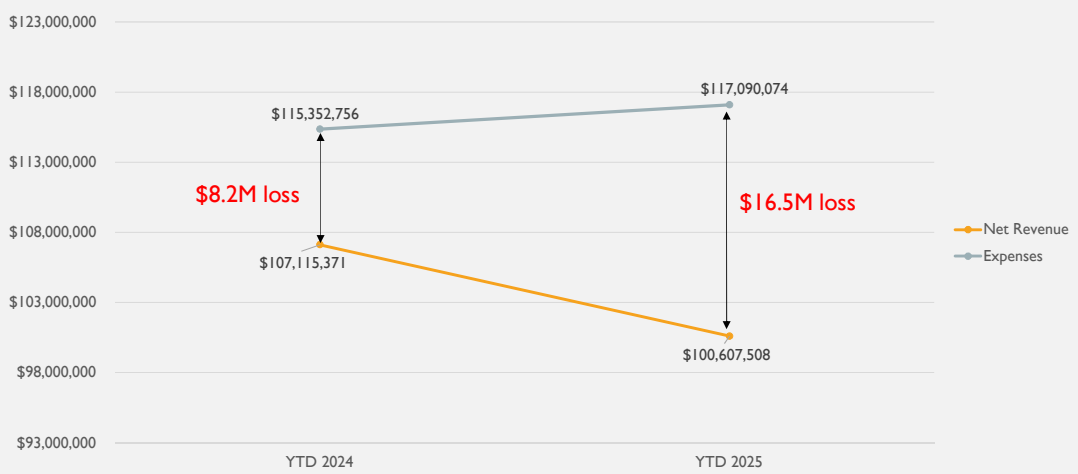
NET PROFIT MARGIN



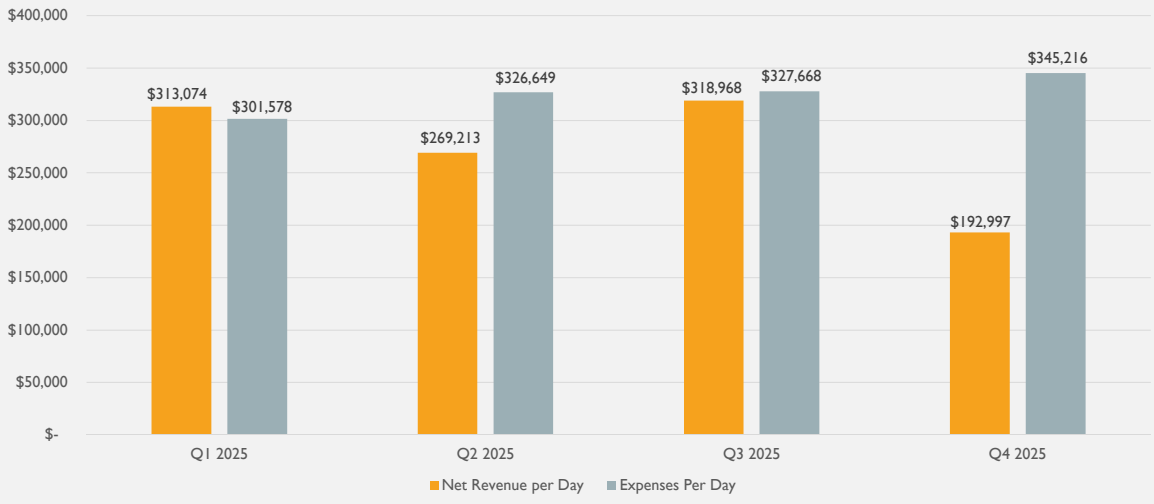
OPERATING LOSS TREND



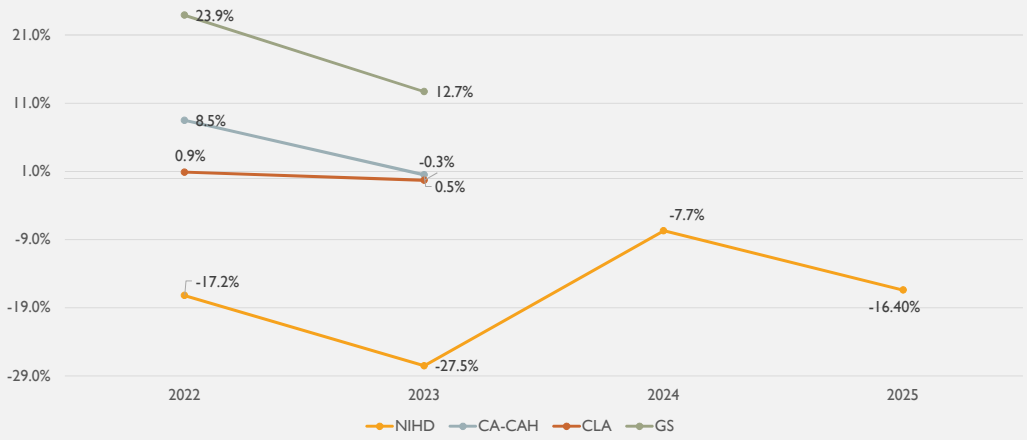
YTD OPERATING INCOME (LOSS) PERFORMANCE



TREND PER CALENDAR DAY



OPERATING MARGIN



WAGE COSTS

	YTD 2024	YTD 2025
Total Paid FTEs	384	395
Salaries, Wages, Benefits (SWB) Expense (incl. contract labor)	$65,089,418	$64,151,246
SWB % of total expenses (including contract labor)	56%	55%
Employed Average Hourly Rate	$51.85	$54.26
Benefits % of Wages	53%	40%

VOLUME & INCOME ACTION PLAN

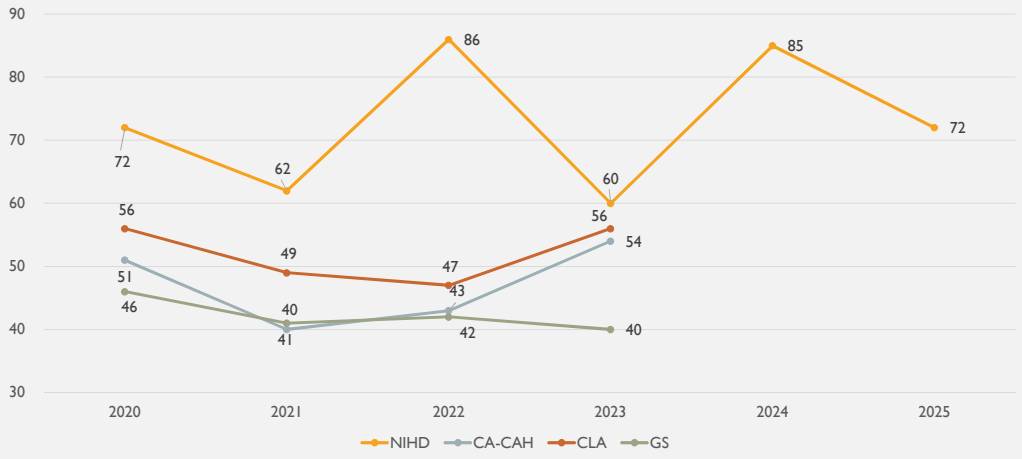
- The Mammoth Orthopedic Institute hit the ground running in July. We anticipate recouping the lost surgical volumes and increasing our revenue.
- We are working on reviewing operational efficiency including OR utilization and space utilization reviews to maximize patient flow and care.
- We are being more deliberate in our service line strategy.
- Additionally, we are educating leaders to be the "CEO of their own cost center" and manage their expenses to budgets FYE 2026.
- We have developed reports to monitor our largest expense better including overtime, missed meal and rest breaks, and call pay to ensure we are staffing effectively. Leaders will be educated in August on how to review these reports, which will be sent out each pay period.
- We have made progress hiring permanent employees instead of contractors, which saves us 32% on average. We have completed trainings with leaders on reports to monitor premium pay including overtime for our contractors.
- We will continue to review opportunities with our benefits broker to save money while still offering quality benefits to our employees.

CASH PERFORMANCE

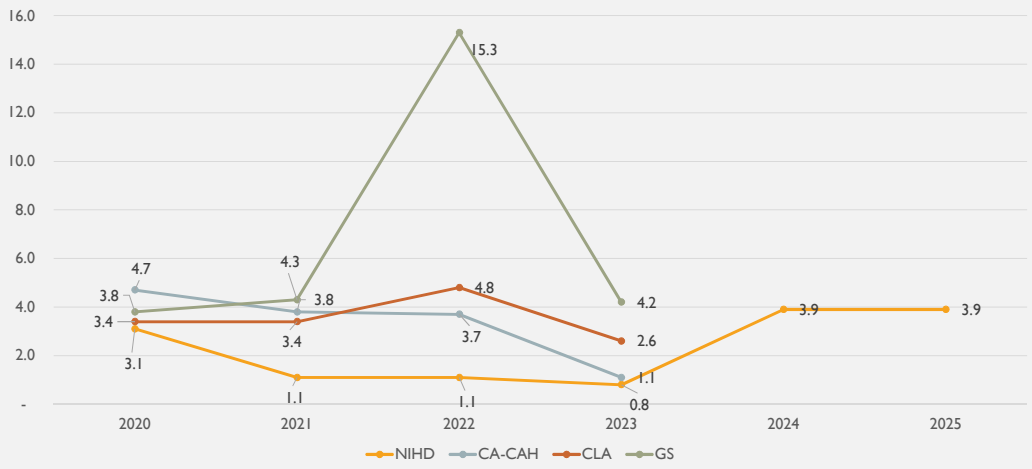
INCOME TO CASH

	FYE 2025
Net Income	**$5,249,885**
Bond Principle Payments	$(1,862,332)
Other Debt (long-term leases & subscriptions)	$(1,509,879)
Capital purchases	$(1,088,396)
Accrued but not paid in cash (timing)	$1,265,721
Impact to Cash	**$(3,194,886)**
Adjusted Net Income	**$2,054,999**

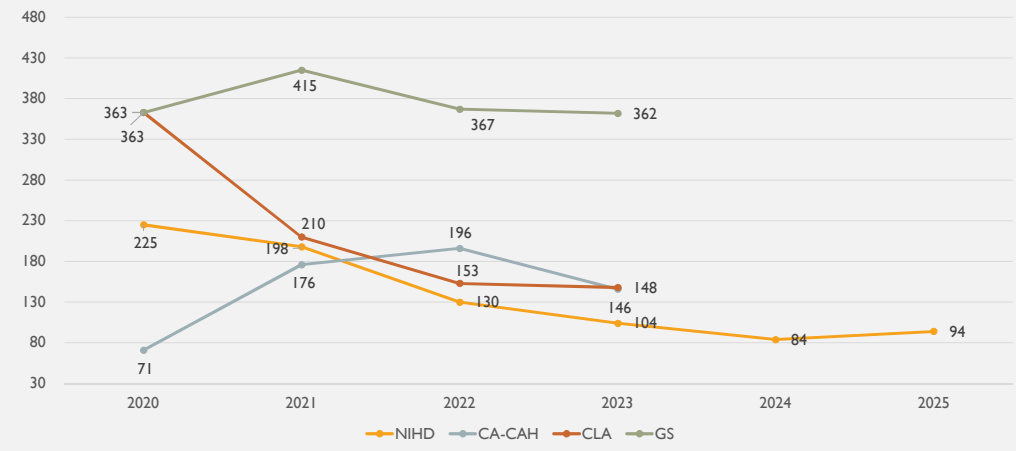
GROSS AR DAYS



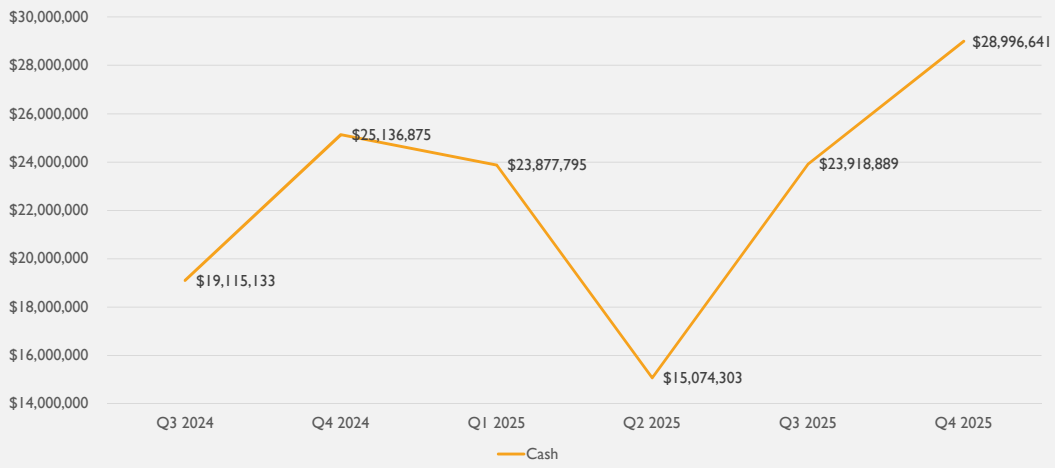
DEBT SERVICE COVERAGE RATIO



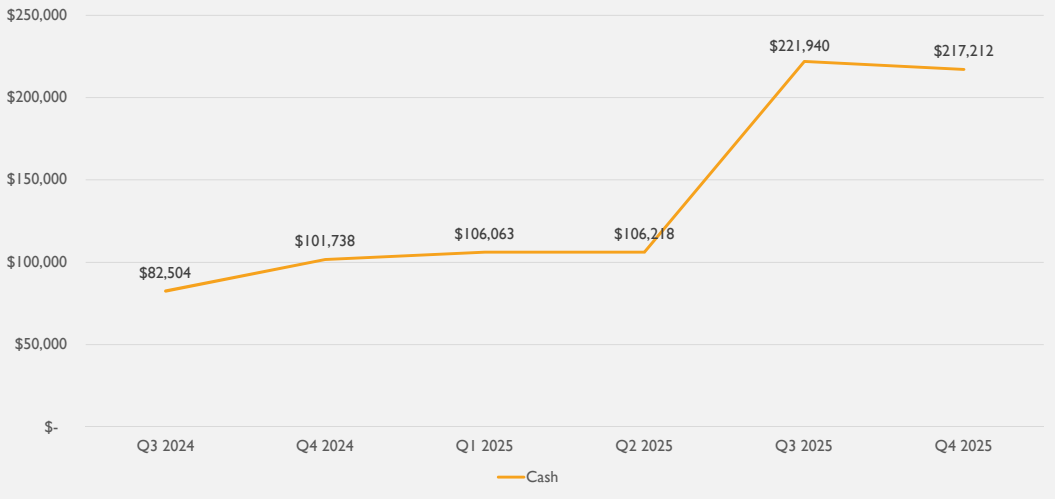
DAYS CASH ON HAND



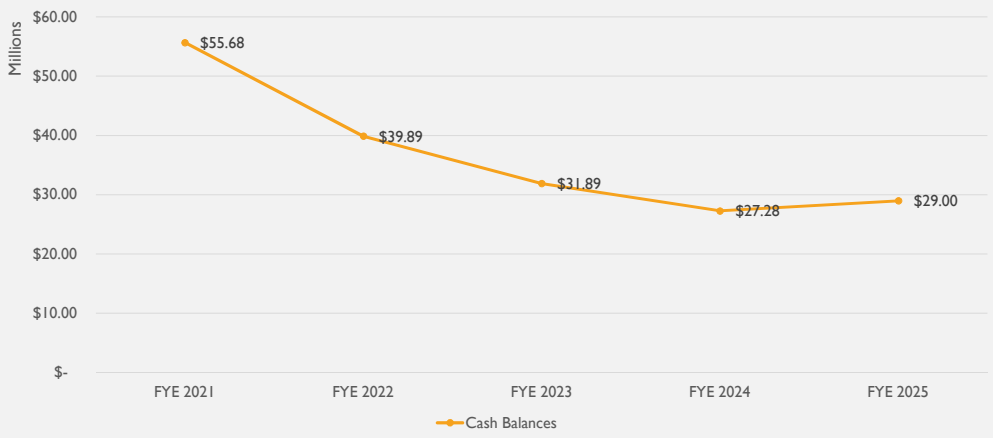
UNRESTRICTED FUNDS



UPFRONT CASH COLLECTIONS



CASH BALANCE TREND



CASH ACTION PLAN

- The cash flow action team is working to improve processes in all aspects of billing and collections.
- We have hired a new AI-based billing company, Jorie, and have hit record cash collections the past few months. The automation is now live in several areas.
- We have switched billing companies for Medicare and Commercial payors to help facilitate a thorough and efficient billing process. This should expedite our cash flow timing and decrease our billing errors.
- Additionally, we have hired two contingency-based companies that will help us recoup money from insurance companies by disputing denials and holding insurance companies accountable for underpayments on claims.
- Lastly, we will evaluate moving money to take advantage of better interest rates along with reviewing early payment of capital appreciation bond to save on interest payments.

Northern Inyo Healthcare District
Income Statement
Fiscal Year 2025

	4/30/2025	Apr Budget	4/30/2024	5/31/2025	May Budget	5/31/2024	6/30/2025	Jun Budget	6/30/2024	2025 YTD	2024 YTD	Budget Variance	PYM Change	PYTD Change
Gross Patient Service Revenue														
Inpatient Patient Revenue	3,003,097	3,168,714	3,215,615	3,371,624	3,526,682	3,646,287	3,271,065	3,058,994	2,799,611	44,044,886	41,353,814	212,071	471,454	2,691,071
Outpatient Revenue	13,297,993	13,441,623	15,650,478	13,103,211	14,185,079	14,890,447	14,026,215	14,099,737	13,848,705	166,541,415	166,032,671	(73,522)	177,510	508,744
Clinic Revenue	1,891,743	1,579,674	1,763,094	1,810,472	1,587,112	1,822,994	1,655,734	1,535,631	1,665,622	21,078,588	19,388,997	120,104	(9,888)	1,689,590
Gross Patient Service Revenue	18,192,833	18,190,012	20,629,186	18,285,307	19,298,872	20,359,728	18,953,014	18,694,362	18,313,938	231,664,888	226,775,482	258,652	639,076	4,889,406
Deductions from Revenue														
Contractual Adjustments	(8,841,205)	(8,800,983)	(10,525,952)	(7,499,521)	(9,183,956)	(9,761,982)	(17,009,328)	(8,297,884)	(9,150,988)	(118,159,553)	(112,228,375)	(8,711,444)	(7,858,339)	(5,931,178)
Bad Debt	(3,774,465)	(597,905)	131,776	(2,837,626)	(582,161)	(538,525)	284,638	(568,882)	(271,822)	(6,686,608)	(1,935,492)	853,520	556,460	(4,751,116)
A/R Writeoffs	(179,014)	(542,909)	(285,526)	(177,633)	(566,533)	(410,472)	(444,054)	(511,874)	(362,039)	(8,730,569)	(5,503,223)	67,820	(82,015)	(3,227,346)
Other Deductions from Revenue	-	-	-	-	-	-	2,665,229	-	-	2,512,611	-	2,665,229	2,665,229	2,512,611
Deductions from Revenue	(12,794,684)	(9,941,797)	(10,679,701)	(10,514,779)	(10,332,650)	(10,710,978)	(14,503,515)	(9,378,640)	(9,784,849)	(131,064,119)	(119,667,090)	(5,124,875)	(4,718,665)	(11,397,029)
Other Patient Revenue														
Incentive Income	-	-	-	2,304	-	-	-	-	-	4,304	-	-	-	4,304
Other Oper Rev - Rehab Thera Serv	-	-	-	-	-	3,163	-	-	-	2,435	6,979	-	-	(4,544)
Medical Office Net Revenue	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Patient Revenue	-	-	-	2,304	-	3,163	-	-	-	6,738	6,979	-	-	(240)
Net Patient Service Revenue	**5,398,149**	**8,248,215**	**9,949,485**	**7,772,831**	**8,966,222**	**9,651,912**	**4,449,499**	**9,315,722**	**8,529,089**	**100,607,508**	**107,115,371**	**(4,866,223)**	**(4,079,589)**	**(6,507,863)**
CNR%	**29.7%**	**45.3%**	**48.2%**	**42.5%**	**46.5%**	**47.4%**	**23.5%**	**49.8%**	**46.6%**	**43.4%**	**47.2%**	**-26.4%**	**-23.1%**	**-3.8%**
Cost of Services - Direct														
Salaries and Wages	3,078,978	3,453,964	2,792,227	3,089,016	3,536,678	2,867,100	4,625,502	3,446,459	2,586,924	35,512,981	33,072,822	1,179,043	2,038,578	2,440,159
Benefits	1,277,083	2,065,622	2,146,672	935,894	2,072,172	1,340,313	478,322	2,046,554	1,246,538	14,329,400	17,447,082	(1,568,233)	(768,216)	(3,117,682)
Professional Fees	1,903,652	1,880,084	1,780,229	2,159,742	1,884,595	1,979,333	1,897,471	1,861,456	1,925,702	22,232,593	21,672,034	36,015	(28,230)	560,559
Contract Labor	355,281	343,860	205,329	292,586	349,333	952,538	422,463	343,860	629,292	4,406,562	5,357,160	78,602	(206,829)	(950,597)
Pharmacy	327,061	461,460	656,870	331,813	461,460	400,601	81,516	461,460	869,201	4,297,639	5,832,893	(379,944)	(787,686)	(1,535,253)
Medical Supplies	289,061	427,518	352,626	247,645	430,271	345,474	1,247,647	427,743	(1,689,273)	6,027,806	3,485,151	819,904	2,936,920	2,542,656
Hospice Operations	-	-	-	-	-	-	-	-	-	-	-	-	-	-
EHR System Expense	44,592	135,000	16,399	49,037	135,000	17,826	44,018	135,000	135,492	431,744	393,606	(90,982)	(91,474)	38,138
Other Direct Expenses	602,461	869,498	571,418	737,203	834,554	562,883	484,303	841,201	681,482	7,762,479	7,981,583	(356,898)	(197,180)	(219,104)
Total Cost of Services - Direct	7,878,169	9,637,006	8,521,770	7,842,936	9,704,063	8,466,067	9,281,241	9,563,734	6,385,358	95,001,204	95,242,330	(282,493)	2,895,883	(241,125)
General and Administrative Overhead														
Salaries and Wages	724,391	-	547,877	510,479	-	444,697	886,490	-	446,557	6,446,994	5,601,993	886,490	439,934	845,001
Benefits	138,697	-	346,888	219,722	-	231,676	116,971	-	209,744	2,492,537	2,942,916	116,971	(92,773)	(450,379)
Professional Fees	431,885	-	153,271	890,001	-	222,585	447,793	-	348,376	4,516,024	3,061,845	447,793	99,418	1,454,179
Contract Labor	97,467	-	114,784	99,759	-	16,409	114,927	-	144,973	962,773	667,446	114,927	(30,045)	295,326
Depreciation and Amortization	409,164	363,578	438,198	409,164	363,578	447,841	490,098	363,578	439,581	5,086,781	5,498,024	126,520	50,517	(411,244)
Other Administative Expenses	277,268	-	336,216	285,999	-	175,162	(152,287)	-	197,765	2,602,545	2,338,203	(152,287)	(350,053)	264,343
Total General and Administrative Overhead	2,078,872	363,578	1,937,234	2,415,124	363,578	1,538,370	1,903,993	363,578	1,786,996	22,107,652	20,110,427	1,540,415	116,997	1,997,226
Total Expenses	**9,957,041**	**10,000,584**	**10,459,004**	**10,258,060**	**10,067,641**	**10,004,437**	**11,185,234**	**9,927,312**	**8,172,354**	**117,090,074**	**115,352,756**	**1,257,922**	**3,012,880**	**1,737,317**
Financing Expense	194,928	183,367	197,249	198,265	183,367	209,254	95,292	185,867	766,491	2,293,576	2,962,306	(90,575)	(671,200)	(668,730)
Financing Income	903,825	238,960	228,125	250,741	259,482	228,125	260,000	294,346	646,162	3,157,257	3,155,532	(34,346)	(386,162)	1,725
Investment Income	58,156	46,181	164,066	54,996	46,181	46,777	28,984	46,181	49,701	560,966	724,763	(17,197)	(20,717)	(163,798)
Miscellaneous Income	69,492	177,387	121,862	243,075	170,125	250,735	8,942,649	212,641	498,962	20,307,804	11,924,005	8,730,008	8,443,687	8,383,799
Net Income (Change in Financial Position)	**(3,722,346)**	**(1,473,208)**	**(192,715)**	**(2,134,682)**	**(808,998)**	**(36,142)**	**2,400,606**	**(244,289)**	**785,068**	**5,249,885**	**4,604,609**	**2,644,895**	**1,615,538**	**645,276**
Operating Income	(4,558,891)	(1,752,369)	(509,519)	(2,485,229)	(1,101,419)	(352,524)	(6,735,735)	(611,590)	356,735	(16,482,566)	(8,237,386)	(6,124,145)	(7,092,470)	(8,245,180)
EBIDA	(3,313,182)	(1,109,630)	245,483	(1,725,518)	(445,420)	411,699	2,890,704	119,289	1,224,650	10,336,666	10,102,633	2,771,415	1,666,054	234,033
Net Profit Margin	-69.0%	-17.9%	-1.9%	-27.5%	-9.0%	-0.4%	54.0%	-2.6%	9.2%	5.2%	4.3%	56.6%	44.7%	0.9%
Operating Margin	-84.5%	-21.2%	-5.1%	-32.0%	-12.3%	-3.7%	-151.4%	-6.6%	4.2%	-16.4%	-7.7%	-144.8%	-155.6%	-8.7%
EBIDA Margin	-61.4%	-13.5%	2.5%	-22.2%	-5.0%	4.3%	65.0%	1.3%	14.4%	10.3%	9.4%	63.7%	50.6%	0.8%

Northern Inyo Healthcare District
Balance Sheet
Fiscal Year 2025

	PY Balances	2/29/2025	2/29/2024	3/31/2025	3/31/2024	4/30/2025	4/30/2024	5/31/2025	5/31/2024	6/30/2025	6/30/2024	PM Change	PY Change
Assets													
Current Assets													
Cash and Liquid Capital	18,718,414	17,437,514	8,770,199	18,774,677	12,778,438	19,449,093	8,030,005	19,669,998	21,374,165	20,757,956	18,718,414	1,087,957	2,039,542
Short Term Investments	6,418,451	7,419,400	6,335,363	7,253,236	6,336,695	7,742,770	6,412,401	7,741,372	6,414,343	7,741,599	6,418,451	227	1,323,148
PMA Partnership	-	-	-	-	-	-	-	-	-	-	-	-	-
Accounts Receivable, Net of Allowance	17,924,674	17,511,087	19,458,681	18,641,177	12,458,272	12,663,338	17,119,074	24,454,016	13,540,975	18,225,043	17,924,674	(6,228,973)	300,369
Other Receivables	4,754,052	10,409,887	19,050,631	9,013,770	18,203,532	9,700,579	17,139,611	(1,534,786)	7,531,522	9,295,249	4,754,052	10,830,035	4,541,197
Inventory	6,103,723	6,125,219	5,158,222	7,049,031	5,162,663	7,043,517	5,200,224	7,034,856	5,203,267	5,334,241	5,193,281	(1,700,614)	140,961
Prepaid Expenses	1,119,559	810,066	1,276,680	1,195,648	1,744,260	1,277,412	1,583,016	900,565	1,192,179	1,221,188	1,119,559	320,624	101,630
Total Current Assets	**55,038,873**	**59,713,172**	**60,049,776**	**61,927,539**	**56,683,861**	**57,876,709**	**55,484,330**	**58,266,021**	**55,256,452**	**62,575,277**	**54,128,430**	**4,309,256**	**8,446,846**
Assets Limited as to Use													
Internally Designated for Capital Acquisitio	-	-	-	-	-	-	-	-	-	-	-	-	-
Short Term - Restricted	1,467,786	1,468,789	1,467,283	1,468,917	1,467,411	1,469,040	1,467,535	1,469,168	1,467,662	1,469,292	1,467,786	124	1,506
Limited Use Assets			-		-		-		-		-	-	-
LAIF - DC Pension Board Restricted	-	-	-	-	-	-	-	-	-	-	-	-	-
LAIF - DB Pension Board Restricted	10,346,490	10,346,490	15,684,846	13,882,457	15,684,846	13,882,457	15,684,846	13,882,457	15,684,846	9,393,030	10,346,490	(4,489,427)	(953,460)
PEPRA - Deferred Outflows	-	-	-	-	-	-	-	-	-	-	-	-	-
PEPRA Pension	-	-	-	-	-	-	-	-	-	-	-	-	-
Deferred Outflow - Excess Acquisitio	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	573,097	-	-
Total Limited Use Assets	10,919,587	10,919,587	16,257,943	14,455,554	16,257,943	14,455,554	16,257,943	14,455,554	16,257,943	9,966,127	11,285,899	(4,489,427)	(1,319,772)
Revenue Bonds Held by a Trustee	376,411	330,616	1,051,852	324,871	1,046,147	319,127	962,817	313,383	957,113	297,382	10,099	(16,001)	287,283
Total Assets Limited as to Use	**12,763,784**	**12,718,991**	**18,777,078**	**16,249,342**	**18,771,501**	**16,243,722**	**18,688,294**	**16,238,105**	**18,682,718**	**11,732,801**	**12,763,784**	**(4,505,305)**	**(1,030,983)**
Long Term Assets													
Long Term Investment	1,846,138	748,360	1,831,779	(597,117)	1,832,199	497,075	1,834,470	496,765	1,840,643	497,086	1,846,138	321	(1,349,052)
Fixed Assets, Net of Depreciation	84,474,743	83,122,430	85,151,277	83,170,782	84,393,675	82,773,362	84,323,364	82,508,539	84,562,800	81,671,110	84,799,308	(837,428)	(3,128,197)
Total Long Term Assets	**86,320,881**	**83,870,790**	**86,983,056**	**82,573,665**	**86,225,875**	**83,270,437**	**86,157,833**	**83,005,303**	**86,403,444**	**82,168,196**	**86,645,446**	**(837,107)**	**(4,477,249)**
Total Assets	**154,123,537**	**156,302,954**	**165,809,910**	**160,750,547**	**161,681,236**	**157,390,868**	**160,330,458**	**157,509,429**	**160,342,614**	**156,476,274**	**153,537,660**	**(1,033,155)**	**2,938,614**
Liabilities													
Current Liabilities													
Current Maturities of Long-Term Debt	4,146,183	4,586,959	11,105,240	4,312,667	3,907,233	4,300,283	3,883,529	4,391,066	4,167,637	3,779,214	4,402,932	(611,852)	(623,718)
Accounts Payable	5,010,089	4,086,194	4,346,694	3,592,092	5,131,234	3,663,678	4,047,103	4,392,528	4,728,733	4,046,243	5,010,089	(346,285)	(963,846)
Accrued Payroll and Related	6,224,657	2,991,863	7,226,154	3,268,949	7,439,170	3,524,904	7,585,529	3,941,303	7,216,488	3,685,124	6,224,657	(256,179)	(2,539,533)
Accrued Interest and Sales Tax	109,159	424,010	238,080	144,235	314,125	220,309	140,964	141,308	39,126	162,526	109,159	21,218	53,368
Notes Payable	446,860	446,860	1,035,689	446,860	931,738	446,860	931,738	339,892	446,860	339,892	446,860	-	(106,968)
Unearned Revenue	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(4,542)	(1,812)	(4,542)	662	-	(4,542)	4,542	4,542
Due to 3rd Party Payors	693,247	693,247	693,247	1,637,684	693,247	1,637,684	693,247	(333,316)	693,247	3,324,903	693,247	3,658,219	2,631,656
Due to Specific Purpose Funds	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Deferred Credits - Pension & Leases	12,599,823	12,583,266	1,925,736	12,581,197	1,923,666	12,579,127	1,921,596	12,577,057	1,919,527	8,758,790	12,599,823	(3,818,268)	(3,841,033)
Total Current Liabilities	**29,225,475**	**25,807,857**	**26,566,297**	**25,979,142**	**20,335,871**	**26,368,305**	**19,201,894**	**25,445,296**	**19,212,280**	**24,096,692**	**29,482,225**	**(1,348,604)**	**(5,385,533)**
Long Term Liabilities													
Long Term Debt	36,301,355	33,732,107	29,290,060	33,749,977	35,863,988	33,648,895	36,434,249	33,547,552	36,382,902	33,252,083	36,301,355	(295,469)	(3,049,272)
Bond Premium	165,618	140,522	178,166	137,384	175,029	134,247	171,892	131,110	168,755	127,973	165,618	(3,137)	(37,645)
Accreted Interest	16,991,065	16,920,864	17,302,780	17,009,899	17,396,138	17,094,610	16,804,350	17,183,644	16,897,707	17,272,679	16,991,065	89,034	281,614
Other Non-Current Liability - Pension	32,946,355	32,946,355	47,257,663	32,946,355	47,257,663	32,946,355	47,257,663	32,946,355	47,257,663	31,874,258	32,946,355	(1,072,097)	(1,072,097)
Total Long Term Liabilities	**86,404,394**	**83,739,848**	**94,028,670**	**83,843,615**	**100,692,818**	**83,824,107**	**100,668,154**	**83,808,662**	**100,707,028**	**82,526,993**	**86,404,394**	**(1,281,669)**	**(3,877,400)**
Suspense Liabilities	-	-	-	-	-	-	-	-	-	-	-	-	-
Uncategorized Liabilities (grants)	31,506	127,821	124,918	139,321	123,693	139,321	124,093	139,321	122,993	61,310	31,506	(78,011)	29,804
Total Liabilities	**115,661,375**	**109,675,526**	**120,719,885**	**109,962,078**	**121,152,382**	**110,331,732**	**119,994,141**	**109,393,279**	**120,042,301**	**106,684,996**	**115,918,124**	**(2,708,284)**	**(9,233,129)**
Fund Balance													
Fund Balance	31,992,031	37,235,861	35,013,046	40,632,146	35,013,047	40,624,917	35,013,047	43,816,486	35,013,057	43,090,884	31,992,031	(725,601)	11,098,854
Temporarily Restricted	1,467,786	1,468,789	1,467,283	1,468,799	1,467,411	1,469,040	1,467,535	1,469,168	1,467,662	1,469,292	1,467,786	124	1,506
Net Income	5,002,346	7,922,778	8,609,695	8,687,524	4,048,396	4,965,178	3,855,735	2,830,496	3,819,593	5,231,102	4,416,468	2,400,606	814,634
Total Fund Balance	**38,462,163**	**46,627,427**	**45,090,024**	**50,788,469**	**40,528,854**	**47,059,136**	**40,336,317**	**48,116,150**	**40,300,313**	**49,791,279**	**37,876,285**	**1,675,128**	**11,914,993**
Liabilities + Fund Balance	**154,123,537**	**156,302,954**	**165,809,909**	**160,750,547**	**161,681,236**	**157,390,868**	**160,330,458**	**157,509,429**	**160,342,614**	**156,476,274**	**153,794,409**	**(1,033,155)**	**2,681,865**
(Decline)/Gain		(1,593,545)	7,268,230	4,447,593	(4,128,674)	(3,359,679)	(1,350,778)	118,561	12,156	(1,033,155)	(6,811,340)	(1,151,716)	5,778,184

Northern Inyo Healthcare District
Long-Term Debt Service Coverage Ratio
FYE 2025

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

Long-Term Debt Service Coverage Ratio Calculation

Numerator:	HOSPITAL FUND ONLY
Excess of revenues over expense	$ 5,249,885
+ Depreciation Expense	5,086,781
+ Interest Expense	2,293,576
Less GO Property Tax revenue	2,170,207
Less GO Interest Expense	486,152
"Income available for debt service"	**$ 9,973,882**
Denominator:	
Maximum "Annual Debt Service"	
2021A Revenue Bonds	$ 112,700
2021B Revenue Bonds	894,160
2009 GO Bonds (Fully Accreted Value)	
2016 GO Bonds	
Financed purchases and other loans	1,546,875
Total Maximum Annual Debt Service	**$ 2,553,735**
	2,553,735
Ratio: (numerator / denominator)	**3.91**
Required Debt Service Coverage Ratio:	1.10
In Compliance? (Y/N)	**Yes**

Unrestricted Funds and Days Cash on Hand

	HOSPITAL FUND ONLY
Cash and Investments-current	$ 28,499,555
Cash and Investments-non current	497,086
Sub-total	28,996,641
Less - Restricted:	
PRF and grants (Unearned Revenue)	-
Held with bond fiscal agent	-
Building and Nursing Fund	-
Total Unrestricted Funds	**$ 28,996,641**
Total Operating Expenses	$ 117,090,074
Less Depreciation	5,086,781
Net Expenses	112,003,293
Average Daily Operating Expense	$ 306,858
Days Cash on Hand	**94**

Northern Inyo Healthcare District
Statement of Cash Flows
Fiscal Year 2025

CASH FLOWS FROM OPERATING ACTIVITIES	
Receipts from and on Behalf of Patients	100,660,045
Payments to Suppliers and Contractors	(49,029,352)
Payments to and on Behalf of Employees	(64,151,246)
Other Receipts and Payments, Net	3,087,515
Net Cash Provided (Used) by Operating Activities	(9,433,038)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES	
Noncapital Contributions and Grants	14,617,744
Property Taxes Received	-
Other	3,157,257
Net Cash Provided (Used) by Noncapital Financing Activities	17,775,001
CASH FLOWS FROM CAPITAL AND CAPITAL RELATED FINANCING ACTIVITIES	
Principal Payments on Long-Term Debt	(1,862,332)
Proceeds from the Issuance of Refunding Revenue Bonds	-
Payment to Defease Revenue Bonds	-
Interest Paid	(2,293,576)
Purchase and Construction of Capital Assets	(1,088,396)
Payments on Lease Liability	(506,751)
Payments on Subscription Liability	(1,003,128)
Property Taxes Received	(93,747)
Net Cash Provided (Used) by Capital and Capital Related Financing Activities	(6,847,930)
CASH FLOWS FROM INVESTING ACTIVITIES	
Investment Income	560,966
Rental Income	-
Net Cash Provided (Used) by Investing Activities	560,966
NET CHANGE IN CASH AND CASH EQUIVALENTS	2,054,999
Cash and Cash Equivalents - Beginning of Year	25,136,864
CASH AND CASH EQUIVALENTS - END OF YEAR	27,191,863